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October 19, 2020

Green Mountain Care Board
State of Vermont
144 State Street
Montpelier, VT 05602

Re: MVP Health Plan, Inc.
2021 Large Group HMO Rate Filing
SERFF #: MVPH-132497714

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 2021 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 and includes proposed rates for all four quarters of 2021. This product portfolio is comprised of base major medial high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and benefit riders. Additional riders were previously available on the MVP Health Insurance Company (MVPHIC) license; however, as of April 2019, the entire product portfolio has migrated to MVP Health Plan.

3. As of February 2020, there were approximately 2,100 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 2021:

Reason for Change	1Q '21 Annual Increase
Manual Rate Change	-3.3%
Age/Gender Factor Changes	1.2%
Change in Retention	1.0%
Total Premium Change	***-1.2%***

   The rate decrease 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 represented in this filing have premium rates based on an average a blend of their own claims experience at approximately 35% and the manual rate at approximately

65%. 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. For this filing, 80% of groups renew in the first quarter.

The total premium changes for quarters 2, 3 and 4 vary slightly from the -1.2% due to quarterly trend changes and COVID-19 adjustments.

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 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 March 2019 through February 2020 and paid through April 2020 (with incurred estimates updated through June 2020) as the base period experience. The base period data is 100% credible. MVP elected not to include 2020 incurral months more recent than February due to COVID-19 suppressed claims which are not representative of 2021 expected claim costs.

   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 1Q21.

   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 12.8% 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

   Claims exceeding $100,000 made up 8.2% of the base period experience. 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 13.1%. 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. This practice is reasonable

and appropriate.

The adjusted claims were projected forward to the midpoint of the 1Q21 rating period using an annual paid medical trend assumption of 7.4% (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 1Q21 rating period using an annual paid Rx trend of 8.6% (elaborated further in item 4 below).

The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q21. These adjustments included projected cost of capitation, non-FFS claim expenses, Rx rebates, and the COVID-19 pandemic (elaborated further in item 5 below). Reflecting these adjustments, the quarterly manual rate change suggested by the data was -7.8% for 1Q21.

MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims and reducing the COVID-19 pent-up demand impact. This results in quarterly manual rate increases of between 1.8% and 2.1% in each quarter of 2021. That is, groups renewing in April will be charged premiums based on manual rates approximately 1.8% - 2.1% higher than groups renewing in January. As noted above, approximately 80% of groups have 1st quarter renewal dates.

Quarter	Manual Rate Change
1Q '21 / 4Q '20	-7.8%
2Q '21 / 1Q '21	1.8%
3Q '21 / 2Q '21	2.0%
4Q '21 / 3Q '21	2.1%

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:* 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 younger than the prior experience period, resulting in decreased revenue available to cover claims. The demographic factors were re-normalized to reflect the updated experience and increased by 1.2% to maintain the necessary premium level. The age/gender normalization methodology appears to be reasonable and appropriate.

3. *Medical Trend:* MVP is requesting a utilization trend of 1.0% and a unit cost trend of 6.6% for 2021. This represents a total allowed trend of 7.7% for 2021. Below are the allowed and paid medical trends:

[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.

Medical Trend	Unit Cost	Utilization	Total Allowed Trend	Paid Trend
2020	3.7%	1.0%	4.7%	5.7%
2021	6.6%	1.0%	7.7%	7.4%
2022	6.2%	1.0%	7.2%	7.4%

The allowed cost trends illustrated above are based on 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 7.4% 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-two months of trend were used to trend the experience period claims forward to 1Q21.

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

Service Category	2020	2021	2022
Inpatient	6.1%	8.5%	8.5%
Outpatient	5.5%	8.5%	8.5%
Physician	2.4%	5.6%	3.9%
Other Medical	3.0%	6.1%	6.1%
Total Allowed Trend	**4.7%**	**7.7%**	**7.2%**

Utilization Trend

MVP analyzed its combined MVPHIC and MVPHP Vermont data for 36 months between 2017 and 2019 to assess the utilization trend. However, 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 (Vermont Health Connect) 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 and review of the 2020 QHP filing and used a utilization trend assumption of 1.0%, consistent with utilization trend used in the 2021 QHP filing. Based on all information available at this time, the utilization trend of 1.0% is reasonable and appropriate.

Unit Cost Trend

The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. Since the filing was submitted, the Green Mountain Care Board has made final decisions regarding 2021 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 ordered hospital budget amounts[2]. The impact of this change is as follows:

[2] https://gmcboard.vermont.gov/FY21IndividualHospitalBudgetIndividual

Manual Rate Change	1Q '21 / 4Q '20	2Q '21 / 1Q '21	3Q '21 / 2Q '21	4Q '21 / 3Q '21
MVP's Initial Assumption	-7.8%	1.8%	2.0%	2.1%
Reflecting Final Order	-8.6%	1.7%	1.9%	2.0%

4. *Rx Trend:* MVP analyzes its pharmacy data by drug category (Generic, Brand, Specialty). MVP is requesting the annual allowed trends illustrated in the chart below, split by calendar year and by drug tier:

	2020 Trend		2021 Trend		2022 Trend	
Tier	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Generic	-16.6%	2.8%	-8.9%	2.3%	-8.9%	2.3%
Brand	11.9%	-6.8%	4.6%	1.5%	4.6%	1.5%
Specialty	6.4%	8.4%	6.0%	9.1%	6.0%	9.1%

The annualized total allowed trend derived from the allowed trends in the chart above is 7.9%, which is composed of a utilization trend of 2.4% and a unit cost trend of 5.3%. The following table shows the actual pharmacy allowed trends for the last 3 years:

Year	Actual Trend
2019/2018	7.1%
2018/2017	0.6%
2017/2016	9.0%

Annual allowed trend factors by drug category were supplied by MVP's pharmacy benefit manager (PBM), reflecting MVP's business in the state of Vermont. The table below shows the comparison of the historical PBM expected trends to the actual allowed trends.

Year	Actual Trend	Expected Trend	Actual-to-Expected Ratio
2019/2018	7.1%	8.2%	0.87
2018/2017	0.6%	11.6%	0.05
2017/2016	9.0%	10.7%	0.84

The annualized effective paid trend is 8.6%, which is shown in Exhibits 2b-d of the filing. The Rx paid trend, which adjusts the allowed trends to account for cost sharing by the insured (by modeling deductible, copay and coinsurance), is used to trend the experience period claim costs to the projection period.

MVP is using 2021 drug rebate forecasts provided by the PBM. These forecasts assume that drug rebates will equal $24.42 PMPM for 1Q 2021 renewals and increasing with pharmacy trend for later quarters.

With the exception of 2018/2017, MVP and their PBM trends have been slightly higher than the actuals seen in that year. L&E considers the 2018/2017 trend to be an outlier due to an unusual negative trend in specialty drugs that year which is not expected to be repeated. As further consideration, it should be noted that MVP's allowed Rx trend in the QHP filing was 7.2%, and the BCBSVT QHP filing assumed an

allowed Rx trend of 13.4%. Considering this information, L&E finds the allowed Rx trend of 7.9% to be reasonable and appropriate.

5. *COVID-19:* A COVID-19 impact of and additional $6.50 PMPM claim costs in 1Q21 is being requested by MVP, which includes $1.50 for pent-up demand and $5.00 PMPM for immunization costs.

   As a result of the COVID-19 pandemic, elective surgeries and associated services were postponed for two months in 2020 (mid-March through mid-May 2020). Based on a Society of Actuaries research paper, "Potential Impact of Pandemic Influenza on the U.S. Health Insurance Industry"[3], the Company assumed that 20% of these deferred services will not be ultimately fulfilled. Based on information from the Company's medical management team, providers of elective services were already working at near full capacity prior to the pandemic.

   The Company believes that providers will be financially incentivized to recoup lost revenue during the pandemic. Therefore, to fulfill the remaining 80% of deferred services, MVP assumed that providers will operate at 110% capacity beginning in August 2020 through April 2021.

   In 2019, elective services cost $45.09 PMPM. An increase of 10% would result in $4.51 PMPM of additional costs. This increase produces an annualized 2021 increase of $1.50 PMPM. This development assumes that there will not be a second wave of stay-at-home orders in 2020 or 2021.

   L&E does not believe that the assumption that providers will run at 110% capacity is adequately supported based on the following:

   - Providers have had an opportunity to receive financial assistance from the government[4] to alleviate financial hardship, which reduces the financial incentive to run at greater than 100% capacity in the future.

   - There is an immense uncertainty regarding how long social distancing, cleaning, and other safety guidelines[5] will continue into 2021, which limits hospital capacity.

   - Vermont had a quicker than average turnaround from shelter-in-place to reopening, which potentially sets the stage for all deferred care to be recouped in 2020 while not exceeding 100% capacity.[6,7]

   - Vermont is unlikely to see a second wave due to its older, more compliant residents and rural environment.

   L&E recommends that the additional PMPM claims costs for COVID-19 pent-up demand be removed.

[3] https://www.soa.org/globalassets/assets/files/research/projects/research-2010-pandemic-health-report.pdf

[4] https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html

[5] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.html

[6] https://governor.vermont.gov/press-release/governor-phil-scott-issues-"stay-home-stay-safe"-order-directs-additional-closures

[7] https://governor.vermont.gov/press-release/governor-phil-scott-announces-some-elective-health-care-procedures-resume

The Company assumed that a vaccine will be available beginning in January 2021, based on the Federal Government announcement of Operation Warp Speed[8] and initiated Phase II/II clinical trials for testing as of July[9]. The Company assumed that the vaccine cost will be $75, which is based on the cost of Tamiflu.

The Company assumed that 80% of the covered population will receive the vaccination in 2021. This assumption was based on published research by Wakely Consulting Group[10]. While the Company acknowledges that flu vaccination rates are lower, at approximately 55%, the Company believes that the vaccination rate for COVID-19 will be higher than the vaccination rate for the flu. This was assumed because of the unique nature of the removal of social distancing requirements being contingent on individuals receiving the vaccine. These COVID-19 vaccination assumptions produce a projected 2021 PMPM cost of $5.00 ($75 * 80% / 12).

L&E believes that the assumed vaccination rate of 80% is not adequately supported based on the following:

- L&E considers the 80% vaccination rate used in the Wakely report to be an example scenario, not the expected scenario.
- The filing does not consider that there could be constraints in supply of a vaccine, once available, which would restrict access to the most vulnerable population initially[11]. The most vulnerable population being covered more widely under Medicare and Medicaid, rather than commercial coverage.
- The filing does not consider potential cost coverage by the federal government.
- The filing does not consider people may be wary of the COVID-19 vaccine initially given the increased speed at which it was developed and therefore potential unknown effectiveness and side effects.

It should be noted that these are the same assumptions that were presented in the 2021 QHP filings that were filed in early May 2020. When asked about more recent data or what MVP consider in light of the fact that 3 or more months of experience was now available to modify or support the assumptions made, MVP stated that they did not make any new considerations based on emerging data. MVP expressed that this decision was due to uncertainty surrounding the completion of the emerging claims data since the pandemic has affected claims processing speeds.

L&E believes a more reasonable assumption for the 2021 COVID-19 vaccination rate is consistent with flu vaccination rates and recommends a vaccination rate assumption of 55%[12], though this

[8] https://www.hhs.gov/about/news/2020/05/15/trump-administration-announces-framework-and-leadership-foroperation-warp-speed.html. Stated goal is "to have substantial quantities of a safe and effective vaccine available for Americans by January 2021."

[9] London School of Hygiene and Tropical Medicine's vaccine pipeline tracker, https://vac-lshtm.shinyapps.io/ncov_vaccine_landscape/

[10] "COVID-19 Cost Scenario Modeling"

[11] https://hub.jhu.edu/2020/07/01/covid-vaccine-ethics-faden/

[12] "https://www.cdc.gov/flu/fluvaxview/coverage-1819estimates.htm"

recommendation is not to insinuate that the severity of COVID-19 is equal to the flu. The impact of this change will be a reduction of approximately 0.6% to rates. In the 2021 QHP filing, the Board ordered that all assumptions regarding COVID-19 be removed.

6. *Retention:* As in the prior approved filing, retention charges are added to the blended pure premium in deriving the group required premium. The 14.3% total retention load is composed of the following:

Retention Item	Retention Percentage
General Expenses	8.6%
Broker Load	2.6%
VT Vaccine Pilot	0.5%
Bad Debt	0.3%
18 V.S.A § 9374(h)(1) Billback	0.3%
Contribution to Reserves (CTR)	2.0%
Total Retention	**14.3%**

The projected administrative expenses of 8.6% of premium is less than the actual calendar year 2019 expenses of 9.3% as seen in the table below.

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
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%
2019	22,511	$499.97	$46.35	9.3%

The administrative load appears to be reasonable and appropriate.

The target loss ratio is decreasing from 86.6% in 1Q 2020 to 85.7% for 2021. This change is the result of increasing the contribution to reserve from 1.0% to 2.0%, the reintroduction of the Comparative Effectiveness Research Tax, an increase in the administrative load from 8.2% to 8.6%, and an increase in the Vermont Vaccine Pilot Program Fee. This is offset by a decrease to the billback amounts paid to the state of Vermont and the removal of the ACA insurer tax.

The federal loss ratio for MVPHP in 2019 is 76.9%, and the rolling three-year average (2017-2019) is 91.8%.

The proposed contribution to reserves (CTR) is 2.0%, which is consistent with historically proposed CTR. In past orders, the Board has reduced the proposed CTR. We recommend that the solvency analysis performed by the Department of Financial Regulation be considered if changes are made to this assumption. The proposed CTR appears to be reasonable and appropriate.

7. *Rate Increase felt by Vermonters:* For calendar year 2019, MVP's large group block of business experienced a 76.7% loss ratio.

Groups	2019 Loss Ratio
Q1 Renewals	73.3%
Terminated Groups & 2Q – 4Q Renewals	100.1%
All Groups Combined	**76.7%**

In practice, the large groups represented in this filing have premium rates based on an average blend of their own claims experience at approximately 35% and the manual rate at approximately 65%. As a result, the -1.2% decrease 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 -0.9%.

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 FY2021 hospital budgets. This will decrease the 2021 first quarter rates by -0.8%.

- *COVID-19 Adjustment:* L&E recommends that the COVID-19 pent-up demand adjustment be removed, and the COVID-19 vaccination adjustment be reduced using a 55% vaccination rate. This will decrease the 2021 first quarter rates by -0.6%.

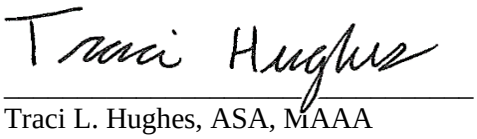
The revised rate increase is as follows:

Quarter	Manual Rate Change
1Q '21 / 4Q '20	-9.2%
2Q '21 / 1Q '21	1.9%
3Q '21 / 2Q '21	2.0%
4Q '21 / 3Q '21	2.0%

Reason for Change	1Q '21 Annual Increase
Manual Rate Change	-4.7%
Age/Gender Factor Changes	1.2%
Change in Retention	1.0%
Total Premium Change	***-2.6%***

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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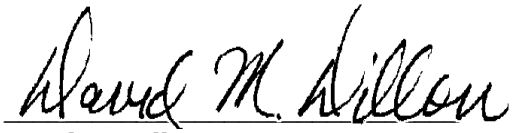

David M. Dillon, FSA, MAAA, MS
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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[13], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[14], 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:

- Traci L. Hughes, ASA, MAAA Consulting Actuary 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 19, 2020. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is October 12, 2020.

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.

[13] 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.

[14] 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.