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October 5, 2021

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

Re: MVP Health Plan, Inc.
2022 Large Group HMO Rate Filing
SERFF #: MVPH-132932250

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 2022 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 2022. This product portfolio is comprised of base major medical high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and benefit riders. The example below demonstrates a 1st quarter 2022 manual rate calculation for a group with a base major medical health plan, a medical benefit rider, a pharmacy benefit rider, and a point-of-service (POS) rider (i.e., adds out-of-network coverage):

a) Base Major Medical Health Plan VT3HMO087ZLBN	$551.24	
b) Medical Rider MV3HMB306L	$6.07	
c) Rx Rider RXVT3HMB500ZL	$82.22	
d) Combined In-Network Manual Base Rate[1]	$639.53	= a) + b) + c)
e) POS Rider SV3HMB101L	3.60%	
f) Combined Manual Base Rate w/ POS Rider	$662.55	= d) * [1 + e)]

3. As of May 2021, there were approximately 2,100 members enrolled in MVP large group plans in Vermont. Approximately 80% have renewal dates during 1st quarter.

   The company's average annual rate increase is 8.5%. Below is the annualized rate change for the first

[1] Base Rate refers to the premium rate prior to the application of rating factors (ex. age/gender) and retention.

quarter renewals in 2022 as initially filed:

Reason for Change	1Q '22 Annual Increase
Base Rate Change	7.7%
Age/Gender Factor Changes	0.0%
Change in Retention	0.7%
Total Manual Rate Change	***8.5%***

The 1Q22 base rate change of 7.7% is equal to previously approved quarterly manual rate changes for 2Q21 thru 4Q21 combined with the proposed 1Q22 quarterly manual rate change and membership distribution shift. This is outlined as follows:

Quarter	1Q '22 Annual Manual Rate Change
2Q '21 / 1Q '21	1.9%
3Q '21 / 2Q '21	1.9%
4Q '21 / 3Q '21	1.9%
1Q '22 / 4Q '21	1.3%
Membership Distribution Shift[2]	0.5%
Total	**7.7%**

The quarterly manual rate changes through the remainder of calendar year 2022 are all equal to 2.1% representing the assumed quarterly trend.

Quarter	Manual Rate Change
2Q '22 / 1Q '22	2.1%
3Q '22 / 2Q '22	2.1%
4Q '22 / 3Q '22	2.1%

The following table outlines the proposed annual base and total manual rate changes for each quarter in 2022.

Quarter	Membership as of May 21	Filed Annual Base Rate Change	Filed Annual Total Manual Rate Change
1Q22	1,677	7.7%	8.5%
2Q22	0	7.9%	8.7%
3Q22	301	8.1%	8.9%
4Q22	116	8.4%	9.1%

The proposed rate changes discussed above reflects the revenue increase 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 blend of their own claims experience at approximately 32% and the manual rate at approximately 68%. 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

[2] The difference in the current membership distribution at the time of the previously approved filing versus this filing.

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.

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-2b and Exhibit 3a-3b) and details pertinent to its actuarial assumptions/experience driving the rate change request. This includes supplemental exhibits comprising historical claim data and the membership, 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 May 2021 (with incurred estimates updated through June 2021) as the base period experience. The base period data is considered 100% credible. MVP elected not to include 2020 incurral months more recent than February 2020 due to COVID-19 impacted claims, which are not anticipated to be representative of 2022 expected claim costs.

   MVP provided historical normalized allowed claims PMPM by month through May 2021 for this block of business, shown in the table below.

Time Period	Normalized All'd Claims PMPM	Observed All'd Claims Trend
2018	$550.11	
2019	$463.12	-15.8%
2020	$574.25	24.0%
1Q21-2Q21	$494.84	-13.8%

   Due to claims historical volatility and the impact of COVID-19 on 2020 claims data, L&E believes utilizing data from March 2019 to February 2020 as the experience period is reasonable and appropriate.

   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 1Q22.

   From the historical medical experience, claims in excess of $250,000 were replaced with a pooling charge. The pooling charge reflects the average cost of claims in excess of $250,000 and is based on historical experience. The pooling charge is equal to 4.4% of claims below the pooling limit. MVP uses a pooling charge to mitigate the impact of catastrophic claims (i.e., those exceeding $250,000 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, the claims 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 $250,000 made up 2.7% of the base period experience. We reviewed the actual large group experience in Vermont and the claims above the pooling limit of $250,000 for the prior 5 years has ranged from 1.4% to 9.3%, with an average of 6.2%. 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 1Q22 rating period using an annual paid medical trend assumption of 6.7% (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[3]. The prescription (Rx) claims were projected forward to the midpoint of the 1Q22 rating period using an annual paid Rx trend of 16.9% (elaborated further in item 4 below).

The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q22. These adjustments included projected cost of capitation, non-FFS claim expenses, Rx rebates, newly added benefits, and COVID-19 boosters (elaborated further in item 5 below). Reflecting these adjustments, the quarterly manual rate change suggested by the data was 1.3% for 1Q22 compared to 4Q21.

Because there is a difference in the membership distribution at the time of the previously approved filing as compared to this filing, there is an adjustment for this change in the mix of enrollment. The company filed an impact of 0.5% to rates. However, during the review, an error was found in the calculation of the membership distribution. The revised calculation is resulted in a -0.3% decrease to the rates. L&E recommends that this adjustment be made.

MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims. This results in quarterly manual rate increases of 2.1% in each quarter of 2022. That is, groups renewing in April will be charged premiums based on manual rates 2.1% higher than groups renewing in January. As noted above, approximately 80% 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 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 this filing utilizes the same experience period as the prior filing, there is no impact to the rates for age/gender normalization. The age/gender normalization methodology appears to be reasonable and appropriate.

[3] 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.

3. *Medical Trend:* MVP is requesting a utilization trend of 1.0% and a unit cost trend of 4.7% for 2022. This represents a total allowed trend of 5.8%[4] for 2022. Below are the allowed and paid medical trends:

Medical Trend	Unit Cost	Utilization	Total Allowed Trend	Paid Trend
2020	3.4%	1.0%	4.4%	5.4%
2021	4.9%	1.0%	6.0%	6.9%
2022	5.7%	1.0%	6.7%	7.7%
2020-2022 Avg.	4.7%	1.0%	5.8%	6.7%

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. Using the paid trends for each year as shown in the table above, MVP derived a total average annual paid medical trend factor of 6.7%, which was applied for 34 months to trend the experience forward to 1Q22.

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 & 2022 QHP filings. 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. For providers not subject to GMCB Hospital Budget Review, unit cost trend assumptions are based on established contracts where available and best estimates of contract negotiations where established contracts are not available. For providers subject to GMCB Hospital Budget Review, unit cost trend assumptions are based on proposed cost increases as submitted by providers for the Hospital Budget Review.

During the review of this filing, it was found that the assumed unit cost trends for some providers subject to GMCB review were not reflective of the most up-to-date and accurate proposed cost increases by service category. MVP provided support to correct those unit cost trends identified but proposed no change to the proposed rate increase due to the overall unit cost impact being less than 0.1%. L&E confirmed that the overall impact to the development of the rate and resulting rate increase calculated is immaterial.

Since the filing was submitted, the Green Mountain Care Board has made final decisions regarding 2022 hospital budgets. The budgeted unit cost increases are lower than anticipated at the time of the filing.

[4] [(1.047)*(1.01)]-1=5.8%

Therefore, we recommend that MVP modify the filing to reflect the ordered hospital budget amounts[5]. The impact of this change is as follows:

Manual Rate Change	1Q '21 / 4Q '20	2Q '21 / 1Q '21	3Q '21 / 2Q '21	4Q '21 / 3Q '21
MVP's Initial Assumption	1.3%	2.1%	2.1%	2.1%
Reflecting Final Order	0.7%	2.0%	2.0%	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	6.0%	10.0%	-3.8%	2.2%	-2.8%	2.6%
Brand	11.7%	6.3%	8.1%	4.8%	4.1%	2.6%
Specialty	5.8%	20.1%	5.3%	10.2%	6.8%	12.0%

The total allowed trends in each year are as follows:

Year	Assumed Trend
2020	22.9%
2021	11.6%
2022	13.1%
2020-2022 Avg.	15.3%

The average annual allowed trend of 15.3% is composed of a utilization trend of 4.7% and a unit cost trend of 10.2%.

The following table shows the actual pharmacy allowed trends for the last 4 years:

Year	Actual Trend
2020/2019	53.9%
2019/2018	7.1%
2018/2017	0.6%
2017/2016	9.0%

[5] https://gmcboard.vermont.gov/hospital_budget_individual_information_FY2022

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
2020/2019	53.9%	5.6%	9.63
2019/2018	7.1%	8.2%	0.87
2018/2017	0.6%	11.6%	0.05
2017/2016	9.0%	10.7%	0.84
4-year Average	17.7%	9.0%	1.96

The annualized effective paid trend is 16.9%, which is shown in Exhibit 2b 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 2022 drug rebate forecasts provided by the PBM. These forecasts assume that drug rebates will equal $32.58 PMPM for 1Q 2022 renewals.

MVP cited that the driver of the large pharmacy trend observed is due to an outlier increase in specialty drug utilization due to chronic condition diagnoses that are non-COVID related that generally require continued Rx use. Even though the actual total Rx trend in 2020 is known, an assumed trend for 2020 that was less than half of the actual was used. MVP made this lower assumption based on information provided by the PBM that was based on a more credible data set that included MVP's VT small group and individual population.

Using MVP's trend assumption, Exhibit 3a shows that the projected gross Rx allowed claims PMPM for 1Q22 is $105.91. Per MVP's response to L&E first rate review objection letter, the actual gross Rx allowed claims PMPM in 2020 $110.67 and the first half of 2021 is $101.32.

Time Period	Rx Allowed Claims PMPM
1Q20-4Q20 (Actual)	$110.67
1Q21-2Q21 (Actual)	$101.32
1Q22 (Projected)	$105.91

L&E would prefer a methodology that utilized the actual 2020 trend, given the specialty drug and chronic condition information previously stated above and lower trends in 2021 and 2022. However, L&E finds the overall projected Rx allowed claims PMPM appear reasonable and appropriate.

5. *COVID-19 Boosters:* A COVID-19 impact of an additional $1.45 PMPM claim costs in 1Q22 is being requested by MVP for COVID-19 booster shots. This cost is based on MVP's flu vaccine uptake of approximately 29% (not including VT Vaccine Pilot utilization) and $56.00 unit cost experience.

   MVP cites the various sources, such as Pfizer and Moderna, NPR, and White House press, as support for the assumption that COVID-19 booster shots will be approved and needed in 2022. As of September 2021,

the CDC recommends an additional dose of the COVID-19 vaccine for moderately to severely immunocompromised adults[6]. At this time, the CDC does not recommend an additional dose for any other population. However, the U.S. Department of Health and Human Services released a statement stating a plan to offer booster shots to all Americans in the fall of 2021, subject to FDA approval and the determination of the safety and effectiveness of a third vaccination dose[7].

MVP provided actual COVID-19 PMPM costs from December 2020 to May 2021 of $1.39, which represents only the administration cost of the vaccine since the drug ingredient cost has been paid for by the federal government. These actual costs provided by MVP represent utilizers of 2-dose vaccinations, while only 1 additional dose is currently expected to be recommended for the booster. Given the additional utilization expected is half of the initial utilization, L&E recommends reducing the assumed booster costs from the assumed $1.45 PMPM to $0.70 PMPM ($1.39*0.5). This will decrease the 2021 first quarter rates by 0.2%.

6. *Retention:* As in the prior approved filing, retention charges are added to the blended pure premium in deriving the group required premium. The 14.0% total retention load is composed of the following:

Retention Item	Proposed 2022 Retention	Approved 2021 Retention
Administrative Expenses	8.2%	8.6%
Other Expenses	3.8%	3.7%
Contribution to Reserves (CTR)	2.0%	1.0%
Total Retention	**14.0%**	**13.3%**

Administrative Expenses

The projected administrative expenses of 8.2% of premium is consistent with the average of the most recent two years of 8.1% and is less than the average of the most recent three years of 8.7%.
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
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%
2020	23,424	$540.97	$38.45	7.1%

The administrative load appears to be reasonable and appropriate.

[6] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/immuno.html
[7] https://www.cdc.gov/media/releases/2021/s0818-covid-19-booster-shots.html

Other Expenses

The breakdown of the other expenses is as follows:

Retention Item	Proposed 2022 Retention	Approved 2021 Retention
Broker Load	2.6%	2.6%
VT Vaccine Pilot	0.5%	0.5%
Bad Debt	0.3%	0.3%
18 VSA 9374(h) Billback	0.3%	0.2%
Comparative Effectiveness Research Fee	0.1%	0.1%
Total Retention	**3.8%**	**3.7%**

Contribution to Reserves (CTR)

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. L&E recommends that the solvency analysis performed by the Department of Financial Regulation (DFR) be considered if changes are made to this assumption. The proposed CTR appears to be reasonable and appropriate.

The target loss ratio is decreasing from the approved 86.7% 1Q 2021 to 86.1% for 2022. This change is the result of increasing the contribution to reserve from 1.0% to 2.0% and is offset by a decrease in the administrative load from 8.6% to 8.2%.

The following table shows estimated premium and admin PMPMs for 2021 and 2022:

Administrative Expense Summary for Large Group Products				
	Member Months	Premium PMPM	Admin PMPM	Expense Ratio
2021	TBD	$490.47	$42.18	8.6%
2022	TBD	$531.96	$43.62	8.2%

The federal loss ratio for MVPHP in 2020 is 100.3%, and the rolling three-year average (2018-2020) is 93.4%.

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

- *Rate Increase Calculation:* Initially, the company filed an 8.5% average rate increase. However, during the review, an error was found in the calculation of the rate increase and the revised calculation is resulted in a -0.3% decrease to the rates.

- *Green Mountain Care Board (GMCB) Hospital Budget:* L&E recommends revising the trends to reflect the final orders regarding FY2022 hospital budgets. This will decrease the 2021 first quarter rates by -0.6%.

- *COIVD-19 Booster*: Given historical actual COVID-19 vaccination costs PMPM and the expectation of only 1 additional vaccine does compared to the initial 2-dose vaccine, L&E recommends reducing the assumed booster costs from the assumed $1.45 PMPM to $0.70 PMPM. This will decrease the 2021 first quarter rates by -0.2%.

The recommended rate increase is as follows:

Reason for Change	1Q '22 Annual Increase
Base Rate Change	6.6%
Age/Gender Factor Changes	0.0%
Change in Retention	0.7%
Total Manual Rate Change	***7.3%***

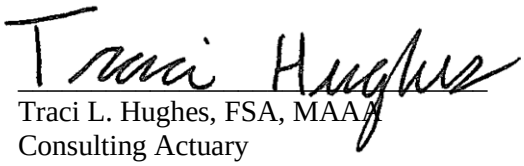
Quarter	1Q '22 Annual Manual Rate Change
2Q '21 / 1Q '21	1.9%
3Q '21 / 2Q '21	1.9%
4Q '21 / 3Q '21	1.9%
1Q '22 / 4Q '21	0.5%
Membership Distribution Shift	0.2%
Total	**6.6%**

Quarter	Manual Rate Change
2Q '22 / 1Q '22	2.0%
3Q '22 / 2Q '22	2.0%
4Q '22 / 3Q '22	2.0%

Quarter	Membership as of May 21	Recommended Annual Base Rate Change	Recommended Annual Total Manual Rate Change
1Q22	1,677	6.6%	7.3%
2Q22	0	6.7%	7.4%
3Q22	301	6.8%	7.5%
4Q22	116	6.9%	7.6%

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

Sincerely,



Traci L. Hughes, FSA, MAAA
Consulting Actuary
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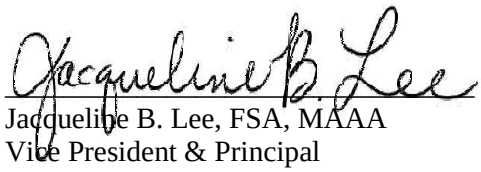

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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[8], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[9], 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, FSA, 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 4, 2021. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is September 7, 2021.

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.

Actuarial Findings

[8] 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.

[9] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

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.