May 18, 2016

Matt Lombardo
MVP Health Insurance Company
625 State Street
Schenectady, NY 12305

Re: MVP Health Plan, Inc.
2017 Vermont Exchange Rate Filing
SERFF Tracking #: MVPH-130558905
Objection #1

Dear Mr. Lombardo:

The following additional information is required for this filing.

Base Period Data

1. Given that the Exchange experience comprises almost 65,000 member months, which is more than 5 times the full credibility standard used by MVP in large group rate-setting, why was ACA compliant experience not at least given greater weight than experience for other blocks of business?
   Source: URRT

Trend

2. For the ACA compliant plans, please provide individual 36 month history of medical claims and Rx claims split by drug category in a format similar to "Rolling 12 Medical and Rx Data.xls" provided in earlier filings and clearly illustrate normalized historic medical and Rx trends.
   a. Please include measures of medical utilization by service category to substantiate the claim that historical utilization trends are weak and not reliable.
3. How do the assumed trends reflect the impact of changes to the Vermont Hospital Budgets?

Experience Adjustments

4. The IBNR adjustment for recent MVP filings with two months of run-out has been approximately 2%. The base period experience in this filing has an extra month of run-out but has essentially the same IBNR adjustment being applied. Support the IBNR adjustments used in this filing, and explain any changes in methodology between recent filings such as MVPH-130435575 and MVPH-130454426.
   Source: Exh 3 Row 5
5. Provide calculations in spreadsheet format of the average "Benefit Relativity" and "Induced Demand" factors of 0.711 and 1.045, respectively, applied to projected claims in Exhibit 6.
   Source: Exh 6 Cells F8, F9
6. The rate calculation assumes that the $6.65 PMPM allocated to claims settlement expense is a claims expense. Explain the nature of this cost further and why it is included in allowed costs rather than treating this expense as an element of retention.
   Source: Exh 3 Row 3
7. Did MVP perform a study of whether their experience is consistent with the HHS induced utilization factors?
8. Please reconcile the capitation and non-FFS medical costs in the actuarial memorandum with the costs shown in Exhibit 3.
   Source: Exh 3 Row 13
9. Please provide the breakdown of subscriber months and member months between contract types for all market segments included in the development of the index rate.

Non-Benefit Expenses

10. The allocation of the Health Care Advocate assessment seems to assume that MVP has a 56.7% Vermont market share based on earned Premium. Provide support for this assumption.
    Source: Actuarial Memorandum Page 9
11. Provide justification for the inclusion of the Health Care Advocate assessment. Our research and discussions with the GMCB does not show that this was approved as an expense for carriers.
    Source: Actuarial Memorandum Page 9
12. Please reconcile the administrative expenses in the Actuarial dataset to the expenses shown in Exhibits 5 and 6.
13. Please reconcile the assumed general admin load with the 2015 Supplemental Healthcare Exhibit.

Metal AV's

14. The Gold plan FRVT-HMO-G-002-N does not meet the de minimis requirement when calculated from the AV calculator. The AV exhibit provided shows an adjustment of 1.0013 made to the calculator AV, which is not addressed in the AV certification provided. Explain and support this factor.
15. Reconcile the actual generic Rx copays to the copays assumed in the AV calculations.

Risk Adjustment

16. The actuarial memorandum states that the projected risk adjustment payment was multiplied by a factor of 2/3 due to the impact of the 2014 open enrollment period and

the low turnover from 2014 members to 2015 members. Please explain this logic more fully. For example:

a. Why would the extended 2014 open enrollment period, which affected all carriers, be expected to increase MVP's risk score in 2017 relative to the market average (or decrease MVP's risk score in 2014)?
b. Risk adjustment payments are a function of several factors including premium levels, which have increased more than 10% since 2014. Was any more sophisticated analysis performed on the risk adjustment payment than estimating a factor of 2/3 due to the reasons stated above?

Source: Actuarial Memorandum Page 8

17. The non-ACA enrollment used in the development of the manual rate was not part of the 2014 risk adjustment payment. However, the relative risk adjustment projection does not take into account the morbidity of these populations. Support the implicit assumption that these populations have similar risk adjustment characteristics to the 2014 Exchange population.
18. How was the preliminary risk adjustment report considered in the development of the population morbidity and/or Risk Adjustment PMPM assumptions?

URRT

19. Provide quantitative support for the development of the following factors and figures in Worksheet 1 of the URRT and how each ties to Exh 3:
    a. Other Factor
    b. Projected Allowed Experience Claims PMPM
    c. Projected Risk Adjustments PMPM
20. Is the manual rate in the URRT reflective of all experience, or non-ACA plans only?

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible, but no later than June 1, 2016.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

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