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June 24, 2016

Mr. Kevin Ruggeberg, ASA, MAAA  
Lewis & Ellis, Inc.  
P.O. Box 851857  
Richardson, TX 75085

Re: 2017 Vermont Exchange Rate Filing  
SERFF Tracking #: MVPH-130558905  
Response to Objection Letter #4

Dear Mr. Ruggeberg:

This letter is in response to your correspondence dated 6/20/16 regarding the above mentioned rate filing. The verbal responses to your questions are provided below and any numerical examples are included in the attached excel workbook with tabs corresponding to each numbered question.

*1. Please explain the services included in the "Other Medical" benefit category on the URRT including the PMPM value and measurement units used.*

Response: The "Other Medical" benefit category in the URRT includes Ambulance services (\$2.36 PMPM, measured on a per-trip basis), Durable Medical Equipment, Prosthetics and Orthotics (\$2.14 PMPM, measured on a per-visit basis), Contraceptives (\$1.68 PMPM, measured on a per-script basis), and the \$6.65 PMPM Claims Settlement Payment (line 3, Exhibit 3 of the Rate Filing).

*2. Exhibit 2a shows an allowed unit cost trend 2.5% plus leveraging factor of 0.2%, please reconcile this value to the URRT.*

Response: The 2.5% Annual Allowed Medical Trend shown on Exhibit 2a of the rate filing is a weighted average of the individual service category trends for medical claims only. In the URRT, this would be found by taking the weighted average of the Inpatient Hospital, Outpatient Hospital, Professional, and Other Medical Cost trends, weighted by the experience period PMPM for each. The leveraging factor of 0.2% shown on Exhibit 2a is not reflected in the trend section of Worksheet 1 of the URRT because this is a factor to show the effect fixed cost sharing has on paid claim trends and the URRT is on an allowed claim basis.

*3. Regarding the Adjustment for \$1,300 Rx Out of Pocket Maximum (Bill H559) discussed on page 6 of the Vermont memorandum,*

*3a. Please explain why the claim adjustments are being processed within MVP's claims system during the experience period considering that Bill H559 was effective beginning October 2012 and the experience period for this filing is Calendar Year 2015.*

Response: MVP and its pharmacy benefit manager (PBM) are still having issues administering Bill H559, particularly for HDHPs where the deductible and out of pocket accumulators need to be synced between MVP and the PBM.

*3b. When do you anticipate all of the claim adjustments to be realized within MVP's claim system?*



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Response: MVP is continually working toward full automation of the Bill, but an estimated time frame for when this will occur has not yet been determined. MVP is currently making manual check payments to members who incur over \$1,300 in Rx cost sharing, and will continue to do so until the Bill is fully automated.

*3c. Please provide quantitative support for the adjustments provided in line 19 of Exhibit 3.*

Response: MVP analyzed the pharmacy claims of members renewing in January 2015 and having a full 12 months of data from January to December. This amounted to 8,923 members, or approximately 84% of the members in the experience period. For each member, the difference between their actual pharmacy cost sharing for the year and \$1,300 was calculated, and any amounts above zero were considered to have been paid by the plan instead of the member. PMPM amounts were calculated for each rating category, and the resulting amounts can be found on Exhibit 3, line 19. Please see a detailed calculation of the amounts by rating category on the tab "Question #3c" of the attached excel file.

*4. Please explain why grandfathered data, indemnity data, association data, and large group data are appropriate sources to use as the basis of the manual rate. Also, please explain how base period claims were adjusted for differences in morbidity between the populations and the projected combined 2017 market.*

Response: As stated in MVP's response to L&E Objection #2, Question #6, all of the risk pool segments used to develop the proposed premium rates are eligible to enroll in the products offered within this filing regardless of their enrollment status during the experience period. Because these members will be eligible to enroll in ACA products during the projection period, it is prudent to include their data in the claim projection used to develop premium rates. MVP adjusted for differences in morbidity between the experience period and projection period by comparing the average HHS age factor by risk pool from the experience period to MVP's current membership as of March 2016 (which was used as the membership projection for 2017).

*5. Regarding the Taxes and Fees included in Exhibit 5, please reconcile to the Taxes and Fees Load included on the URRT.*

Response: Please see the tab "Question #5" of the attached excel file which reconciles Exhibit 5 of the rate filing to the URRT. Please note that the 1.249% Paid Claim Taxes and Assessments and \$0.13 HHS Risk Adjustment User Fee on Exhibit 5 are reflected in other places of the URRT Worksheet 1 and are therefore not included in this reconciliation. Additionally, any flat PMPM amounts were converted to a percent of premium (to be entered into the URRT) using the Single Risk Pool Gross Premium Avg. Rate PMPM.

*6. Regarding the Loss Ratio development shown on page 11 of the Vermont Actuarial Memorandum, the Claims, Taxes/ Assessments (including adding in the risk adjustment fee), and the Premiums included in the Loss Ratio Development provided on page 11 of the Vermont Actuarial Memorandum do not match the URRT. Please explain.*

Response: The claims in the Loss Ratio Development section of the Actuarial Memorandum do not reflect changes in membership and plan design from the experience period to the projection period whereas the URRT's Projected Incurred Claims reflect these changes.

*7. On page 4 of the State Actuarial Memorandum, MVP discusses adjustments made to the experience period to adjust for large claims. Were similar adjustments made in the experience when performing the trend analysis? If so, please describe and show the emerging experience before and after the adjustments were made. If no such adjustments were made, please explain why.*



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Response: MVP did not make any adjustments for large claims when performing trend analyses. The unit cost trends reflect known and assumed price increases from MVP's provider network, and would affect both large and small claims equally. Utilization trend analysis was performed without consideration to the severity of the claims, only the frequency.

8. Please explain why Column V, Line 38 of Worksheet 1 of the URRT, [Projected Incurred Claims] which equal \$422.23 is different from the claims expense of \$433.34 of the Target Loss Ratios for 2017 VT Exchange shown on page 11 of the State Actuarial Memorandum [which is also the same amount shown on Exhibit 3. Index Rate].

Response: As stated in the response to question #6 above, the amount shown on Exhibit 3 is the projected paid claims PMPM without considering membership mix changes from non-ACA compliant plans to ACA compliant plans from the experience period to the rating period. The number in the URRT reflects the average Net Claim Cost PMPM from Exhibit 6 by plan weighted on MVP's 2017 projected membership (which is not the same membership base used to develop the rates on Exhibit 3).

9. Please provide the historical experience to support the 0.40% of premium load to reflect non-payment of premium.

Response: Please see the following table which shows MVP's bad debt as a percentage of premium for small group and individual ACA compliant products in 2014 and 2015. MVP's premium billing department anticipates an average bad debt percentage of 0.40% which falls between the historical averages for this block.

Bad Debt as a Percent of Premium, ACA Compliant Plans, 2014-15				
Year	Group Size	Premium	Bad Debt	Bad Debt / Premium
2014	Small Group	\$9,054,927	\$26,404	0.29%
2014	Individual	\$13,347,427	\$38,258	0.29%
2015	Small Group	\$11,647,934	\$85,741	0.74%
2015	Individual	\$15,076,698	\$114,741	0.76%

10. Please explain how you allocated your administrative expenses to this block of business.

Response: MVP's finance team manages administrative expense allocations. The allocation of expenses is determined based on cost drivers by department and accounts for fixed and variable administrative expenses. For example, to determine the allocation of call center salaries to this block of business, the number of calls fielded for this block of business is compared to the total number of calls fielded by call center representatives. That percentage is then multiplied by total call center salaries to determine the administrative expense allocation for this block.

11. Please explain how MVP Health Plan's business practices as a nonprofit differ from MVP Health Insurance Company and how those differences impact premiums.

Response: MVP's business practices do not vary between products filed on MVP Health Plan and MVP Health Insurance Company. MVP Health Insurance Company business practices align with its parent company, MVP Health Care, which is a nonprofit insurer. Premiums for products offered by MVP Health Insurance Company are 2% higher than MVP Health Plan due to a required premium tax applied to any products offered on an Article 42 license.



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*12. Please describe your quality improvement initiatives, wellness benefits, and charitable giving and the costs associated with each activity within those categories.*

Response: MVP takes part in two major quality improvement initiatives in Vermont. The first is Vermont Blueprint for Health. This is a statewide multi-payer demonstration that includes two types of payments to providers to help manage care for the community, Patient-Centered Medical Home payments and payments to support the Community Health Teams. In 2015, MVP paid \$812,673 in PCMH and CHT support payments. The second initiative is a Quality Incentive program with the Healthfirst IPA. The IPA is eligible to receive withhold returns based on quality performance standards (scored using Nation HEDIS benchmark data). The award for 2015 is still being calculated.

MVP offers a wellness benefit to all of the non-standard plan enrollees in the marketplace. The benefit provides up to \$50 per year to adult members in reimbursements, contingent on performing several tasks related to a healthy lifestyle. The approximate cost of this benefit is \$0.84 per member per year as of 2016 (unchanged from 2015).

MVP's charitable giving was in excess of \$1.5 million across all licenses in 2015. MVP focuses its financial community support on programs and events in its service area that promote wellness, fitness and healthy lifestyles, enhance the health of individuals and our communities, and improve the efficiency of health care or enhance the vitality of the community.

*13. Please explain your provider contracting timeline. When do you establish the rates you will pay different providers and how often are they renegotiated?*

Response: MVP's provider contracting timeline is continuous and the renegotiations vary based on the length of the contract.

*14. Please explain any assumptions you made in your filing based on current and upcoming Health Care reform initiatives in Vermont.*

Response: MVP has not made any assumptions based on current or upcoming Health Care reform initiatives in Vermont.

*15. Please indicate whether as a result of legislative changes in Vermont during the 2016 session you expect to make any adjustments to the above captioned filing that will affect rates and that are not already incorporated into the filing. Provide details including the rate impact for each adjustment.*

Response: MVP does not expect to make any further adjustments to rates based on legislative changes during the 2016 session. MVP has already incorporated the assessment due to bill H.873 being passed.

*16. Please explain why your reinsurance costs increased significantly between your 2016 and 2017 filings (2016 and 2017 Actuarial Memorandums, p. 3, "Summary of Experience Period Non-FFS and Capitation Amounts").*

Response: MVP disagrees with the assertion that reinsurance costs increased significantly between the 2016 and 2017 filings. Please see the tab "Question #16" on the attached excel file which calculates the Net Reinsurance Expense PMPM for the entire block as a whole. As you can see, the Net Reinsurance Expense was over \$1.00 PMPM lower in calendar year 2015 than calendar year 2014 (which was \$0.21 PMPM). This is due to an increase in the



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frequency and/or severity of claims subject to the reinsurance threshold. Note that MVP's proposed premium rates reflect its expected net reinsurance cost for 2017 which is \$0.20 PMPM (see page 7 of the Actuarial Memorandum).

*Revision to Objection Letter #2, Question #5 Response:*

Note that MVP has revised the 2017 "Approved/Assumed" column in the excel response for Objection Letter #2, Question #5. After further conversations with MVP's informatics staff, it was determined that MVP's negotiated discounts have been approved for the facilities that were labeled as "Approved" in the initial response, but since the VT Hospital Budgets for 2017 have not yet been finalized, this portion of the trend is assumed. As a result, MVP has revised the 2017 "Approved/Assumed" column to "Assumed" for all of the facilities subject to the VT Hospital Budget.

If you have any questions or require any additional information, please contact me at 518-388-2483.

Sincerely,

A handwritten signature in black ink that reads "Matthew Lombardo".

Matthew Lombardo, FSA, MAAA  
Associate Director, Actuarial Services  
MVP Health Care