MVP HEALTH CARE
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June 23, 2017

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

Re: 2018 Vermont Exchange Rate Filing
SERFF Tracking #: MVPH-131034103

Dear Mr. Ruggeberg:

This letter is in response to your correspondence received 06/19/2017 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. How many individuals enrolled in Medicaid in 2016 enrolled in your QHPs for 2017? How did this enrollment affect your trend estimates for 2018?

Response: MVP does not participate in Medicaid in the state for Vermont. MVP does not track a member's previous coverage status, unless they were previously enrolled in one of MVP's other product lines. Therefore, the number of members switching from Medicaid to MVP's QHPs for 2017 is unknown, and we made no adjustments to our rate filing to account for this fact.

2. Paragraph 6 refers to calculating the impact of cost share leveraging on the carrier's share of medical cost. Did you incorporate the adjustments made to QHP cost sharing to keep the plans aligned with federal AV requirements? If you did not adjust for these changes, please provide calculations of how this impacts the trend assumption.

Response: MVP did not reflect the changes in cost sharing from 2016 to 2018 due to plan design changes in the leveraged trend in the rate filing. To do so would require MVP to re-price every experience period claim and re-calculate every member's accumulators, which is not feasible given time and resource restraints. MVP has reflected changes made to keep plans within federal AV guidelines in the plan's benefit relativities on Exhibit 6.

3. Please provide a more qualitative explanation to support your claim that utilization will increase in 2018. Please include your clinical team's interpretation and justification of your statistical results.

Response: MVP's actuarial team consulted its clinical team to understand if there were any new programs put in place between the experience period and present that would help offset the utilization increases that have been experienced in the recent past. MVP's clinical team is continuously reviewing its policies and procedures, but they agreed there haven't been any program changes that would offset our utilization trend projections.

4. PBMs are responsible for managing Rx costs and as such may have a vested interest in stating a conservative trend. Do you have any internal trend analytics to support the reasonableness of the PBM findings? Please provide historic PBM forecasts compared to actual trends for 2014-2016.

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Response: MVP disagrees with the notion that its PBM would have a vested interest in stating a conservative trend. Because the PBM and MVP enter into a contract, intentionally misstating trends would destroy the PBM's integrity and hamper future negotiations between the PBM and MVP. MVP believes that the PBM is the best source for its pharmacy trends because of the unique knowledge that the PBM presents and its relation to the pharmaceutical market as a whole.

Please see the tab labeled "Question #4" on the attached Excel workbook which provides historical trends from MVP's past two Exchange rate filings as well as actual allowed claim trends for 2015 and 2016. Please note that prior to the 2016 Exchange filing, MVP did not use the current PBM it is using. Also, for the 2016 Exchange filing, MVP was using national trends provided by the current PBM. In the 2017 filing and going forward, MVP had access to trend projections that were tailored specifically to MVP's different books of business.

5. Please provide quantitative and qualitative support for the expected impact due to new Vermont rules on limiting opiate prescriptions.

Response: MVP has not performed a quantitative analysis of the impact of these new rules when developing this rate filing. Based on conversations with our pharmacy department, we expect there could be increased medical costs due to the additional evaluation visits necessary to implement the policy. This will be offset by the reduction in pharmacy claims for opioids, but doctors may replace opioid treatment with other drug therapies. These therapies could increase or decrease total pharmacy costs compared to before the new rules, dependent on the class of drugs replacing opioids and the utilization of potential replacements.

6. Please provide quantitative and qualitative support for the expected impact due to new rules requiring generic substitution for interchangeable biological products.

Response: Based on conversations with MVP's legal department, these new rules have not been approved as Vermont law. Therefore, MVP has not considered their possible impact on its rate filing.

7. Have you studied the impact of providers driving costs? For example:

- *a. Services moving into high cost health systems;*
- *b. Services moving from PCP to specialist; or*
- *c. Services moving from an office setting to a facility setting.*

If so, please provide the study.

Response: These studies were not performed for this rate filing.

8. Please explain how ACA growth in insured population creating less bad debt and growth in covered members (and in turn more FFS volume helping to ease provider overhead strain) haven't led to lower unit cost increases.

Response: Due to the hospital budgeting system in Vermont, MVP has limited influence over unit cost increases requested by providers. To the extent that the process described happens, it is one of many factors that go into negotiations between MVP and health care facilities in Vermont, and would be extremely difficult to isolate and quantify.

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9. Please describe any vended services from the corporate for-profit parent.

Response: MVP Health Care operates as a not-for-profit company. There are no services that are vended from MVP Health Care to MVP Health Plan. MVP Health Care provides employees to MVP Health Plan via MVP Service Corporation, but this transaction is done on a cost basis and MVP Health Care receives no profit from this transaction.

10. Is any overhead from the parent passed through to the VT non-profit?

Response: MVP Health Plan, a subsidiary of MVP Health Care, is domiciled in New York and operates in both New York and Vermont. MVP Health Care does not own a Vermont-specific company. MVP Health Care's overhead costs are allocated among all of the companies it owns based on MVP's cost allocation model which assesses costs based on various cost drivers.

11. Please provide support for your CTR estimate.

a. Other carriers in the market include a detailed exhibit of their CTR needs – please provide a similar exhibit or the components required for us to replicate the other carrier's exhibit including anticipated investment income, target RBC ratio, and current and projected authorized control level.

Response: MVP Health Plan's reserves are governed by New York State regulations which dictate a minimum reserve level of 12.5% of premium. While this block of business represents a small portion of MVP Health Plan's total business, MVP strives to manage the blocks separately so that we are indifferent to membership shifts between states on MVPHP.

Please see the tab "Question #11" in the attached Excel workbook for a calculation of MVPHP's allocated reserves for this block of business as a percent of the premium. MVPHP's total reserves as a percentage of its premium were approximately 16.14% at the end of 2016. Because of significant membership growth in 2017 as well as the 1.0% CTR approved in the 2017 Exchange filing, MVP is projected to be under the statutory minimum (12.5%) if this block of business were to be managed on its own. MVP has displayed that a CTR of 2.0% in the 2018 filing would take reserves up to 13.0% of 2018 premiums, above the minimum but well below what MVP targets for its companies. Reducing the CTR in the 2018 Exchange rates to 1.0% or 0.0% would continue to place MVPHP's Vermont-specific business under the statutory minimums for 2018.

MVP strives to manage the business in both states such that if one state were to halt all business, the other state would be able to remain solvent on its own. Viewed through this lens, reducing the CTR assumption could potentially harm the long-term viability of MVP's VT Exchange business.

b. How does your parent impact your CTR requirement?

Response: MVP Health Care is a not-for-profit company with no additional assets outside of the regulated entities. All of MVP Health Care's reserves are held by the regulated entities themselves.

c. Do you have a target RBC and/or run simulations models to validate the need for this RBC level?

Response: MVP's goal is to maintain a minimum RBC ratio for MVP Health Plan of 500% with a targeted ratio of 700%. Converted to a percent of premium basis, this means a minimum of 16% of premium with a target of 20%. MVP would require a CTR in this filing of approximately 4.8% to reach the minimum target of 16% for this specific block of business. MVP does not run simulation models to validate the need for this RBC level.

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If you have any questions or require any additional information, please contact me at 518-386-7213.

Sincerely,

Eric Bachner, ASA
Senior Actuarial Analyst
MVP Health Care