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625 State Street, PO Box 2207
Schenectady, NY 12301-2207
mvphealthcare.com

June 1, 2016

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

Re: 2017 Exchange rate filing
SERFF Tracking #: MVPH-130558905

Dear Mr. Ruggeberg:

This letter is in response to your correspondence received 05/18/16 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. 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?

Response: To develop premium rates, MVP gave equal weight to every member month in the experience period, regardless of enrollment status. To be consistent with this logic, MVP used all ACA compliant data on worksheet 1 of the URRT (to be in compliance with the URRT instructions) and used a credibility factor equal to [ACA Compliant MMs in experience period] / [Total ACA and non-ACA Compliant MMs in experience period].

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.

Response: For rolling 3- and 6-month trends, normalized for age factors and on annualized basis, please the tab "Question #2" in the attached excel spreadsheet. Please note that the completed medical claims on this tab may not tie out to the rate filing Exhibit 3 as the application of IBNR is different on each exhibit (IBNR is applied monthly on the attached tab and is applied to the entire experience period on Exhibit 3 of the rate filing).

2a. Please include measure of medical utilization by service category to substantiate the claim that historical utilization trends are weak and not reliable.

Response: Please see the tab "Question #2a" in the attached excel file that shows historical utilization trends for the combined ACA Small Group and Individual market. MVP has graphed utilization/1000 for inpatient days as well as outpatient and physician visits for the 24 months beginning January 2014. A best fit logarithmic trend line has been plotted for each graph along with the coefficient of determination (R-squared value).

While the rolling 12 data would suggest a strong fit for a negative utilization trend, there is severe pent-up demand for services in the beginning of 2014 (particularly in January, February, and May). This skews the rolling 12 month graphs into showing declining demand for services. To remove the impact of pent-up demand on historical utilization, MVP has also graphed the rolling 12 month periods removing the first five periods to display the impact these early months are having on historical trends. In particular, note the changes to the R-squared value for

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outpatient and physician utilization as well as the change from negative to positive utilization trend for these service categories after the first five rolling 12 month periods are removed.

3. How do the assumed trends reflect the impact of changes to the Vermont Hospital Budgets?

Response: The trends reflected in the proposed premium rates represent a combination of the approved Vermont Hospital Budgets as well as known and assumed contractual reimbursement changes between MVP and the provider community.

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.

Response: For an illustration of the IBNR factors by data pool by month, please see the tab "Question #4" in the attached excel spreadsheet. Please note that due to the way our IBNR models are calculated, the non-ACA compliant 51-100, small group, and individual data pools share IBNR factors while the non-ACA Agriservices model has its own factors. The ACA compliant small group and individual data also share a model.

MVP's experience period data was paid through February 2016 with the incurred estimates to calculate IBNR updated as of March 2016. The time period used for paid run-out is consistent with the two prior filings listed. Therefore, the IBNR factor should be consistent between filings, provided that there is not a large change in the incurred estimate between months.

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.

Response: Please see the tab "Question #5" in the attached excel spreadsheet for a weighted average of these factors.

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.

Response: The claims settlement expense reflects a payment that will be made to a group of VT providers and therefore is a claim expense and not a retention element. MVP had stalled negotiations with the providers throughout 2015 and finally reached an agreement late in the year. Claims were processed in 2015, but the claims did not reflect the final agreed upon reimbursement rates. The difference between the claims processed through MVP's payment system and the negotiated contract rate was computed and represents the value of the claims settlement expense. This amount is being held as an accrual by MVP's finance department until the claims are reprocessed.

7. Did MVP perform a study of whether their experience is consistent with the HHS induced utilization factors?

Response: MVP has analyzed historical experience and found that the utilization spread among metal levels is much larger than the prescribed induced utilization factors. MVP has chosen to use the HHS factors with sloping to capture

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benefit differences within metal levels. Please see the following table which calculates assumed induced utilization factors from the experience period ACA compliant data.

Normalized Induced Utilization Factors, ACA Compliant plans, 2015 Calendar Year

Small					
Metal Level	MMs	Allowed PMPM	HHS Age Fx	Normalized Allowed PMPM	Assumed IU Factor
Platinum	7380	$585.06	1.709	$342.30	1.550
Gold	2792	$535.05	1.676	$319.27	1.446
Silver	9439	$385.84	1.501	$257.04	1.164
Bronze	7784	$337.37	1.528	$220.81	1.000

Individual					
Metal Level	MMs	Allowed PMPM	HHS Age Fx	Normalized Allowed PMPM	Assumed IU Factor
Platinum	2177	$1,321.58	2.063	$640.55	3.721
Gold	1230	$957.45	1.856	$515.77	2.996
Silver	12041	$560.44	1.780	$314.77	1.828
Bronze	20867	$284.74	1.654	$172.15	1.000
Catastrophic	1211	$66.54	1.041	$63.93	0.371

8. Please reconcile the capitation and non-FFS medical costs in the actuarial memorandum with the costs shown in Exhibit 3.

Response: Please see the tab "Question #8" in the attached excel spreadsheet.

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.

Response: Please see the tab "Question #9" in the attached excel spreadsheet.

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.

Response: The Health Care Advocate assessment as passed allocated 24.2% of the fee to BCBSVT and 24.2% to all other insurers in the market. The 56.7% market share is therefore MVP's share of the non-BCBSVT earned premium collected. For this assumption, MVP assumed that all other carriers' premium beside our own and CIGNA's was immaterial, and used total non-government earned premium from the 2015 annual Supplemental Health Care Exhibit to calculate the market share. Please see the following calculation of the market share.

A)	MVP's 2015 Commercial Health premiums earned (SHCE Part 1, Line 1.1)	$64,908,654
B)	CIGNA's 2015 Commercial Health premiums earned (SHCE Part 1, Line 1.1)	$49,573,513
C)	Total non-BCBSVT 2015 Commercial Health premiums earned [A) + B)]	$114,482,167
D)	MVP's share of non-BCBSVT 2015 Health premiums earned [A) / C)]	**56.7%**

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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.

Response: According to discussions with our legal department, bill H.873 has been signed into law on May 25, 2016. This bill, under Section 28 18 V.S.A § 9607, provides funding for the Office of the Health Care Advocate in the following percentages: 27.5% by the state, 24.2% by hospitals, 24.2% by medical service corporations, and 24.2% by health insurance companies. Per discussions with state officials, the total amount allocated to insurance companies other than BCBSVT for FY 2017 is $123,333. The assessment is MVP's estimated share of this amount.

12. Please reconcile the administrative expenses in the Actuarial dataset to the expenses shown in Exhibits 5 and 6.

Response: Please see the following table, which lists the administrative expenses in the Actuarial dataset by category and the associated line(s) from Exhibit 5 of the rate filing. Please note that all percent of premium loads are converted to a PMPM basis using the "Future Year 1" line of the dataset (premium PMPM calculated as cell F158 / cell D158).

Reconciliation of Actuarial dataset to Rate Filing Exhibit 5, PMPM basis

Line Item in Actuarial Dataset	Amount	Line item in Exhibit 5	Amount	Notes
Taxes, Licenses & Fees	$2.82	2017 Billback- Health Care Advocate	$0.49	
		VT Vaccine Pilot	$2.33	0.5% of Premium
Exchange Fees	$0.33	HHS Risk Adjustment User Fee	$0.13	
		Comparative Eff Research Tax	$0.20	
All Other Admin Expense	$38.46	General Administrative Load	$35.10	
		National Network Fee	$1.50	
		Bad Debt	$1.86	0.4% of Premium
Profit/Risk Margin	$4.66	Contribution to Reserves	$4.66	1.0% of Premium

13. Please reconcile the assumed general admin load with the 2015 Supplemental Healthcare Exhibit.

Response: Please see the following table which details the lines that compose the administrative expenses from the 2015 Supplemental Health Care Exhibit shown in the actuarial memorandum.

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Details of 2015 Supplemental Health Care Exhibit Administrative Expenses

MVP Health Plan & MVP Health Insurance Company

Line Number in SHCE	Line Name in SHCE	Individual	Small Group Employer	Total
1.7	Regulatory authority licenses and fees	$31,579	$19,120	$50,699
6.6	TOTAL of Defined Expenses Incurred for Improving Health Care Quality	$123,177	$180,180	$303,357
8.3	TOTAL Claims Adjustment Expenses	$265,152	$359,587	$624,739
10.1	Direct sales salaries and benefits	$78,983	$107,346	$186,329
10.4	Other general and administrative expenses	$951,129	$1,171,857	$2,122,986
	Total Admin Dollars, SHCE	$1,450,020	$1,838,090	$3,288,110
O4	Member Months	39,551	53,993	93,544
	Admin Dollars PMPM, SHCE	$36.66	$34.04	$35.15

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.

Response: The 1.0013 adjustment factor reflects the impact of reduced mail order copays which are not included in the AV calculator. MVP calculated this adjustment factor using its pricing model and this plan was the only plan that required an adjustment. Our pricing model assigns a benefit AV of 79.6% for this plan without mail order copays and a 79.7% AV for the plan as filed. Therefore, the adjustment made to the AV calculator is equal to [0.797] / [0.796], or approximately 0.13%. The Department of Vermont Health Access submitted an objection to our form filing on April 16 which mandated this change.

15. Reconcile the actual generic Rx copays to the copays assumed in the AV calculations.

Response: Approximately 26% of Tier 1 scripts are on the VBID list and have reduced copays. MVP has calculated the generic copay in the AV calculator as a weighted average of the traditional generic copay and the VBID copay based on this factor, rounded to the nearest dollar.

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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?*

Response: The extended open enrollment period in 2014 does not necessarily indicate MVP's relative risk position will increase or decrease, but it puts a high degree of uncertainty around every carrier's relative risk position in 2014. MVP's preliminary risk adjustment results for 2015 were drastically different than actual 2014 results (see response to Question #18 below). Because there is so much uncertainty in the actual 2014 risk adjustment results representing the market-wide average risk and there are significant changes between actual 2014 results vs. 2015 preliminary results, MVP chose to estimate a risk adjustment factor equal to 2/3 of its 2014 risk adjustment results for the proposed premium rates. Note MVP recognizes that 2015 actual risk adjustment results will be known prior to the Green Mountain Care Board rendering a final decision for the proposed premium rates.

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.

Response: MVP reviewed allowed PMPM costs for the ACA population vs the non-ACA population used for setting premium rates. Over the experience period, the non-ACA population allowed PMPM was 2.7% higher than the allowed PMPM for the ACA compliant block ($471.91 vs $459.35). Because the allowed costs of the two populations were similar, MVP assumed the morbidity between the two populations was also similar which implies the risk adjustment position assumed for the ACA population is a reasonable assumption for the non-ACA population.

18. How was the preliminary risk adjustment report considered in the development of the population morbidity and/or Risk Adjustment PMPM assumptions?

Response: MVP paid $2.69M into the risk adjustment program for 2014 dates of service, and the preliminary risk adjustment report from CMS indicated that MVP would receive $1.88M for 2015 dates of service. Because 80.6% of members that were enrolled in ACA compliant plans with MVP in 2015 were also enrolled in ACA compliant plans with MVP in 2014, a change of this magnitude did not seem reasonable in our opinion. Additionally, MVP does not know how frequently BCBSVT submits claims to the EDGE and qualification criteria for the preliminary report is only through 3Q 2015. Therefore, if BCBSVT 4Q 2015 claims were not complete, the preliminary results would be skewed. As described above, the difference between actual 2014 results and the preliminary 2015 results is one of the reasons that MVP is adjusting its 2014 risk adjustment results by a factor of 2/3 for its 2017 risk adjustment assumption.

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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

Response: The other factor of 1.006 reflects the "Adjustment for experience period vs projected membership characteristics" represented in line 20 on Exhibit 3 of the rate filing. Please see the following calculation of the factor.

Derivation of Other Factor, URRT Wksh 1

	Item Name	Location / Calculation	ACA Compliant Small Group	ACA Compliant Individual	Total ACA Compliant
A)	Member Months	Line 1 of Exh. 3	27,395	37,526	64,921
B)	Adjustment for experience period vs projected membership characteristics	Line 20 of Exh. 3	($1.17)	$5.29	$2.56
C)	Experience Period Allowed Claims PMPM	Cells H24:H27 + H29 of the URRT Wksh 1			$451.89
D)	Experience Period Allowed Claims Adjusted for projected membership characteristics	[B] + [C]			$454.45
E)	Factor Adjustment for projected membership characteristics	[D] / [C]			1.0057
F)	Other Factor	URRT Wksh 1 Cell K24			1.006

b. Projected Allowed Experience Claims PMPM

Response: The Projected Allowed Experience Claims PMPM is a member month weighted average of the ACA compliant Projected Allowed PMPM and the non-ACA compliant Projected Allowed PMPM (used as the Credibility Manual in this case). This number is not reflected anywhere on Exhibit 3 of the rate filing as MVP does not set premiums using allowed claims.

c. Projected Risk Adjustments PMPM

Response: The Projected Risk Adjustments PMPM of ($29.55) is the sum of the Federal Risk Adjustment Impact (line 30 on Exhibit 3) of $29.42 PMPM and the HHS Risk Adjustment User Fee of $0.13 PMPM (found on Exhibit 5 of the rate filing).

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20. Is the manual rate in the URRT reflective of all experience, or non-ACA plans only?

Response: The credibility manual rate in the URRT is reflective of non-ACA plans only. It is designed to make the Projected Allowed Experience Claims PMPM mimic the weighting (based on member months) of our ACA and non-ACA data in the rate filing.

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

Sincerely,

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