MVP HEALTH CARE
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June 26, 2020

Ms. Traci Hughes, ASA, MAAA
Lewis & Ellis, Inc.
700 Central Expressway South, Suite 550
Allen, TX 75013

Re: 2021 Vermont Exchange Rate Filing
SERFF Tracking #: MVPH-132371260

Dear Ms. Hughes:

This letter is in response to your correspondence received 06/19/20 regarding the above-mentioned rate filing. The responses to your questions are provided below.

1. Please specify whether the filing assumes that MVPHP will be responsible for billing consumers who purchase plans on Vermont Health Connect (VHC) in 2021. List any changes to the filing that are needed to reflect that MVPHP will not be responsible for consumer billing in 2021.

Response: This filing assumes that the transition in billing from Vermont Health Connect to MVP will take place beginning in January 2022 as opposed to January 2021. MVP did build administrative expense in this filing to support building out and testing the billing functionality as that work will be done in 2021. However, no expenses related to actual billing of individual members is assumed in this filing.

2. Do cost sharing plans take more administrative time than other QHPs and therefore represent a larger portion of administrative costs? If yes, does MVPHP "silver stack" these costs or spread them out across all plans?

Response: MVP's administrative cost allocation model does not allocate expenses at this level of detail (Silver CSR plans as compared to all other plans). However, MVP has built "shadow claim" functionality in its claim processing software, which allows the company to track both actual claim expense as well as CSR claim expense on all claims in an automated fashion. Because the process is automated, there is not significant expense associated with tracking and reporting CSR claim expenses. MVP does not "silver stack" these expenses.

3. Please provide an update of your PBM's actual-to-expected trend analysis for the last four years.

Response: Please see the following table for this trend analysis. Trends are taken from the most recent rate filing where a trend occurred (for instance, the 2018 to 2019 expected trend is taken from the 2020 VT Exchange filing).

While reviewing the table, it is important to note that this is a risk-adjusted population, and MVP's membership and demographic mix have changed considerably over the period being measured. Therefore, reviewing the actual-to-expected trends in isolation does not indicate the impact of these trends on MVP's financial performance.

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The trends provided by the PBM are calculated based on a static population at the time trends are produced. MVP's membership has grown from about 10% of the market in 2016 to 40% of the market in 2019, and MVP's risk adjustment payment as a percentage of premium has also increased during the same period. These year over year population and risk morbidity changes impact the mix of drugs members are purchasing which can skew actual trends.

Comparison of Actual to Expected Pharmacy Allowed Trend, 2016 to 2019, VT Exchange

Year	Actual	Expected
2019/2018	3.6%	7.4%
2018/2017	5.1%	12.4%
2017/2016	5.2%	11.1%
2016/2015	8.6%	8.8%

4. MVPHP has experienced large growth in its VHC population over the last few years. Please provide any assumptions built into the filing for the increase in membership or change in membership mix, including the following:
a. Changes in pooling level, and
b. Impact from mix of individual or small groups.

Response: MVP generally has not taken its large growth in market share into account when rating. Items may be adjusted that are specific to one subset of the population to reflect current membership as opposed to experience period membership (such as projected membership in Silver on exchange plans for the Silver load). Specifically related to changes in pooling level, MVP has not considered changing the level it is pooling claims at to reflect a larger market share. Specifically related to the mix of individual and small groups, MVP prices using a single risk pool, so an adjustment is not warranted except for specific circumstances (such as the Silver on exchange adjustment made above).

5. Please confirm the accuracy of the below-provided table that lists proposed rates and rate components, allowed (ordered) rates and rate components, and actual rate components. If the cell is blank or you believe the value listed is incorrect, please provide the value that you believe is correct.

In your response, please provide any caveats or qualifications that are necessary to prevent the response from being misleading.

Response: MVP has amended the table as shown below. To calculate utilization trend, MVP compared utilization per 1,000 members for each service category (defined by MVP as Inpatient, Outpatient, Physician and Other) from calendar year 2018 to calendar year 2019 and then weighted those trends by the percentage of allowed costs in each bucket during calendar year 2018.

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MVP would like to caveat that filtering down allowed claim trend to two component numbers (utilization and unit cost) can be misleading, for reasons including but not limited to:

-Allowed Medical Trend does not consider population changes or changes in morbidity within the previously insured population. This can skew both total trends as well as utilization and intensity trends. As an example, an older population generally uses both more services and more intense services, which would increase both utilization and unit cost trends as MVP has calculated them. In a risk-adjusted environment, allowed trends should be viewed in tandem with the change in a carrier's risk position to view the total claim trend for a given year.

-Claim shifts between service categories can increase/decrease total allowed trends while also increasing/decreasing utilization trends within those categories. For example, shifting surgeries previously performed in an Inpatient setting to an Outpatient setting will simultaneously increase Outpatient utilization and total allowed costs and decrease Inpatient utilization and total allowed costs (while likely decreasing total allowed claim costs). This is not easily quantifiable into a single unit cost and a single utilization trend figure.

-The intensity of services is not considered in the table. MVP is implicitly assuming that it is included under unit cost trends, but this produces misleading results if the intent is to measure the change in cost for a given service over time. For example, if a higher-intensity Outpatient service is replaced with a lower-intensity service, the utilization change would be 0.0% and the unit cost trend would be below zero. However, the costs of both services may have increased over time, which would not be evident based on the data provided. Additionally, MVP used admits as the utilization measure for Inpatient services. To the extent that the average length of stay changes over time, this would be captured in the unit cost trend as opposed to the utilization trend.

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Year Filed Docket #		2020 GMCB-006-20rr	2019 GMCB-05-19rr	2018 GMCB-008-18rr
Members		36,980	30,887	25,223
Average Rate Change	Proposed	7.3%	10.9%	10.9%
	Allowed	NA	10.1%	6.6%
Allowed Medical Trend	Proposed	5.9%	3.7%	3.2%
	Allowed	NA	4.9%	3.4%
	Actual*	NA	NA	9.0%
Medical Unit Cost	Proposed	4.8%	3.7%	3.2%
	Allowed	NA	3.9%	3.4%
	Actual*	NA	NA	13.3%
Medical Utilization	Proposed	1.0%	0.0%	0.0%
	Allowed	NA	1.0%	0.0%
	Actual*	NA	NA	-3.8%
Allowed Rx Trend	Proposed	7.3%	8.2%	13.3%
	Allowed	NA	8.2%	13.3%
	Actual*	NA	NA	3.6%
General Admin Load (PMPM)	Proposed	$43.75	$42.00	$39.80
	Allowed	NA	$42.00	$39.80
	Actual*	NA	NA	$39.86
CTR	Proposed	1.5%	1.5%	2.0%
	Allowed	NA	1.0%	1.5%

6. MVPHP is proposing an increase for pent-up demand from Covid-19. These are services which were expected to be performed in 2020. As such, the HCA expects that the cost was built into the premium rates for 2020. Please demonstrate how this additional cost in 2021 premiums is not double charging members.

Response: The rates proposed by MVP are developed to be actuarially sound. According to Actuarial Standard of Practice #26, Section 2.1, actuarial soundness is defined as [emphasis added] "for business in the state for which the certification is being prepared ***and for the period covered by the certification***, ***projected premiums in the aggregate***, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, ***are adequate to provide for all expected costs, including health benefits***, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital." Therefore, MVP must consider health claims expected to incur in and only in 2021 when setting premium rates that are effective for 2021. If MVP were to reduce rates in 2021 for claims that were expected to occur but did not in 2020, those rates would be considered inadequate based on actuarial principles.

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7. In your response to question 14 of Objection Letter 1, you state that your assumption of an 80% Covid-19 vaccine rate is "consistent with the paper published by Wakely." Please confirm that you are referring solely to the sentence in the last paragraph on page 11 of Wakely's March 30, 2020 Covid-19 Cost Scenario Modeling paper which begins, "For example..." If you believe the paper provides additional support for your assumption of an 80% vaccination rate beyond this sentence, please specify where this support is.

Response: We confirm that the statement on page 11 was the specific support from this paper for an 80% vaccination rate.

8. Vermont implemented a special enrollment period (SEP) in response to the Covid-19 crisis which is still open. Please provide the number of Vermonters who have enrolled in an MVPHP plan using this SEP, broken out by CSR plan and metal level.

Response: MVP does not receive detailed data on why a member enrolled or changed coverage outside of open enrollment. Therefore, it is impossible for MVP to determine whether a member enrolled with MVP specifically using the COVID-19 SEP or if it was for a Qualifying Event unrelated to COVID-19 (change in family status, change in employment, change in APTC/CSR eligibility, etc.). MVP has enrolled 1,618 members between March and May 2020 which were not enrolled prior to March 2020. That is slightly lower than the 1,724 new members enrolled between March and May 2019, but it is impossible in either case for MVP to determine where or if these members had health insurance coverage previously.

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

Sincerely,

Eric Bachner, ASA
Leader, Actuarial, Commercial/Government Programs
MVP Health Care