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

September 12, 2019

Mr. Josh Hammerquist, FSA, MAAA
Lewis & Ellis, Inc.
P.O. Box 851857
Richardson, TX 75085

Re: 2020 Large Group HMO Rate Filing
SERFF Tracking #: MVPH-132048265

Dear Mr. Hammerquist:

This letter is in response to your correspondence received 08/29/2019 regarding the above mentioned rate filing. The responses to your questions are provided below.

1. Provide detailed quantitative support for the medical unit cost trend and the pharmacy unit cost and utilization trends.

Response:

Facility Trends

For Facility (Inpatient and Outpatient) trends, facilities can generally be bucketed into three categories:

1. Vermont facilities under GMCB jurisdiction
2. Facilities MVP negotiates contractual discounts with directly but are not under GMCB jurisdiction
3. Facilities under a rental network arrangement, facilities that are non-participating, or facilities where discounts are negotiated on a claim-by-claim basis.

The starting point for MVP's facility trends in this rate filing are facility claims processed for all Vermont members for the calendar year 2018. MVP has used all Vermont data as it intends to use this base for both this filing as well as any other rate filings in Vermont with the same effective date.

For facilities under GMCB jurisdiction, MVP is using the approved rate increases for 2019 as summarized on page 3 in the attached document, "GMCB Approved Hospital Budget Decisions Sept 12 2018 updated Sept 18 2018.pdf", with the following exceptions:

[PARAGRAPHS REDACTED]

Non-GMCB Facilities

For hospitals that negotiate contractual discounts with MVP directly but are not governed by the GMCB, the trends reflected are the most up-to-date information based on negotiations with the respective facilities. **[REDACTED]**

The final bucket reflects all remaining facilities with utilization by VT Exchange members, and **[REDACTED]** percent of the claim dollars in this bucket are handled under MVP's rental network. MVP contracts with a partner to provide in-network access to hospitals throughout the country.

[PARAGRAPHS REDACTED]

Physician Trends

[PARAGRAPHS REDACTED]

Medical Utilization Trends

MVP aggregated utilization data for all its Vermont members for the 36-month incurred time period January 2016 to December 2018. Claims were paid as of February 28, 2019 and completed with IBNR as necessary. MVP made two adjustments to this base utilization data when attempting to predict utilization for this rate filing:

1) Because of MVP's rapid membership growth from 2016 to 2018 in this block of business, it is difficult to compare overall utilization data from year to year. To normalize for this, MVP only analyzed claims for members who stayed with MVP for the entire 36-month period of the analysis. While this reduced the amount of data MVP used to forecast significantly, it enabled us to view a population that was relatively static over time and therefore view organic utilization trend as opposed to population changes.
2) To offset the effect of #1, MVP normalized its population for age and gender. Because we are using a static population, we also were concerned about the impact 3 years of aging would have on the data. The goal was to create a utilization trend for a generic member in the population, not for a specific member who ages over time.

[PARAGRAPHS REDACTED]

Pharmacy Trends

MVP is provided with pharmacy trend estimates by its Pharmacy Benefit Manager, CVSHealth. These trends are run for all of MVP's Vermont fully insured membership (ACA, Small Grandfathered and Large Group) and use historical utilization and unit cost data for those populations. This historical data is combined with CVSHealth estimates of changes in utilization, unit cost and generic dispensing rates to calculate their best estimate of Gross PMPM claim cost trends for 2019 and 2020. Please see the attached exhibit (CONFIDENTIAL MVP_Vermont_4Q2018_CSTM_02142019) which provides CVSHealth's best estimate of trends as of the time of the filing.

[PARAGRAPHS REDACTED]

2. Discuss the credibility of the base period experience. What are the suspected drivers of the worse than expected experience?

Response: MVP has assumed that the base period experience is 100% credible. Over the past two years, MVP has seen a rapid increase in medical claim expense. This has been driven by both changes in morbidity to existing groups as well as several groups with lower morbidity leaving MVP. There has been a shift in market dynamics in the Vermont large group market away from fully insured products and toward alternative funding arrangements. It appears that the fully insured market is being selected against and MVP believes that its current mix of groups is representative of all the groups willing to purchase fully insured coverage in Vermont.

3. Describe how the 10.9% increase to the quarterly manual rate translates to an annual increase of 15.6%.

Response: The 10.9% quarterly manual rate increase reflect the proposed change in the manual rates from 4Q 2019 to 1Q 2020. In order to calculate the annual manual rate increase for a group that renews in 1Q 2020, you also need to incorporate the quarterly changes from 2Q to 4Q 2019. Those quarterly changes (2Q 2019/1Q 2019, 3Q 2019/2Q 2019 and 4Q 2019/3Q 2019) were 1.4% as approved in the prior filing. The 15.6% annual manual rate increase reflects the product of the 4 quarterly increases.

4. Provide quantitative support for the pooling charge of 9.92% for claims above $100,000 and also provide the historical experience of claims above $100,000 over the past five years for this block.

Response: Please see the tab "Question #4" in the attached Excel file for the implied pooling charges from the Vermont Large Group population for the past 5 calendar years. Because of the wide variability in implied pooling charges, MVP has chosen to use a pooling charge of 9.92%. This is the historical average of implied pooling charges for MVP's experience rated large group population in New York, which is much larger and more stable than the Vermont population.

5. Provide support for the 3.206 IBNR factor given the two months of claim run-out that was used. Provide actual to expected IBNR estimates for the prior 3 years.

Response: While the incurred estimates included two months of claim run-out, the actual paid claim data in the filing incorporated zero months of claim run-out. Said differently, the 3.206 IBNR factor for the incurred month of April 2019 includes claims both know and paid in May and June of 2019 as well as an estimate of remaining incurred claims as of June 2019. Please see the tab "Question #5" in the attached Excel document for a table which breaks out the incurred estimate for each month of the experience period into three components: paid claims as of April 2019, paid claims in May and June 2019 and remaining reserve as of June 2019. As you can see in the table, the majority of claims considered "IBNR" in the rate filing were actually known claims as of the time of the filing but were not included as paid claims in the data.

To compare actual to expected IBNR estimates, please see the following table that provide the annual incurred estimates from MVP's Vermont model. Each year is shown as of the following February (assuming 2 months of run-out on the most recent incurred month) as well as the ultimate incurred estimate (assumed as of June 30, 2019). Restatement of incurred estimates have been under 1.3% for the prior 3 years.

Calendar Year	Incurred Estimate as of the Following February	Ultimate Incurred Estimate (as of 6/30/19)
2016	$26,260,355	$26,435,344
2017	$39,672,377	$40,178,539
2018	$97,878,075	$96,746,833

The 12-month IBNR factor, assuming two months of paid claim run-out as known at the time of the filing, is 1.025. This is in line with recent filings that have included two months lag between paid claims and incurred estimates.

6. Clarify if the calculation of the $0.82 PMPM for the reclassification of antidepressants and antipsychotic/antimanic agents as preventive is based on claims that occurred before the deductible or for claimants who would not have hit the deductible with these claims removed.

Response: The $0.82 PMPM considers claims that were paid by a member under their deductible using MVP's claims payment software. Those claims were paid by the member and will now be covered by MVP.

MVP recognizes that it is possible some members who hit their deductible with these claims may otherwise not have hit their deductible (and, therefore, MVP should only reflect a portion of the amount above as additional claim expense). MVP pulled member-level claim detail for this population and found that there were 0 cases of members hitting their deductible utilizing these drugs that would not have without the drugs. Therefore, the $0.82 PMPM is the best estimate of the net claim cost increase to MVP due to this change.

7. Provide quantitative and qualitative support for the $3.86 Medical Home and PCP Incentive.

Response: The $3.86 PMPM line item for Medical Home and PCP Incentives include the following programs:

OneCare Population Health Management Payment (**$1.82 PMPM**)- MVP is estimated to pay $3.25 per attributed member per month to OneCare as part of our ACO risk share arrangement. This payment is to cover population health management work performed by OneCare. MVP's best estimate is that 56% of members will attribute to OneCare as part of the arrangement. Therefore, MVP has built $1.82 ($3.25 times 56%) PMPM into the rates.

Subsequent negotiations have determined that large group Vermont members will not be included in the risk deal for 2020. Therefore, MVP is amenable to removing this $1.82 PMPM load from the rates.

Blueprint for Health Patient Centered Medical Homes ($1.19 PMPM)- MVP pays a PMPM fee to PCMHs as part of the state's Blueprint for Health program. MVP's best estimate of the 2020 cost per attributed member per month is $4.00 and 29.7% of members attributed to a PCMH in 2018. Therefore, MVP has built in $1.19 PMPM ($4.00 times 29.7%) into rates to account for this program.

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

Community Health Teams Payments ($0.85 PMPM)- MVP provides funding for Community Health Teams (CHTs) in Vermont, also as a part of the Blueprint for Health program. MVP's payments in the first two quarters of 2019 amounted to $0.85 PMPM across all lines of business, and MVP does not expect these costs to increase at a rate faster than MVP's membership growth from 2019 to 2020. Therefore, MVP has built $0.85 PMPM into the rates for 2020.

8. Provide additional qualitative support for the rationale behind making the adjustment on line 14b of Exhibit 3a.

Response: As part of the rating formula, MVP adjusts a group's manual rate based on the Standard Industrial Code (SIC) factor table provided in the filing. The table is calculated such that an average group is a 1.0 factor. MVP's manual rates reflect a mix of business that does not average out to a 1.0 member-weighted factor. Therefore, an adjustment to the manual rates is needed that is the inverse of the experience period average SIC factor. That way, a group with a SIC factor of 1.05 will have a manual rate that is 5% greater than an average group.

9. Provide quantitative and qualitative support for the 5.5% increase for the PMPM administrative costs.

Response: When setting premium rates for all of MVP's blocks of business, the contribution to administrative expenses is considered collectively across the enterprise to ensure that in total MVP can cover the anticipated corporate administrative budget for the coverage year. Projections for membership, fully insured premiums, Administrative Services Only (ASO) administrative fees, anticipated administrative funding for the New York State Medicaid Managed Care program and MVP's administrative cost allocation models were all considered to project overall contribution to administrative expenses for 2020 and used to inform pricing assumptions.

MVP's enterprise-wide membership has declined while global administrative costs continue to rise. Please see the table below for a summary of MVP's enterprise-wide over recent time periods. Over the past 15 months, MVP's enterprise-wide membership has declined by 5.2%.

	Dec 2017	**Dec 2018**	**Mar 2019**
MVP Enterprise Wide Members	592,228	567,663	561,520
% Change Compared to Prior Period	n/a	-4.1%	-1.1%

MVP has found that a 5.5% increase to the admin expense on a PMPM basis is sufficient to cover administrative expenses given increasing expenses and declining membership. Because premiums are proposed to increase at a faster rate than the increase in PMPM administrative expenses, MVP is proposing to decrease its admin load as a percentage of premium. Note this PMPM change in administrative expense is consistent with the change in the admin load for MVP's 2020 VT Exchange filing.

10. Provide the actual historical average increase for the Covered Lives Assessment.

Response: Please see the tab "Question #10" in the attached Excel document which provides historical increases to the Covered Lives Assessment in New York. MVP would also like to note that this assessment only applies to subscribers that live in New York. Based on July 2019 membership, this would result in an approximate annual cost of $6,000 across the entire Vermont large group block of business.

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

11. Provide quantitative support for the 1.0% assumption for the ACA Insurer Tax.

Response: Please see the tab "Question #11" in the attached Excel document for a quantitative derivation of MVP Health Care's actual 2018 ACA Health Insurer Tax liability by licensed entity.

Per United States Treasury Regulation § 57.4(a)(3), the Health Insurer Tax for fee years 2019 and forward are equal to "The applicable amount in the preceding fee year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii))." Because of this clause, the Tax will remain a consistent percentage of nationwide premium beginning in 2018. This has the effect of fixing MVP's tax load as a percentage of premium.

The only change that would affect MVP Health Care's global liability for the tax would be a shift of revenue between MVP's companies. MVP Health Plan has a portion of its revenue exempted from the tax due to its tax-exempt status, so a shift to or away from this company could change the total liability as a percentage of premium. However, MVP sensitivity tested these changes and found that, even in the most extreme scenarios, the liability as a percentage of premium would not change within 0.1%.
Therefore, we are confident in assuming a 1.0% Health Insurer Tax load for MVP Health Plan for 2020, consistent with the actual liability percentage for 2018.

12. Provide quantitative support for the calculation of the value of the benefits associated with the Safe Harbor riders.

Response: In MVP's internal benefit relativity model, all pharmacy claims that would be classified as preventive under this benefit (including claims for members that do not have the benefit) are flagged as being preventive. MVP then creates two sets of its distribution tables for qualified HDHP plans- one with these claims included and one with these claims excluded. That way, MVP can create a benefit relativity for every plan design with and without the Safe Harbor rider. The value of the rider is then calculated as the difference between computed manual rates with and without the rider.

A quantitative derivation of the Safe Harbor rider can be found by comparing the rows for coplan VT3HDH02AXL on Exhibit 3e in the rate filing. The difference between the "Total Required Revenue for 4Q19 After Resloping" for the designs with and without the rider is $5.87 ($426.40 with the rider, $420.53 without the rider). Multiplying this re-sloped 4Q19 rider cost by the quarterly manual rate increase of 10.9% results in a 1Q 2020 rider cost of $6.51 (which is the cost of the rider RXVT3HDH510L-b on Exhibit 4b for 1Q 2020).

13. Provide quantitative support for the calculation of the value of the updated wellness program.

Response: MVP's current wellness program provides $200 in rewards for completing a Personal Health Assessment and $125 in reimbursements for gym membership or other physical well-being programs. Based on experience period data, those claims totaled approximately $0.59 PMPM across all large groups in New York and Vermont with $0.35 PMPM attributable to the $200 reward program and $0.24 PMPM attributable to the $125 reimbursement program.

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

For 2020, MVP has increased the wellness reimbursement to $200 as well as included many new activities across the wellness spectrum. Therefore, MVP assumed that any members currently utilizing the reimbursement would increase their reimbursement to $200. This increase in the reimbursement amount is worth $0.14 PMPM ([$200 / $125] -1 * $0.24 = $0.14). Additionally, MVP is instituting a rewards program where members can receive $50 per quarter if their wearable device registered with MVP's vendor meets a step threshold for the time period. Based on data provided by MVP's vendor, MVP estimates that reward claims will account for approximately 0.1% of member months in each quarter. Therefore, MVP has assumed an additional $0.05 PMPM for this portion of the program ($50 * 0.1%).

After examining the assumptions reflected in the line item "Other Medical Expense not in warehouse", it was recognized that this additional $0.19 PMPM is not being captured. MVP requests that this amount be added into the final approved rates.

14. Please confirm that the Experience Rated Addendum will be filed each year and anytime a change is made to the factors within.

Response: MVP agrees that a new Experience Rated Addendum will be filed every year and anytime a change is made to the factors within.

15. Please confirm that the Experience Rating Formula will be filed anytime a change is made.

Response: MVP files the Experience Rating Formula (including Exhibits A to C) as a part of every filing. If changes are made to the Formula from prior years, MVP will indicate the changes in the Actuarial Memorandum as part of the filing.

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