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September 24, 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 09/18/2019 regarding the above-mentioned rate filing. The responses to your questions are provided below.

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

Response: Please see the tab "Question #1" in the attached Excel document for the completed table.

2. Provide any caveats or explanations necessary to understand the numbers in the table above.

Response: MVP moved all its' existing large-group business from the MVP Health Insurance Company (MVPHIC) to MVP Health Management Organization (MVPHMO), effective upon renewal, beginning in the 3rd quarter of 2018. Because the actuals provided include some blend of MVPHIC and MVPHMO business over the course of time, MVP has changed the final column from the 1Q/2Q 2018 MVPHMO filing to the 1Q/2Q 2018 MVPHIC filing (Docket # GMCB-011-17rr).

The latest actual data MVP has is for 1Q/2Q 2018 renewals. The data is incomplete for most 3Q/4Q 2018 renewals, therefore MVP has not provided it (Docket # GMCB-007-18rr).

MVP has interpreted "Total Administrative Expenses PMPM" to be equivalent to the Administrative Expense load assumed in premium rates multiplied by the expected premium PMPM. The actuals for the time period reflect lines 6.6, 8.3, 10.1 and 10.4 of the Supplemental Health Care Exhibit for Vermont Large Group (combining MVPHIC and MVPHP).

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 2017 to calendar year 2018 and then weighted those trends by the percentage of allowed costs in each bucket during calendar year 2017.

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:

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-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.

-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.

3. Please complete the table below from last year's responses to HCA questions (Sept. 20, 2018 Response), providing the overall average, the premium-weighted average, and the range of actual rate increases experienced by the groups covered by the filing in 2018, 2019 to date, 2020 projected. Please explain any differences between the 2018 numbers provided here and the partial 2018 numbers.

Response: Please see the following table which provides the information requested. The average for 2018 changed slightly from the January to July 2018 line previously provided due to two groups who changed riders which were implemented retrospectively.

VT Large Group Revenue Changes, by Group, Renewal Periods 2016-2020

Renewal Year	Minimum Increase	Maximum Increase	Average Increase	Average Increase (Premium Weighted)
2016	-8.82%	17.87%	2.29%	1.22%
2017	-8.52%	-6.25%	-1.45%	-3.33%
2018 Jan. – July	-7.00%	16.81%	3.92%	4.07%
2018	-7.00%	16.81%	3.75%	3.98%
2019	-8.65%	14.03%	4.23%	4.53%
2020 Proj.	5.28%	14.51%	8.34%	8.37%

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4. As in previous filings, the year's filed Experience Rated Addendum contains the following statement:

> *Adjustments may be made due to items such as poor claim and enrollment experience data being presented for new groups, the group's claim trend being historically different than the averages, variability in claims experience, participation levels/group size changes, plan sponsor contribution levels, number of plan offerings, plan sponsor and covered population stability, and plan sponsor persistency. Adjustments may be both positive and negative but will not be larger than 10% in either direction.*

As shown above, you reported last year that your maximum increases in 2016 and 2018 were significantly higher than 10%. Please demonstrate that you have maintained your 10% rule in the application of your underwriting discretion.

Response: The paragraph shown above falls in the Addendum under the heading of "Underwriting Judgment / Group Risk Assessment" which corresponds to Section IV, Line 5 of the formula. This line is an additional factor that may be applied *after* the manual pure premium and the experience pure premium are calculated and blended.

Therefore, the formula does not indicate that the maximum rate increase for a group will be less than 10% (as inferred in the question). The formula indicates that a rate, encompassing a group's credibility and experience, can be adjusted by up to +/-10% for the above listed considerations.

As an example, the formula could produce a rate increase of 25% for a group which is large enough to use 100% of its' own experience in rate development. The underwriter, using the discretion listed above, adjusts the rate increase downward by 10%. The formula is still being followed, but the proposed rate increase is +12.5% (1.25 times 0.90 = 1.125).

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

Year Filed Docket #		2020 GMCB-008-19rr	2019 GMCB-010-18rr	2018 GMCB-007-18rr	2018 GMCB-011-17rr
Members		1,798	2,171	2,275	1,995
Allowed Medical Trend	Proposed	5.1%	3.9%	2.5%	3.0%
	Allowed	NA	3.5%	2.5%	3.0%
	Actual*	NA	NA	NA	11.8%
Medical Unit Cost	Proposed	4.1%	3.9%	2.5%	2.4%
	Allowed	NA	3.5%	2.5%	2.4%
	Actual*	NA	NA	NA	-1.7%
Medical Utilization	Proposed	1.0%	0.0%	0.0%	0.6%
	Allowed	NA	0.0%	0.0%	0.6%
	Actual*	NA	NA	NA	13.8%
Allowed Rx Trend	Proposed	8.5%	13.3%	11.4%	11.8%
	Allowed	NA	13.3%	11.4%	11.8%
	Actual*	NA	NA	NA	0.6%
Total Administrative Charges PMPM	Proposed	$47.40	$45.03	$46.12	$45.15
	Allowed	NA	$44.08	$44.54	$45.15
	Actual*	NA	NA	$48.67	$48.67
CTR	Proposed	2.0%	2.0%	2.0%	2.0%
	Allowed	NA	1.5%	1.5%	2.0%