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

June 21, 2023

Michael Barber
General Counsel
Green Mountain Care Board

Re:	MVP Health Plan, Inc. 2024 Individual Market Rate Filing	GMCB-004-23rr SERFF No. MVPH-133660955
	MVP Health Plan, Inc. 2024 Small Group Market Rate Filing	GMCB-005-23rr SERFF No. MVPH-133660956

Dear Mr. Barber:

This letter is in response to your correspondence received 06/07/23 regarding the above-mentioned rate filings. The responses to your questions are provided below.

1. In our decision last year, MVP was ordered to include "detailed information on the efforts it has taken to encourage enrollment through VHC and the effectiveness of these efforts" in its 2024 individual rate filing. Provide this information.

Response:

The answer below was prepared by our marketing department.

2021

- Targeted letters sent to approximately 1,400 Vermont members in April of 2021. This was a collaborative, multi-carrier effort with VHC
- Boosted Social Media
    - Facebook Post 1 (June 4 – June 18): Reach of 1,861 with 515 engagements
    - Facebook Post 2 (June 17 – June 30): Reach of 6,408 with 72 engagements
    - Instagram Post (June 10 – June 30): Reach of 4,028 with 918 engagements
- Paid Search
    - June: 5,143 searches, 78 conversions
    - July: 17,126 Searches, 284 conversions
- Banner ad on SHOP page launched in June. This directed individuals to VHC for more information on ARPA
- Copy added to **mvphealthcare.com/Vermont**, directing members to VHC for more information about the subsidies
- 2022 Individual Lead Packets, Individual OE renewal materials, and VT OE Acquisition DM featured information about ARPA
- Targeted email sent in August to 940 Vermont members had a 52.26% open rate

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2022

- Targeted emails for Vermont Town Halls; both emails had more than a 50% open rate
- FAQs for Customer Care in preparation of VHC Press Release

2023

- Renewal notices, which go out annually to all Vermont Individual plan members
- Lead packet cover letters, which is a tool for prospective members requesting information from MVP

2. Provide MVP's 2022 Supplemental Health Care Exhibit.

Response: Please see the provided attachment, *MVPHP VT SHCE*.

3. For the most recent year for which data are available (please specify), provide the dollar value of payments and the percentages of payments made by MVP under each alternative payment model category below across MVP's individual and small group plans and identify the relevant program or payment arrangement(s).

Response: Please see the table below.

2022			
HCP-LAN Category	**Program or Payment Arrangement(s)**	**$ value**	**% of total**
Category 1: FFS-No link to Quality and Value			
1: FFS-No link to Quality & Value		$173M	75%
Category 2: FFS-Link to Quality and Value			
2A: Foundational payments for infrastructure & operations		$0	0%
2B: Pay for reporting		$0	0%
2C: Pay for performance		$0	0%
Category 3: APMs Built on FFS Architecture			
3A: APMs with shared savings	OneCare VT	$59M	25%
3B: APMs with shared savings and downside risk		$0	0%
3N: Risk based payments NOT linked to quality		$0	0%
Category 4: Population-Based Payment			
4A: Condition-specific population-based payment		$0	0%

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4B: Comprehensive population-based payment		$0	0%
4B with reconciliation to FFS and ultimate accountability for TCOC		$0	0%
4B with NO reconciliation to FFS		$0	0%
4C: Integrated finance & delivery system		$0	0%
4N: Capitated payments NOT linked to quality		$0	0%

4. Explain whether MVP observed an increase in cancellations or shifts in enrollment by metal level due to the high premium increases in 2023.

Response: MVP did have a decrease in membership from 2022 to 2023. Both the Small Group and Individual markets contracted in size over the same time period, so it is hard to say how many of the members left to go to a competitor due to the premium increases, left to the level funded market, or were able to obtain government funded coverage.

MVP also saw a general increase in the lower cost metal levels as a percentage of membership. Buydown from one metal level to another is not something that would be attributed to solely high premium increases in 2023, but instead is something that generally happens over time with any increase of health care costs. Also, the membership growing as a percentage in the lower metal levels doesn't mean members are moving there, it could just be members leaving the higher metal levels and obtaining coverage elsewhere.

There are many reasons members may not be enrolled in the same metal level in the following year and we don't feel it is appropriate to attribute that solely to the high premium increases in 2023.

5. Describe how MVP prospectively assesses its solvency and explain how the projected contribution to surplus from each filing and MVP's prospective assessment of solvency would be impacted if the rates were reduced by 1%, 2%, 3%, 4%, and 5% (assuming no corresponding decrease in costs).

Response: The answer below was prepared by our Finance department.

In accordance with New York State's Enterprise Risk Management (ERM) requirements, MVP assesses its prospective solvency in relation to its risk profile. To calculate the target capital position for each year, MVP aggregates regulatory capital, risk capital and an additional capital buffer. Regulatory capital requirements are assessed based upon actual and projected premiums. The risk capital is determined based upon the Company's annual Risk Control Self-Assessment and stochastic modelling methods. The additional capital buffer is 5% of the sum of both the regulatory capital and the risk capital estimates. MVP's available capital is the sum of its actual and projected reserves which are calculated based upon MVP's actual and projected performance in the Company's regulated entities.

MVP annually requests premium rates that are believed to be actuarially sound and developed in accordance with actuarial standards of practice based on all available information at the time rates are developed. The GMCB's

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Actuary does a thorough review of the rates for actuarial soundness. While MVP's Actuary may disagree on occasion with the GMCB's Actuary, those disagreements are grounded in sound actuarial principles.

Health Plans take tremendous risk when guaranteeing premium rates for an insured population as they must pay for all covered benefits regardless of cost. A risk margin is standard actuarial practice and part of premium rate development to account for adverse deviation in projected costs as well as a means to adhere to minimum regulatory reserve requirements.

When regulators reduce actuarial sound premium rates to remove risk margins and to 'make premiums more affordable' it compromises a Health Plan's ability to serve members and remain a viable option in the marketplace.

Below is a summary of MVP's performance over the past 5 years. MVP has collectively lost $31M in the past 5 years and is anticipating a significant loss in 2023. The GMCB has contributed to this loss by way of year over year non actuarial sound cuts to MVP's requested premium rates.

Year	Operating Margin	Medical Loss Ratio
2018	($0.7M)	92.2%
2019	($1.8M)	93.3%
2020	$17M	86.4%
2021	($23M)	101.1%
2022	($22.3M)	101.9%
Cumulative 2018-2022	($30.8M)	94.7%
2023 Projection (as of Jan23)	$(14.3M)	

MVP is a diversified not for profit insurer doing its best to serve New York and Vermont customers across multiple lines of business. Each of the markets we serve must be self-sustaining over the long run and be expected to contribute to a healthy (not excessive) overall reserve level. Markets that do not have that expectation due to circumstances outside of MVP's control will be reevaluated. New York Regulators do not expect MVP's New York Markets to subsidize Vermont Markets or vice versa.

A healthy reserve position allows for continued risk taking, innovation and reinvestment. It allows MVP to achieve our Mission, Vision and Purpose which is to improve health and provide peace of mind, create healthier communities and find a better way to help our members achieve their best health through innovation.

As of 12/31/2022 MVP Health Plan had total net assets of $413.5 million on $3.14 billion in revenue. The reserves as a percentage of premium was at 13.16%. NYS requires that we maintain a 12.5% reserve ratio vs premiums earned. MVP has an RBC of 369%. Since premiums need to increase each year just to keep up if the cost of care increases we must maintain a profit margin just to maintain our current reserve position. A 1% reduction in Vermont premiums is worth approximately $2.75M in lost reserves. A 5% reduction would yield a very significant loss of $13.75M. Continuing losses in VT Small Group and Individual products are not sustainable for MVP. Our for profit competitors are much larger and better capitalized then MVP. Regional not for profit plans must remain profitable in order to serve the communities we work and live in.

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6. The Board is interested in better understanding how MVP reimburses non-hospital affiliated providers in its service area and what MVP has assumed in the filings regarding reimbursement increases for these providers. To that end,

a. Describe the mechanisms by which MVP reimburses non-hospital-affiliated providers. For example, does MVP use fee schedules? If so, how many fee schedules does MVP maintain and what types of services or providers does each apply to?

b. Describe the magnitude and timing of any reimbursement increases for nonhospital-affiliated providers expected between now and the end of 2024, identify where in the filing these increases are reflected, and explain whether the increases will be across-the-board or targeted to certain providers or codes.

c. How does MVP define each provider type and how does this definition relate to the "professional" premium category of the URRT?

Response:

a. For non-hospital-affiliated providers, MVP signs agreements addressing the fee schedule under which the provider's claims will be reimbursed. The most common fee schedule used is based on percentage of Medicare RVU. In several service types such as Behavioral Health, Physician Therapy, Occupational Therapy, MVP and the providers can agree on a fee schedule of flat fees for each service. MVP maintains more than 1000 different fee schedules for providers in Vermont, varied by line of business, product type and provider specialty for over 60 different provider groups we have relationships with.

b. The vast majority of MVP's contracts renew on January 1st. The estimated impact of these renewals is built into the physician trend in the rate filing. It is possible that providers may ask for or propose new fee schedules to MVP off cycle. The nature of the increases can vary by provider and what fee schedule they are currently on.

c. The 'professional' provider type in the URRT is all services that are not inpatient or outpatient. This is analogous to "PHY" trend in our rate filing. Everything medical that is not Inpatient or outpatient is defined as physician.

7. Explain how, if at all, MVP assesses the equity and sufficiency of payments across care settings.

Response: The answer below was prepared by our Network department.

To ensure parity across the network for like services, MVP created a fee exception committee that meets bi-weekly to review any reimbursement requests that deviate from our standard fee schedule. This committee requires that the contract manager provide documented justification and analytics for granting an exception, which is based on the criteria below. The committee then determines if the request will be approved, denied or negotiated further. The information and decisions are also tracked in a database which is maintained by Network Management. In terms of payment sufficiency, MVP does evaluate rates based on competitive intelligence and/or provider feedback. As an example, behavioral health providers in Vermont had notified us that our rates had not kept up with industry standards the past few years and upon further evaluation, MVP did grant a significant increase to the BH community fee schedule in 2022 to remain competitive in the VT market.

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8. The Board is interested in understanding how charge increases allowed in the individual and small group filings compare to actual charge increases implemented by MVP. To that end, please provide, in a table format for each year since 2014:

a. The charge increases for non-hospital-affiliated providers allowed in MVP's individual and small group filings and the actual increases implemented by MVP. Explain any variances.

b. The charge increases for hospitals allowed in the rate filing and the actual increases implemented by MVP. Explain any variances.

Response: MVP has a document retention policy of 6 years for rate filing related documents and therefore only has this information back through 2016. That information is provided below.

[redacted]

Year	[redacted]
2016	
2017	
2018	
2019	
2020	
2021	
2022	

b. Please see the table below. The slight variations seen below are due to the hospital budgets being finalized after the rate filings, and therefore can create variances between the rate filing and the approved trends.

Year	[redacted]
2016	
2017	
2018	
2019	
2020	
2021	
2022	

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If you have any questions or require any additional information, please contact me at cpontiff@mvphealthcare.com.

Sincerely,

Christopher Pontiff, FSA, MAAA
Senior Director, Commercial Pricing, Network & Trend Actuary
MVP Health Care, Inc.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1

(To Be Filed by April 1 - Not for Rebate Purposes - See Cautionary Statement at https://content.naic.org/sites/default/files/inline-files/committees_e_app_blanks_related_shce_cautionary_statement.pdf)

REPORT FOR: 1. CORPORATION: MVP Health Plan, Inc. 2. LOCATION: Schenectady, NY 12305

95521202221646100 2022 Document Code: 216

NAIC Group Code 1198 BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2022 NAIC Company Code 95521

Supp216.1 Vermont

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9						
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Individual	5 Small Group Employer	6 Large Group Employer	7 Small Group	8 Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
1. Premium:															
1.1 Health premiums earned (From Part 2, Line 1.11)	101,274,821	139,012,036	12,916,304								55,980	36,700,604	289,959,745	XXX	289,959,745
1.2 Federal high risk pools														XXX	
1.3 State high risk pools														XXX	
1.4 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)	101,274,821	139,012,036	12,916,304								55,980	36,700,604	289,959,745	XXX	289,959,745
1.5 Federal taxes and federal assessments	80,726	119,326	5,859										205,911		205,911
1.6 State insurance, premium and other taxes (Similar local taxes of $.....0)															
1.6A Community Benefit Expenditures (informational only)															
1.7 Regulatory authority licenses and fees	2,848	3,811	348								2	417	7,426		7,426
1.8 Adjusted Premiums Earned (Lines 1.4 - 1.5 - 1.6 - 1.7)	101,191,247	138,888,899	12,910,097								55,978	36,700,187	289,746,408	XXX	289,746,408
1.9 Net assumed less ceded reinsurance premiums earned	(180,148)	(271,798)	(29,299)									(53,403)	(534,648)	XXX	(534,648)
1.10 Other adjustments due to MLR calculations - Premiums														XXX	
1.11 Risk Revenue														XXX	
1.12 Net adjusted premiums earned after reinsurance (Lines 1.8 + 1.9 + 1.10 + 1.11)	101,011,099	138,617,101	12,880,798								55,978	36,646,784	289,211,760	XXX	289,211,760
2. Claims:															
2.1 Incurred claims excluding prescription drugs	86,406,567	119,697,133	9,599,494								37,034	36,756,139	252,496,367	XXX	252,496,367
2.2 Prescription drugs	18,800,986	29,040,456	2,445,479									8,535,965	58,822,886	XXX	58,822,886
2.3 Pharmaceutical rebates	6,251,416	10,176,418	1,154,834									5,185,542	22,768,210	XXX	22,768,210
2.4 State stop-loss, market stabilization and claim/census based assessments (informational only)	1,391,445	1,725,548	169,334										3,286,327	XXX	3,286,327
3. Incurred medical incentive pools and bonuses	590,757	941,978	62,127									289,272	1,884,134	XXX	1,884,134
4. Deductible Fraud and Abuse Detection/Recovery Expenses (for MLR use only)	11,180	6,333											17,513		17,513
5.0 TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 3) (From Part 2, Line 2.15)	99,546,894	139,503,149	10,952,266								37,034	40,395,834	290,435,177	XXX	290,435,177
5.1 Net assumed less ceded reinsurance claims incurred	60,054	(825,970)	(96,761)										(862,677)	XXX	(862,677)
5.2 Other adjustments due to MLR calculations - Claims	(5,264,447)	(5,022,387)											(10,286,834)	XXX	(10,286,834)
5.3 Rebates Paid										XXX	XXX	45,542	45,542	XXX	45,542
5.4 Estimated rebates unpaid prior year										XXX	XXX	45,542	45,542	XXX	45,542
5.5 Estimated rebates unpaid current year										XXX	XXX			XXX	
5.6 Fee for service and co-pay revenue														XXX	
5.7 Net incurred claims after reinsurance (Lines 5.0 + 5.1 + 5.2 + 5.3 - 5.4 + 5.5 - 5.6)	94,342,501	133,654,792	10,855,505								37,034	40,395,834	279,285,666	XXX	279,285,666
6. Improving Health Care Quality Expenses Incurred:															
6.1 Improve health outcomes	293,775	406,272	37,344								2	350,460	1,087,853		1,087,853
6.2 Activities to prevent hospital readmissions															
6.3 Improve patient safety and reduce medical errors	138,952	210,278	18,210									342,430	709,870		709,870
6.4 Wellness and health promotion activities	59,975	76,740	9,724									71,580	218,019		218,019
6.5 Health Information Technology expenses related to health improvement	11,916	17,393	1,428								2	5,249	35,988		35,988
6.6 TOTAL of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1 + 6.2 + 6.3 + 6.4 + 6.5)	504,618	710,683	66,706								4	769,719	2,051,730		2,051,730
7. Preliminary Medical Loss Ratio: MLR (Lines 4 + 5.0 + 6.6 - Footnote 2.0) / Line 1.8	0.989	1.010	0.854							XXX	XXX	1.122	XXX	XXX	XXX
8. Claims Adjustment Expenses:															
8.1 Cost containment expenses not included in quality of care expenses in Line 6.6	1,637,943	1,350,678	121,780								49	1,028,365	4,138,815		4,138,815
8.2 All other claims adjustment expenses	525,746	811,521	67,820								134	186,974	1,592,195		1,592,195
8.3 TOTAL Claims adjustment expenses (Lines 8.1 + 8.2)	2,163,689	2,162,199	189,600								183	1,215,339	5,731,010		5,731,010
9. Claims Adjustment Expense Ratio (Line 8.3 / Line 1.8)	0.021	0.016	0.015								0.003	0.033	XXX	XXX	XXX

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1 (Continued)

(To Be Filed by April 1 - Not for Rebate Purposes)

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9						
	1	2	3	4	5	6	7	8							
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
10. General and Administrative (G&A) Expenses:															
10.1 Direct sales salaries and benefits	229,980	359,033	101,303								493	57,775	748,584		748,584
10.2 Agents and brokers fees and commissions			304,313								725	470,093	775,131		775,131
10.3 Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)															
10.4 Other general and administrative expenses	5,075,197	6,646,903	609,286								5,433	3,104,337	15,441,156		15,441,156
10.4A Community Benefit Expenditures (informational only)															
10.5 TOTAL General and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)	5,305,177	7,005,936	1,014,902								6,651	3,632,205	16,964,871		16,964,871
11. Underwriting Gain/(Loss) (Lines 1.12 - 5.7 - 6.6 - 8.3 - 10.5)	(1,304,886)	(4,916,509)	754,085								12,106	(9,366,313)	(14,821,517)	XXX	(14,821,517)
12. Income from fees of uninsured plans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
13. Net investment and other gain/(loss)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX	
14. Federal income taxes (excluding taxes on Line 1.5 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX	
15. Net gain or (loss) (Lines 11 + 12 + 13 - 14)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	(14,821,517)	XXX	(14,821,517)
16. ICD-10 Implementation Expenses (informational only; already included in general expenses and Line 10.4)															
16A. ICD-10 Implementation Expenses (informational only: already included in Line 10.4)															
OTHER INDICATORS:															
1. Number of Certificates / Policies	9,136	12,337	1,113								426	5,552	28,564		28,564
2. Number of Covered Lives	12,722	20,593	1,864								684	5,552	41,415		41,415
3. Number of Groups	XXX	1,450	10	XXX							67	3	1,530		1,530
4. Member Months	165,273	249,356	22,029								8,628	63,722	509,008		509,008

(a) Is run off business reported in Columns 1 through 9 or 12? Yes[ ] No[X]
(b) If yes, show the amount of premiums and claims included: Premiums $.....0 Claims $.....0

AFFORDABLE CARE ACT (ACA) RECEIPTS, PAYMENTS, RECEIVABLES and PAYABLES

	Current Year		Prior Year	
	Comprehensive Health Coverage		Comprehensive Health Coverage	
	1 Individual Plans	2 Small Group Employer Plans	3 Individual Plans	4 Small Group Employer Plans
ACA Receivables and Payables				
1. Permanent ACA Risk Adjustment Program				
1.0 Premium adjustments receivable/(payable)	(13,226,575)	(7,567,830)		
2. Transitional ACA Reinsurance Program				
2.0 Total amounts recoverable for claims (paid & unpaid)		XXX		XXX
3. Temporary ACA Risk Corridors Program				
3.1 Accrued retrospective premium				
3.2 Reserve for rate credits or policy experience refunds				
ACA Receipts and Payments				
4. Permanent ACA Risk Adjustment Program				
4.0 Premium adjustments receipts/(payments)			(5,318,918)	(15,390,198)
5. Transitional ACA Reinsurance Program				
5.0 Amounts received for claims		XXX		XXX
6. Temporary ACA Risk Corridors Program				
6.1 Retrospective premium received				
6.2 Rate credits or policy experience refunds paid				

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 2

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: MVP Health Plan, Inc. 2. LOCATION: Schenectady, NY 12305

NAIC Group Code 1198 **BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2022** **NAIC Company Code 95521**

		Business Subject to MLR								10	11	12	13
		Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9			
		1	2	3	4	5	6	7	8				
		Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	Government Business (Excluded by Statute)	Other Health Business	Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA	Total (a)
1.	Health Premiums Earned:													
1.1	Direct premiums written	101,468,737	139,365,451	12,932,161								55,980	36,700,604	290,522,933
1.2	Unearned premium prior year													
1.3	Unearned premium current year													
1.4	Change in unearned premium (Lines 1.2 - 1.3)													
1.5	Paid rate credits												45,542	45,542
1.6	Reserve for rate credits current year			35,316										35,316
1.7	Reserve for rate credits prior year			35,316									749,505	784,821
1.8	Change in reserve for rate credits (Lines 1.6 - 1.7)												(749,505)	(749,505)
1.9	Premium balances written off	193,916	353,415	15,857										563,188
1.10	Group conversion charges													
1.11	TOTAL Direct premiums earned (Lines 1.1 + 1.4 - 1.9 + 1.10)	101,274,821	139,012,036	12,916,304								55,980	36,700,604	289,959,745
1.12	Assumed premiums earned from non-affiliates													
1.13	Net assumed less ceded premiums earned from affiliates													
1.14	Ceded premiums earned to non-affiliates	180,148	271,798	29,299									53,403	534,648
1.15	Other adjustments due to MLR calculation - Premiums													
1.16	Net premiums earned (Lines 1.11 - 1.5 - 1.8 + 1.12 + 1.13 - 1.14 + 1.15)	101,094,673	138,740,238	12,887,005								55,980	37,351,164	290,129,060
2.	Direct Claims Incurred:													
2.1	Paid claims during the year	100,862,263	139,837,027	11,204,789								37,034	39,234,338	291,175,451
2.2	Direct claim liability current year	9,796,098	13,295,787	1,087,897									1,352,222	25,532,004
2.3	Direct claim liability prior year	11,471,247	14,140,691	1,468,891									2,252,475	29,333,304
2.4	Direct claim reserves current year													
2.5	Direct claim reserves prior year													
2.6	Direct contract reserves current year													
2.7	Direct contract reserves prior year													
2.8	Paid rate credits												45,542	45,542
2.9	Reserve for rate credits current year			35,316										35,316
2.10	Reserve for rate credits prior year			35,316									749,505	784,821
2.11	Incurred medical incentive pools and bonuses (Lines 2.11a + 2.11b - 2.11c)	590,757	941,978	62,127									289,272	1,884,134
	2.11A Paid medical incentive pools and bonuses current year	787,053	1,280,572	62,283									289,658	2,419,566
	2.11B Accrued medical incentive pools and bonuses current year	(51,748)	(103,206)	(713)									(179)	(155,846)
	2.11C Accrued medical incentive pools and bonuses prior year	144,548	235,388	(557)									207	379,586
2.12	Net healthcare receivables (Lines 2.12a - 2.12b)	230,977	430,952	(66,346)									(2,476,440)	(1,880,857)
	2.12A Healthcare receivables current year	3,884,840	5,980,353	507,607									692,562	11,065,362
	2.12B Healthcare receivables prior year	3,653,863	5,549,401	573,953									3,169,002	12,946,219
2.13	Group conversion charge													
2.14	Multi-option coverage blended rate adjustment													
2.15	TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 2.4 - 2.5 + 2.6 - 2.7 + 2.8 + 2.9 - 2.10 + 2.11 - 2.12 + 2.13 + 2.14)	99,546,894	139,503,149	10,952,268								37,034	40,395,834	290,435,179
2.16	Assumed Incurred Claims from non-affiliates													
2.17	Net Assumed less Ceded Incurred Claims from affiliates													
2.18	Ceded Incurred Claims to non-affiliates	(60,054)	825,970	96,761										862,677
2.19	Other Adjustments due to MLR calculation - Claims	(5,264,447)	(5,022,387)											(10,286,834)
2.20	Net Incurred Claims (Lines 2.15 - 2.8 - 2.9 + 2.10 + 2.16 + 2.17 - 2.18 + 2.19)	94,342,501	133,654,792	10,855,507								37,034	41,099,797	279,989,631
3.	Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)	11,180	6,333											17,513

(a) Column 13, Line 1.1 includes direct written premium of $.....0 for stand-alone dental and $.....55,980 for stand-alone vision policies.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: MVP Health Plan, Inc. 2. LOCATION: Schenectady, NY 12305

NAIC Group Code 1198 BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2022 NAIC Company Code 95521

All Expenses		Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
		1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
1.	Individual Comprehensive Coverage Expenses:										
1.1	Salaries (including $.....0 for affiliated services)	276,123		134,437	32,885	11,321	454,766	765,446	321,793	2,812,173	4,354,178
1.2	Outsourced services	8,612		4,004	1,237	272	14,125	705,912	15,929	670,836	1,406,802
1.3	EDP Equipment and Software (incl $.....0 for affiliated services)	345			22,962		23,307	134,912	58,190	527,776	744,185
1.4	Other Equipment (excluding EDP) (incl $.....0 for affiliated services)	8		6	3	1	18	2,250	1,630	9,675	13,573
1.5	Accreditation and Certification (incl $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
1.6	Other Expenses (incl $.....0 for affiliated services)	8,687		505	2,888	322	12,402	29,423	128,205	1,426,216	1,596,246
1.7	Subtotal before reimbursements and taxes (Lines 1.1 to 1.6)	293,775		138,952	59,975	11,916	504,618	1,637,943	525,747	5,446,676	8,114,984
1.8	Reimbursements by uninsured plans and fiscal intermediaries										
1.9	Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	471,961	471,961
1.10	TOTAL (Lines 1.7 to 1.9)	293,775		138,952	59,975	11,916	504,618	1,637,943	525,747	5,918,637	8,586,945
1.11	TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							27,240			27,240
2.	Small Group Comprehensive Coverage Expenses:										
2.1	Salaries (including $.....0 for affiliated services)	381,008		203,607	49,615	16,494	650,724	1,070,614	499,611	3,425,642	5,646,591
2.2	Outsourced services	12,476		5,975	1,867	411	20,729	52,263	24,023	944,355	1,041,370
2.3	EDP Equipment and Software (incl $.....0 for affiliated services)	457			20,897		21,354	183,005	92,281	663,835	960,475
2.4	Other Equipment (excluding EDP) (incl $.....0 for affiliated services)	12		8	4	1	25	3,215	2,403	11,517	17,160
2.5	Accreditation and Certification (incl $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
2.6	Other Expenses (incl $.....0 for affiliated services)	12,319		688	4,357	487	17,851	41,581	193,202	1,216,534	1,469,168
2.7	Subtotal before reimbursements and taxes (Lines 2.1 to 2.6)	406,272		210,278	76,740	17,393	710,683	1,350,678	811,520	6,261,883	9,134,764
2.8	Reimbursements by uninsured plans and fiscal intermediaries										
2.9	Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	346,960	346,960
2.10	TOTAL (Lines 2.7 to 2.9)	406,272		210,278	76,740	17,393	710,683	1,350,678	811,520	6,608,843	9,481,724
2.11	TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							39,910			39,910
3.	Large Group Comprehensive Coverage Expenses:										
3.1	Salaries (including $.....0 for affiliated services)	35,010		17,550	4,382	1,352	58,294	94,856	41,597	418,787	613,534
3.2	Outsourced services	1,115		562	165	35	1,877	4,602	2,010	80,239	88,728
3.3	EDP Equipment and Software (incl $.....0 for affiliated services)	35			4,792		4,827	18,334	7,657	65,017	95,835
3.4	Other Equipment (excluding EDP) (incl $.....0 for affiliated services)	1		1			2	282	202	1,209	1,695
3.5	Accreditation and Certification (incl $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
3.6	Other Expenses (incl $.....0 for affiliated services)	1,183		97	385	41	1,706	3,706	16,354	413,119	434,885
3.7	Subtotal before reimbursements and taxes (Lines 3.1 to 3.6)	37,344		18,210	9,724	1,428	66,706	121,780	67,820	978,371	1,234,677
3.8	Reimbursements by uninsured plans and fiscal intermediaries										
3.9	Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	36,878	36,878
3.10	TOTAL (Lines 3.7 to 3.9)	37,344		18,210	9,724	1,428	66,706	121,780	67,820	1,015,249	1,271,555
3.11	TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							3,407			3,407

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
4. Individual Mini-Med Plans Expenses										
4.1 Salaries (including $.....0 for affiliated services)										
4.2 Outsourced services										
4.3 EDP equipment and software (including $.....0 for affiliated services)										
4.4 Other equipment (excluding EDP) (including $.....0 for affiliated services)										
4.5 Accreditation and certification (including $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
4.6 Other expenses (including $.....0 for affiliated services)										
4.7 Subtotal before reimbursements and taxes (Lines 4.1 to 4.6)										
4.8 Reimbursements by uninsured plans and fiscal intermediaries										
4.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
4.10 TOTAL (Lines 4.7 to 4.9)										
4.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
5. Small Group Mini-Med Plans Expenses										
5.1 Salaries (including $.....0 for affiliated services)										
5.2 Outsourced services										
5.3 EDP Equipment and Software (including $.....0 for affiliated services)										
5.4 Other equipment (excluding EDP) (including $.....0 for affiliated services)										
5.5 Accreditation and certification (including $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
5.6 Other expenses (including $.....0 for affiliated services)										
5.7 Subtotal before reimbursements and taxes (Lines 5.1 to 5.6)										
5.8 Reimbursements by uninsured plans and fiscal intermediaries										
5.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
5.10 TOTAL (Lines 5.7 to 5.9)										
5.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
6. Large Group Mini-Med Plans Expenses										
6.1 Salaries (including $.....0 for affiliated services)										
6.2 Outsourced services										
6.3 EDP equipment and software (including $.....0 for affiliated services)										
6.4 Other equipment (excluding EDP) (including $.....0 for affiliated services)										
6.5 Accreditation and certification (including $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
6.6 Other expenses (including $.....0 for affiliated services)										
6.7 Subtotal before reimbursements and taxes (Lines 6.1 to 6.6)										
6.8 Reimbursements by uninsured plans and fiscal intermediaries										
6.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
6.10 TOTAL (Lines 6.7 to 6.9)										
6.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (Cols. 6 to 9)
7. Small Group Expatriate Plans Expenses										
7.1 Salaries (including $.....0 for affiliated services)										
7.2 Outsourced services										
7.3 EDP equipment and software (including $.....0 for affiliated services)										
7.4 Other equipment (excluding EDP) (including $.....0 for affiliated services)										
7.5 Accreditation and certification (including $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
7.6 Other expenses (including $.....0 for affiliated services)										
7.7 Subtotal before reimbursements and taxes (Lines 7.1 to 7.6)										
7.8 Reimbursements by uninsured plans and fiscal intermediaries										
7.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
7.10 TOTAL (Lines 7.7 to 7.9)										
7.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
8. Large Group Expatriate Plans Expenses										
8.1 Salaries (including $.....0 for affiliated services)										
8.2 Outsourced services										
8.3 EDP equipment and software (including $.....0 for affiliated services)										
8.4 Other equipment (excluding EDP) (including $.....0 for affiliated services)										
8.5 Accreditation and certification (including $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
8.6 Other expenses (including $.....0 for affiliated services)										
8.7 Subtotal before reimbursements and taxes (Lines 8.1 to 8.6)										
8.8 Reimbursements by uninsured plans and fiscal intermediaries										
8.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
8.10 TOTAL (Lines 8.7 to 8.9)										
8.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
9. Student Health Plans Expenses										
9.1 Salaries (including $.....0 for affiliated services)										
9.2 Outsourced services										
9.3 EDP equipment and software (including $.....0 for affiliated services)										
9.4 Other equipment (excluding EDP) (including $.....0 for affiliated services)										
9.5 Accreditation and certification (including $.....0 for affiliated services)		XXX	XXX	XXX	XXX					
9.6 Other expenses (including $.....0 for affiliated services)										
9.7 Subtotal before reimbursements and taxes (Lines 9.1 to 9.6)										
9.8 Reimbursements by uninsured plans and fiscal intermediaries										
9.9 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
9.10 TOTAL (Lines 9.7 to 9.9)										
9.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										