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September 1, 2020

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

Re: 2021 Large Group HMO Rate Filing  
SERFF Tracking #: MVPH-132497714

Dear Ms. Hughes:

This letter is in response to your correspondence received 08/25/2020 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. For Vermont providers governed by the GMCB, support should reconcile to the most recently submitted budget changes. The support for all other providers should include the data and any adjustments that were made to the data to determine the best estimated of unit cost changes.*

Response: This response has been determined to be confidential and will be provided under separate cover

*2. Please provide detailed quantitative and qualitative support for the pharmacy unit cost and utilization trends provided in Exhibit 2. This should include information provided by the PBM.*

Response: 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 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 2020 and 2021. MVP also applies its best estimate of contract changes between the experience period and the rating period to the unit cost information using a trend model provided by CVSHealth. Please see the attached exhibit (CONFIDENTIAL MVP\_Vermont\_4Q2019\_CSTM\_04132020) which provides CVSHealth's best estimate of trends as of the time of the filing.

The individual cost components (unit cost and utilization by Generic/Brand/Specialty) are calculated as follows:

**Generic:** Unit Cost trend is represented by Generic Non-Specialty Cost/Day trend which is found in cell L46 on Page 1 (2020) and Page 2 (2021) of the attached. Generic Non-Specialty Gross Cost PMPM Trend can be found in cell J46 on Page 3 (2020) and Page 4 (2021) of the attached. Utilization is then calculated by taking Gross Cost PMPM Trend divided by the unit cost trend.



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**Brand:** Unit Cost trend is represented by Brand Non-Specialty Cost/Day trend which is found in cell M46 on Page 1 (2020) and Page 2 (2021) of the attached. Brand Non-Specialty Gross Cost PMPM Trend can be found in cell F46 on Page 3 (2020) and Page 4 (2021) of the attached. Utilization is then calculated by taking Gross Cost PMPM Trend divided by the unit cost trend. The impact of brand drugs moving to generic is implicitly covered under the cost/day trend under this methodology. This reflects the utilization of the current drug being re-weighted from the brand bucket to the generic bucket.

**Specialty:** Utilization trend is represented by Specialty Utilization trend which is found in cell N47 on Page 1 (2020) and Page 2 (2021) of the attached. Specialty Gross Cost PMPM can be found in cell G47 on Page 1 (2020) and Page 2 (2021) of the attached. Specialty unit cost trend is then calculated by taking Gross Cost PMPM Trend divided by the utilization trend.

CVSHealth buckets non-Specialty drugs by the first 2 characters of the GPI and Specialty drugs using their proprietary Rx Navigator methodology. The individual contribution of these buckets to Gross Cost PMPM trend can be found in column I of Page 1 (2020) and Page 2 (2021) of the attached. The Other bucket for non-Specialty claims includes all GPI categories not explicitly listed and the other bucket for Specialty claims include all conditions not explicitly listed.

MVP uses the trend factors calculated above and applies them to the experience period cost per script and scripts per 1,000 members to compute an annual paid trend. Scripts per 1,000 is trended using the utilization trends, while the allowed cost per script and coinsurance cost per script amounts are trended using the unit cost trends. Copay per script amounts are not trended and the deductible per script amounts are trended using the paid leveraging factor.

All of these trended items are then converted to a PMPM using the formula ( projected cost per script \* projected scripts per 1,000 members / 12,000 ) and the projected paid claims PMPM is calculated as the difference between the projected allowed claims PMPM and the sum of the cost sharing PMPM amounts. The total (24 month) paid trend (gross of rebate changes) is then calculated as the projected paid claims PMPM divided by the experience period paid claims PMPM.

The paid claims net of pharmacy rebates is calculated as the projected net paid claims PMPM divided by the experience period net paid claims PMPM.

*3. Please provide a historical A-to-E analysis of the actual pharmacy trends vs. the PBM/Company expected pharmacy trends. The analysis should include at least 3 years of data.*

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 LG HMO filing).

While reviewing the table, it is important to note that the expected trends are developed on MVP's total Vermont business and the actual trends are MVP's Vermont large group business. As Large group makes up a small percentage of the total Vermont business, it is expected that actual trends will differ from expected.



**Comparison of Actual to Expected  
Pharmacy Allowed Trend, 2017 to 2019,  
VT Large Group**

Year	Actual	Expected
2019/2018	7.1%	8.2%
2018/2017	0.6%	11.6%
2017/2016	9.0%	10.7%

4. Discuss the credibility of the base period experience. Furthermore, why was a more recent experience period used given that data is available through July 2020 at the time of this filing?

Response: MVP has assumed that the base period experience is 100% credible. A more recent period was not selected due to uncertainty surrounding IBNR in recent months data. The data for this filing was compiled in early June, and therefore data through May was available. At the time the data was pulled, the IBNR being placed on the months on March, April and May at the time was uncertain due to COVID-19's impact on claim utilization and opted to choose an experience period with more claims runout for a more accurate picture of the entire experience period. Even with more run-out available, MVP is electing to not include the months of March, April or May in its experience period as COVID-19 suppressed claims in these months which we do not believe is representative of monthly claims costs that will occur in 2021.

5. Describe how the -7.8% decrease to the quarterly manual rate translates to an annual decrease of -3.3%

Response: The -7.8% quarterly manual rate decrease reflects the proposed change in the manual rates from 4Q 2020 to 1Q 2021. To calculate the annual manual rate change for a group that renews in 1Q 2021, you also need to incorporate the quarterly changes from 2Q to 4Q 2020. Those quarterly changes (2Q 2020/1Q 2020, 3Q 2020/2Q 2020 and 4Q 2020/3Q 2020) were 1.6% as approved in the prior filing. The -3.3% annual manual rate decrease reflects the product of the 4 quarterly changes.

6. Please provide quantitative support for the pooling charge of 12.8% for claims above \$100,000 and discuss the historical and expected net gain or loss from pooling claims (cost vs. benefit).

Response: Please see the tab "Question #6 and #7" in the attached Excel file for the implied pooling charges compared to the filed 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 12.8%. 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. Because the pooling charge is set equal to the expected claims cost in excess of \$100,000, there is no expected gain/loss from pooling.



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7. Please provide the historical experience of claims above \$100,000 over the past five years for this block.

Response: Please see the tab "Question #6 and #7" in the attached Excel file for the implied pooling charges from the Vermont Large Group population for the past 5 calendar years.

8. Provide quantitative and qualitative support for the each of the three capitation and/or non-FRDM claims expense items, shown at the top of page 4 of the actuarial memorandum.

Response:

**Other Medical Expense Not In Warehouse-** The \$1.49 in this item can be broken down as:

Claims Settlements and Adjustments Outside of Claim Processing System- This is worth \$1.32 PMPM and reflects adjustments to claims or amounts paid to providers that are not processed through our claims processing system. For example, contract negotiations and implementation are sometimes delayed past the effective of the contract change. In these instances, MVP will cut a check for a provider rather than reprocess the claims that were incurred between the effective of the contract and the implementation date in our claims processing system.

Mass Pool Fee- \$0.17 PMPM and reflects a fee that is an assessment for services rendered in the state of Massachusetts.

**Net Reinsurance Expense-** The \$0.48 PMPM in this item is calculated as the expected cost to MVP based on its current reinsurance contract. The calculation is [ $\$1.82$  from current contract \* 1.05 for trend \* (1- 75% target MLR)] = \$0.48. MVP's 2021 reinsurance contracts were not finalized at the time of filing and a 5% trend on reinsurance premium was assumed in the calculation.

**Medical Home and PCP Incentive-** The \$1.72 PMPM line item for Medical Home and PCP Incentives include the following programs:

Blueprint for Health Patient Centered Medical Homes (\$1.00 PMPM)- MVP pays a PMPM fee to PCMHs as part of the state's Blueprint for Health program. MVP's best estimate of the 2021 cost per attributed member per month is \$3.22 and 31.0% of members attributed to a PCMH in January and February of 2020. Therefore, MVP has built in \$1.00 PMPM ( $\$3.22$  times 31.0%) into rates to account for this program.

Community Health Teams Payments (\$0.72 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 quarter of 2020 amounted to \$0.72 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 2020 to 2021. Therefore, MVP has built \$0.72 PMPM into the rates for 2021.



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*9. Please provide support for the assumed COVID-19 immunization cost of \$75. Was the potential for government-funded cost coverage considered?*

Response: Wakely Consulting Group prepared a report titled "COVID-19 Cost Scenario Modeling" for America's Health Insurance Plans on March 30, 2020. In that report, Wakely assumed that the cost of a vaccination for COVID-19 was equal to the cost of a script of Tamiflu from the 2017 IBM MarketScan Research Database. MVP pulled claim data for Tamiflu for VT Exchange members in 2019 and found that the average cost was approximately \$75 for brand Tamiflu scripts. Therefore, MVP assumed \$75 for the price of the vaccine immediately upon release. MVP did consider the potential for government funding of the vaccine but there has been no confirmation that such funding will occur; as a result, MVP must assume it will not be funded.

*10. Please provide further support for the assumed COVID-19 immunization rate of 80% considering high potential for constraints in supply of a vaccine in its initial production and likely prioritized access for the most vulnerable population, whom are mostly not covered commercially.*

Response: MVP believes the unique nature of the virus makes it more likely that people would seek the vaccination which is why MVP is assuming 80% utilization consistent with the paper published by Wakely. While constraints in supply may exist initially, MVP is assuming that over the course of 2021 enough doses would be commercially available to allow for any individual to receive the vaccine if they choose. Additionally, it is likely that the removal or lessening of many social distancing regulations will be contingent on individuals or populations achieving a vaccination rate, which would require the commercial population to have access to the vaccine as well.

*11. Please disclose the assumed date that the COVID-19 immunization will become available and provide support for the assumption*

Response: An exact date for the immunization has not been assumed by MVP for purposes of the filing. However, several companies have successfully completed Phase I studies and have initiated Phase II/III clinical trials for testing on potential immunizations (see the London School of Hygiene and Tropical Medicine's vaccine pipeline tracker, [https://vac-lshtm.shinyapps.io/ncov\\_vaccine\\_landscape/](https://vac-lshtm.shinyapps.io/ncov_vaccine_landscape/)). The World Health Organization has announced their organization of a "Solidarity Trial" whereby these trials will be prioritized and organized in such a way as to accelerate the timeline of Phase II and Phase III trials and get an immunization to market quicker than normal. Finally, the Federal Government announced on May 15 their organization of Operation Warp Speed, whose stated goal is "to have substantial quantities of a safe and effective vaccine available for Americans by January 2021." (<https://www.hhs.gov/about/news/2020/05/15/trump-administration-announces-framework-and-leadership-for-operation-warp-speed.html>) At this time, MVP is assuming a vaccine will be ready to be mass produced and distributed in early 2021 and optimistically that distribution will be available earlier in the year.



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*12. Please provide support for the assumption that 20% of deferred elective services will be eliminated.*

Response: MVP chose a 20% deferral rate based on a 2010 research paper sponsored by the Society of Actuaries called "Potential Impact of Pandemic Influenza on the U.S. Health Insurance Industry"

(<https://www.soa.org/globalassets/assets/files/research/projects/research-2010-pandemic-health-report.pdf>).

On page 28 of the report, the author states "Reports have shown that this deferral of care during a crisis is often not recaptured but is instead a net savings to the system. This effect has been quantified by assuming a 5 percent reduction in individuals seeking elective services in a moderate scenario, and a 20 percent reduction in a severe scenario." The author cites research including experience with other major disruptions to the health care supply chain in modeling those assumptions.

*13. Please provide support for the assumption that providers will perform 110% of elective services from August 2020 through April 2021.*

Response: Based on information provided to us by our medical management team, providers of elective services were already working at near to full capacity prior to the pandemic during regular working hours. To make up for lost revenue while services were canceled, MVP is assuming providers will increase capacity through extended hours or working weekends. While providers are financially incentivized to perform as many services as possible to recoup lost revenue, there is an upper bound on the number of services they can provide. A lack of physical (number of available rooms, the potential for personal protective equipment shortages) and human capital (nurses, doctors and other support staff) as well as the additional time spent following the more stringent sanitation practices in the wake of the pandemic place a cap on how many services can be provided at one time.

MVP settled on the 110% assumption by balancing patient need for these services to be done with the limits described above. While we do feel that working above an assumed capacity for a long period of time is not sustainable, in the short-term it can be reasonably accomplished.

*14. Please provide paid and estimated completed incurred claims PMPM for elective services (including only those services included in the 2019 \$45.09 PMPM disclosed on page 5 of the actuarial memorandum) from January 2020 through July 2020.*

Response: Please see the following table that includes the requested PMPM's. Please note that this table represents the same population that was used to derive the \$45.09 mentioned above.



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Elective Surgery Data January to July 2020		
Month	Paid Claims	Incurred Claims Estimate
202001	\$45.49	\$46.19
202002	\$38.71	\$39.66
202003	\$27.20	\$28.10
202004	\$7.21	\$7.60
202005	\$20.13	\$22.46
202006	\$33.71	\$40.40
202007	\$16.97	\$40.36

15. The COVID-19 impact assumed in this filing is the exact same as what was filed in the VT Exchange 2021 filing which was filed in May. How was approximately 3 months of additional data gained between that filing and this filing considered in the development and selection of the filed COVID-19 impact? Did emerging data further support the assumed impact?

Response: MVP did not consider the 3 additional months of data in this filing due to the uncertainty surrounding the completion of this data. As the COVID-19 pandemic has affected claims processing speeds as well as claim receipts, the process of assigning IBNR to claims during the pandemic is highly uncertain. Therefore, MVP would not feel comfortable using this data from these months to form decisions until there is more runout.

16. Please provide an itemized (broker fees, bad debt, covered lives assessment, vaccine pilot, taxes, etc.) breakdown of the administrative expenses and taxes/fees PMPM, as approved in the 2020 rate filing and as filed in the 2021 rate filing. Please provide support for any differences.

Response: Please see table below for the itemized breakdown requested.

Breakdown of Taxes/Fees in 2020 Filing vs 2021 Filing for VT Large Group		
	Approved in 2020 Filing	In Proposed 2021 Filing
Broker Load	2.3%	2.6%
VT Vaccine Pilot	0.31%	0.45%
Bad Debt	0.25%	0.25%
ACA Insurer Tax	1.00%	0.00%
Comparative Effectiveness Research Fee	\$0.00	\$0.21
18 VSA 9374(h) Billback	\$1.93	\$1.84

Support for difference are as follows:



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**Broker Load-** This is determined on a group by group basis and MVP reflects the prior years average broker load in the manual rates with the understanding that this value can vary for each group as they are rated.

**VT Vaccine Pilot-** In MVP's 2020 Large group filing the vaccine pilot cost assumed for state fiscal year(SFY) 2020 was \$4.54 PMPM for children and \$0.56 PMPM for Adults. For SFY 2021 \$10.07 PMPM for children and \$1.02 PMPM for adults was assumed. In MVP's 2021 Large group filing, the costs are \$9.26 PMPM for children and \$0.96 PMPM for adults for SFY 2021 and \$10.60 PMPM for children and \$1.09 PMPM for adults in SFY 2021. The increase in projected PMPM costs for this program combined with the fact that MVP has a higher share of it members of children in the current experience period compared to the experience period in the previous filing are driving the 0.14% increase in the VT vaccine pilot.

**ACA Insurer Tax-** This tax was active for the calendar year 2020 but has been repealed for the calendar year 2021.

**Comparative Effectiveness Research Fee-** Originally scheduled to end in 2019 (with final payments due in 2020), the Further Consolidated Appropriations Act of 2020 extended CERF for ten years through 2029.

**18 VSA 9374(h) Billback-** \$1.84 PMPM is added for fees MVP must pay to the State of Vermont to help fund expenses incurred by state agencies and other non-profit organizations on MVP's behalf, including the Green Mountain Care Board, the Vermont Program for Quality in Health Care, Inc. and the Office of the Health Care Advocate. Due to MVP's rapid membership growth from 2017 to 2020 as well as changes to funding mechanisms for each of the programs, MVP is estimating its combined liability for 2020 to be \$859,089. This is spread across MVP's entire Vermont membership as of February 2020 to calculate the estimated PMPM payment. In MVP's 2020 VT LG filing the estimated liability was \$758,553 which translated to \$1.93 PMPM.

*17. Please provide the projected average rate change, as filed, for groups renewing in the first quarter of 2021. Please provide quantitative and qualitative support for any differences between this Q121 renewal average rate change versus the -1.2% manual rate change.*

Response: MVP's underwriting team has not yet completed rate changes for any groups renewing in the first quarter of 2021. Therefore, at this time MVP cannot provide any data on the average projected rate change as it does not exist yet. The -1.2% manual rate change assumes that groups are rated at 100% of the manual rates which is not true for the groups. With group specific experience factoring into their premium rates for the first quarter 2021, it is expected that the rate changes felt by groups will vary from the -1.2% manual change

*18. Please provide the 2019 loss ratio experienced for Q1 renewals groups, Q2-Q4 renewal groups, terminated groups, and all groups combined.*

Response: Please see the following table that shows loss ratios by the requested groupings.





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Loss Ratio's for Vermont Large Group		
Grouping	MLR	Member Months
Q1 Renewal Groups	73.3%	17252
Q2-Q4 Renewal Groups	88.7%	5153
Terminated Groups	110.3%	5802
All Groups	76.7%	22405

19. Please provide the federal loss ratio for this block of business in 2017, 2018, & 2019.

Response: Please see the following table that shows loss ratios by year.

Federal Loss Ratio By Year	
Year	Federal MLR
2017	93.9%
2018	104.7%
2019	76.9%

20. Please confirm that no costs were included in the rate development associated with OneCare Vermont.

Response: MVP confirms that no costs were included associated with OneCare Vermont.

21. Please provide claim lag triangles for this block of business for incurred claims January 2019 through July 2020, paid through July 2020.

Response: Please see the tab "Question #21" in the attached excel file for the requested claim lag triangle.



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If you have any questions or require any additional information, please contact me at [CPontiff@mvphealthcare.com](mailto:CPontiff@mvphealthcare.com).

Sincerely,

A handwritten signature in black ink that reads "Chris Pontiff". The signature is fluid and cursive, with a long horizontal stroke extending from the end of the name.

Christopher Pontiff, ASA  
Leader, Actuarial  
MVP Health Care

	2019	2018	2017	2016	2015
<b>Claims above \$100k Pooling Point</b>	\$879,404	\$2,601,477	\$1,920,576	\$493,971	\$551,737
<b>Claims below \$100k Pooling Point</b>	\$8,024,161	\$10,450,989	\$9,263,239	\$9,312,494	\$12,151,741
<b>Member Months</b>	22,405	26,740	25,368	29,662	44,348
<b>Claims &gt;\$100k PMPM</b>	\$39.25	\$97.29	\$75.71	\$16.65	\$12.44
<b>Claims &lt;\$100k PMPM</b>	\$358.14	\$390.84	\$365.15	\$313.95	\$274.01
<b>Filed Pooling Charge</b>	9.92%	9.16%	9.16%	9.16%	7.40%
<b>Pooling Charge</b>	10.96%	24.89%	20.73%	5.30%	4.54%

