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October 4, 2024

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

Re: 2025 Large Group HMO Rate Filing
SERFF Tracking #: MVPH-134197798

Dear Ms. Hughes:

This letter is in response to your correspondence received 10/01/24 regarding the above-mentioned rate filing. The responses to your questions are provided below.

1. Regarding the response to question #7 of the previous objection – Why isn't multiple years of VT data used to increase the credibility of the VT data and calculate the pooling adjustment, consistent with the pooling adjustment applied in the manual rate development, instead of using NY data?

Response: Even after accounting for multiple years of data, we are still unsure whether the low membership count in our Vermont block of business would be sufficient to develop pooling charges, given the sporadic nature of claims (particularly at the higher pooling points). As a point of reference, MVP's New York large group experience rated block of business was approximately 47,000 average lives in 2023, so even three years of Vermont data would be 10% of the size of one year of the New York population.

We were comfortable with using New York charges despite our comments below (regarding network differences between NY and VT) because while facility contracts are different in various markets, the majority of high-cost claims are paid in a similar fashion across states.

2. In calculating the manual rate, MVP now assigns 75% credibility to the current year and 25% credibility to the prior year manual rate claim cost, as explained on page 6 of the act memo. Did MVP consider other data sources to enhance credibility of the manual rate? Please discuss other possible methods and why they were not chosen.

Response: Some other data sources MVP could have used, and reasons why we did not use them, can be found below. Please note that this list is not meant to be exhaustive, either in the potential data sources or the reasons why those alternative sources were not chosen.

Consulting with Outside Actuaries to use Vermont Data: MVP could potentially have worked with an actuarial consultant with access to Vermont-specific large group data to supplement their manual rates. This, however, comes with trade-offs including actuarial resources to manage the relationship, the cost of contracting the consultant, and the potential availability of Vermont-specific data. The first two have an associated cost that would be high relative to the potential revenue at stake and would either significantly impact administrative costs allocated to this line of business (and therefore premiums) or cause other lines of business to absorb this administrative cost.

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Additionally, there is risk that the data provided by outside consultants is not representative of the types of risk MVP possibly can or ultimately does take on, particularly in a state which has a large Administrative Services Only (or similarly arranged) market.

Using National or Publicly Available Large Group Data Sets: Another option would be to use publicly available data that is generally nationwide in scope. This comes with the additional pricing risk of large groups in other states being different than those who are in Vermont. Given that Vermont (along with several other states) is unique in its regulatory and hospital contracting environment, it is unlikely that data from across the nation (even if adjusted for unit cost differences) would be a representative sample of the population available in Vermont.

Using MVP Large Group Experience Rated Data from New York: While this would be the best option out of those listed to supplement our Vermont data, MVP feels that it still falls short. To start, the health care industry in Vermont is very unique even when compared to New York, particularly in the areas of physician vs. facility utilization of certain services (Vermont has relatively low utilization of non-facility surgical and specialist procedures relative to New York and much higher utilization of facilities), the contracting environment with facilities in Vermont (both in the role of the GMCB as well as the lack of competition in metropolitan areas in Vermont, compared to New York), and the utilization of services (Vermont having, all else being equal, healthier individuals).

This makes a direct comparison between New York and Vermont difficult. This difficult comparison is exacerbated by MVP's broad geographic footprint in New York, where our population is split relatively evenly between the Capital District (the closest comparison to Vermont), the Hudson Valley area (which shares more in common with healthcare utilization in New York City than Upstate NY or New England), and the Western part of the state (which also has its own unique contracting environment and cost structure).

Because of the nature of this geography, any New York data that could be used would have to be adjusted for network and risk differences. MVP currently has limited analytic capabilities to "re-price" our claim-level data at different facilities across our footprint, making comparisons between hospitals with different contract structures difficult, and building this functionality will continue to take time and resources. Adjusting for risk differences between the populations would also consume resources that would be forced to be passed on to consumers or other lines of business.

Overall, while it possible that using New York or outside data *may* improve credibility and therefore pricing accuracy (with the obvious caveat that pricing risk is two-tailed and any inclusion of new data may decrease accuracy) in Vermont large group, MVP views the currently proposed process as one which balances accuracy and administrative costs, given the constraints of our current population and the potential market of "winnable" business.

3. Please provide quantitative support for the impact of the Vermont hospital budget orders. (Posted here: https://gmcboard.vermont.gov/node/11552)

Response: The charge increases in the table result in a 2.4% lower average rate increase than the budget assumptions in MVP's initial filing. Note that we used the total approved charge increase, but this often differs by inpatient, outpatient, and physician. Please see the "Question 3" tabs in the attached Excel document for quantitative support by hospital. Some portions of this response are confidential and will be provided under separate cover.

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

Sincerely,

Eric Bachner, ASA
Director, Commercial Market & Valuation Actuary
MVP Health Care, Inc.