STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Plan, Inc. Third Quarter 2018 and Fourth Quarter 2018 Grandfathered Small Group EPO/PPO Rate Filing	)))))	GMCB-005-18rr SERFF No.: MVPH-131432994

DECISION AND ORDER

Introduction

Vermont law requires that health insurers submit major medical rate filings to the Green Mountain Care Board, which shall approve, modify, or disapprove the filing within 90 calendar days of its receipt. 8 V.S.A. § 4062(a)(2)(A). On review, the Board must determine whether the proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. § 4062(a)(3).

Procedural History

On March 22, 2018, MVP Health Plan, Inc. (MVPHP or "the carrier") submitted its Third Quarter 2018 (3Q18) and Fourth Quarter 2018 (4Q18) Grandfathered[1] Small Group EPO/PPO Rate Filing to the Board via the System for Electronic Rate and Form Filing (SERFF).[2] On March 29, 2018, the carrier amended the filing, removing one of the base plans and its accompanying preventative pharmacy rider. On April 3, 2018, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid representing the interests of Vermont health insurance consumers, entered an appearance as a party to this filing.

On May 11, 2018, the Board posted to the web the Department of Financial Regulation's (DFR) analysis regarding this filing's impact on the insurer's solvency. On May 22, 2018, the Board posted to the web an actuarial memorandum provided by its contract actuaries, Lewis & Ellis (L&E). The Board solicited written public comments on this filing through June 5, 2018. No members of the public provided comment. The parties waived hearing in this matter and filed memoranda in lieu thereof. *See* GMCB Rule 2.000, § 2.309(a)(1).

Findings of Fact

1. MVPHP is a non-profit New York health insurer licensed as a health maintenance organization (HMO) in New York and Vermont. MVPHP is owned by MVP Health Care, Inc. (MVP), a New York corporation that transacts health insurance business in New York and Vermont through a variety of for-profit and non-profit subsidiaries. MVPHP provides EPO and

[1] Grandfathered plans may not include some rights and protections provided under the Affordable Care Act. To qualify as a grandfathered plan, a health plan must have been in effect on or before March 23, 2010 and have not been materially changed to reduce benefits or employer contributions since that time. 45 C.F.R. § 147.140.

[2] The contents of the SERFF filing and all other documents referenced in this Decision & Order are available at http://ratereview.vermont.gov/node/696.

PPO products to individuals and employers in the small and large group markets in New York and Vermont. L&E Memo at 1.

2. Beginning with this filing, MVP has changed the entity under which it files this product from MVP Health Insurance Company (MVPHIC) to MVPHP. Where applicable, both the old and new product names have been displayed in the filing, and the proposed rate increases compare the new MVPHP product to the previous MVPHIC product. SERFF Filings (Actuarial Memoranda)[3] at 1.

3. This filing reflects the proposed 3Q18 and 4Q18 rates for MVPHP's small group grandfathered HMO product portfolio comprising high deductible health plans (HDHPs). This is a closed block of business with a declining membership. As of January 2018, there were approximately 1,361 members. Of these, 120 (9%) have a 3Q18 effective date and 144 (11%) have a 4Q18 effective date. L&E Memo at 1.

4. MVPHP proposes a 2.1% average annual rate increase for members renewing in 3Q18 and a 0.9% average annual increase for those renewing in 4Q18. On a quarterly basis, the carrier proposes a 0.9% increase from 2Q18 to 3Q18, and a 1.1% increase from 3Q18 to 4Q18. MVPHP Memo at 1.

5. To form a credible experience base for projecting its 3Q18 and 4Q18 rates, MVPHP used grandfathered small group claim data for the period from November 2016 through October 2017 and paid through January 2018 (with incurred estimates updated through February 2018), excluding groups that terminated coverage as of January 2018. MVPHP adjusted the data to reflect incurred but not reported paid claims (IBNR) and replaced high-cost claims (in excess of $100,000) with a pooling charge. L&E Memo at 2-3.

6. MVPHP adjusted its rating methodology to reflect the impact of enrollment growth and termination, adjusting the experience period claims by approximately 0.1 percent based on the expected variation in claims by policy month. Rates were also adjusted for observed changes in the covered population's average age since the experience period, resulting in an 0.6% increase in the proposed rates. *Id.* at 3.

7. MVPHP projected its experience forward using an annual paid medical trend assumption of 3.3%. Due to its concern that membership growth in its other blocks of business would impact total utilization trend, the carrier did not incorporate a utilization trend. *Id.*

8. The carrier projects an annualized effective paid pharmacy trend of 16.8%, based on allowed pharmacy trends provided by its pharmacy benefits manager (PBM). L&E Memo at 4; MVPHP Memo at 5.

9. MVPHP assumes a general administrative expense load of 8.4% of premium, including an assumption of 2.0% contribution to reserve (CTR). L&E Memo at 4; MVPHP Memo at 5.

[3] We refer to these documents collectively as the "MVPHP Memo."

10. The carrier exceeded the federal minimum loss ratio (MLR) requirement for 2015, 2016 and 2017, and has therefore not been required to issue rebates to consumers. For 3Q18, MVPHP anticipates that the proposed rates will generate an MLR of 90.1%,[4]exceeding the federal requirement of an 80% MLR for the small group market. *See* 45 C.F.R. 158.210(c). The carrier did not implement the Board's order in Docket No. GMCB-012-17rr, however, to count the billback imposed by 18 V.S.A. § 9374(h)(1) and the HCA assessment as an administrative expense for loss ratio purposes. L&E Memo at 5-6.

11. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR assessed the impact of the proposed filing on the carrier's solvency. Noting that it is not MVPHP's primary regulator, that New York State regulators have expressed no concerns about the carrier's solvency, and that all of MVPHP's health operations in Vermont account for approximately 2.9% of its total premiums written in 2017, DFR determined that the carrier's Vermont operations pose little threat to the carrier's solvency. DFR nonetheless opined that the rates as filed will promote MVPHP's solvency absent a finding by L&E that they are inadequate. *See* Solvency Analysis at 2.

12. Based on its independent review and analysis, L&E opines that the filings do not produce rates that are excessive, inadequate, or unfairly discriminatory, and therefore recommends that the Board approve them without modification. L&E Memo at 7.

13. The HCA asserts that MVPHP failed to address statutory criteria such as affordability or systemic cost reduction efforts, and requests that the Board reduce the requested premium increase by a minimum of one percent. HCA Memo in Lieu of Hearing at 6-7, 10. MVPHP requests that the Board approve the filing without modification. MVPHP Memo in Lieu of Hearing at 4.

Standard of Review

The Board reviews rate filings to ensure that a proposed rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust unfair inequitable, misleading, or contrary to the laws of this State." 8 V.S.A. § 4062(a)(3); GMCB Rule (Rule) 2.000, § 2.301(b). Although the first several terms—excessive, inadequate, or unfairly discriminatory—are defined actuarial standards, other standards by which the Board reviews rate filings are "general and open-ended," the result of "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16. The Board additionally takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); Rule 2.000, § 2.401.

In arriving at its decision, the Board must consider the Department's analysis and opinion of the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2)(B), (3). The Board must also consider any public comments received on a rate

[4] As opposed to calculation of the traditional loss ratio, calculation of the federal minimum loss ratio under the ACA allows insurers to adjust for quality improvement activities and expenditures on taxes, licensing and regulatory fees.

filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id.* § 2.104(c).

Conclusions of Law

At the outset, we agree with and adopt our actuary's opinion, based on review of the filing and historical utilization data, that MVPHP's proposed medical trend assumptions, including its use of a 0% utilization trend based on a concern that membership growth outside of this book of business is impacting the trend, are actuarially reasonable and appropriate. Finding of Fact (Finding) ¶ 7. Given the small population within this block of business, we also accept our actuary's opinion that MVPHP's pharmacy trend assumption—developed from an estimate provided by its pharmacy vendor—is reasonable and appropriate. Finding ¶ 8. Further, while MVPHP's proposed 3.3% medical trend is below the 3.5% growth target set in Vermont's All-Payer ACO Model Agreement with the federal government, we remind it of our reasonable expectation that it engage in vigorous contract negotiations with providers—within and outside of our borders—in a way that promotes parity between academic medical centers, community hospitals and independent practices, and the resulting reimbursement levels that reflect actual costs of care, rather than site of service.

Turning next to administrative expenses, notwithstanding our actuary's opinion that the carrier's proposed 8.4% administrative expense load accurately reflects the costs associated with administrating claims for this block of business, we order it to achieve further efficiencies and reduce its administrative expenses by 0.2%. In doing so, we hope to incentivize the carrier to find innovative ways to increase efficiencies and to review internal policies and practices that serve only to increase the financial burdens on members via premiums that are rising at an unsustainable pace. We also note that the carrier has failed to implement our prior order to treat billback expenditures as claims expenses for purposes of calculating its loss ratio, *see* Finding ¶10, and caution that we will not accept future filings without this change.

Last, we reduce the proposed CTR from 2.0% to 1.0%. This reduction helps address valid concerns raised by the HCA regarding affordability of the proposed rates, while maintaining the carrier's reserve level above the 12.5% minimum threshold required by its New York State regulator.

As the HCA correctly notes, MVPHP did not specifically address statutory factors such as affordability, access to and quality of care, the standards by which the Board must access the filing. As modified, however, the rates strike an appropriate balance between fairness and equity to policyholders on one hand, and rate stability and insurer solvency on the other. Because the modified rates are neither excessive nor inadequate and are squarely within the range of actuarial reasonableness, they will encourage future pricing stability and therefore promote policyholders' access to and quality of care.

Order

For the reasons discussed above, the Board modifies MVPHP's 3Q18 and 4Q18 Grandfathered Small Group EPO/PPO Rate filing by adjusting CTR from 2.0% to 1.0% and reducing the administrative expense load by 0.2%. We then approve the filing.

SO ORDERED.

Dated: June 20, 2018 at Montpelier, Vermont

s/ Kevin Mullin, Chair	)	
	)	
s/ Jessica Holmes	)	GREEN MOUNTAIN
	)	CARE BOARD
s/ Robin Lunge	)	OF VERMONT
	)	
s/ Tom Pelham	)	
	)	
s/ Maureen Usifer	)	

Filed: June 20, 2018

Attest: s/ Jean Stetter, Administrative Services Director
Green Mountain Care Board,

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (email address: agatha.kessler@vermont.gov). Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed with the Clerk of the Board within ten days of the date of this decision and order.