

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.)	GMCB-008-18rr
2019 Individual and Small Group Market)	
Rate Filing)	
)	SERFF No. MVPH-131497138
)	
)	

DECISION AND ORDER

Introduction

On May 11, 2018, MVP Health Plan, Inc. (MVP), one of the two carriers offering qualified health plans in Vermont, proposed an average annual rate increase of 10.9% over 2018 individual and small group rates, with increases ranging from 4.2% to 30.7%. Based on our review of the record, the testimony and evidence presented at hearing, and our statutory directives and commitment to approve the most affordable rates possible without threatening the carrier’s financial stability—thus enabling it to continue to offer health insurance in Vermont’s individual and small group market—we modify the rates downward as explained below, and then approve the filing.

Background

1. The Patient Protection and Affordable Care Act (ACA), signed into law on March 23, 2010, fundamentally changed the federal government’s role in regulating health insurance and required the establishment of state health insurance exchanges where individuals, families and small businesses could shop for qualified health insurance coverage. In 2011, the Vermont legislature enacted Act 48 which included the creation of Vermont Health Connect (VHC), the state’s health benefit exchange. VHC allows Vermonters to compare qualified health plans (QHPs) for individuals, families and small employers (up to 100 employees) with rates based on a single risk pool, or “merged market.” *See* 33 V.S.A. §§ 1803, 1811.

2. Health insurance plans on VHC are offered to consumers in bronze, silver, gold, and platinum metal levels, as well as catastrophic coverage for qualifying individuals.¹ *See* 42 U.S.C. § 18022(d)(1). Each of the four metal levels corresponds to an “actuarial value” (AV)—the expected percentage of claims for essential health benefits that a health insurer will cover on average. The bronze plans have the lowest AV and least generous coverage, while the platinum plans, with the highest AV, have the most generous coverage.

3. The ACA and state law incorporate several mechanisms to make health insurance plans offered on the exchange more affordable for individuals without employer-sponsored insurance. Taxpayers may be eligible for premium assistance, based on a percentage of their

¹ Catastrophic coverage, which is characterized by low premiums and high deductibles, is available primarily to persons under thirty years of age. *See* 42 U.S.C. § 18022(e).

household incomes and calculated relative to the second lowest cost silver plan, through federal advanced premium tax credits (APTCs)² that can be applied to the cost of any metal level plan. *See* 26 U.S.C. § 36B (“Refundable credit for coverage under a qualified health plan”).

4. The ACA also requires insurers to reduce out-of-pocket costs for enrollees earning from 100% to 250% of the federal poverty level (FPL) through cost sharing reductions (CSRs). *See* 42 U.S.C. § 18071. Until this past year, the federal government offset the cost of CSRs by making CSR payments directly to insurers. In October 2017, however, the federal government announced that it would no longer make CSR payments to insurers, notwithstanding the insurers’ continued obligation to offer CSRs to enrollees. *See* Letter from Eric Hargan, Acting Secretary, U.S. Dep’t of Health & Human Services, to Seema Verma, Administrator, Centers for Medicare & Medicaid Services (Oct. 12, 2017), *available at* <https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf>. To date, the federal government has not resumed making these payments to insurers.

5. In addition to federal premium assistance, Vermonters at or below 300% of the FPL who purchase coverage through VHC are eligible for Vermont premium assistance that reduces their premium contribution by 1.5% below the amount available under the federal law, *see* 33 V.S.A. § 1812(a), and Vermont cost-sharing assistance that further reduces enrollees’ deductibles and copayments. 33 V.S.A. § 1812(b).

6. To counter the financial impact from the federal defunding of CSRs, the Vermont legislature enacted Act 88 (2018), effective February 21, 2018. The Act allows health insurers to offer silver-level nonqualified health benefit plans off the exchange. The “reflective silver plans” must be similar to silver plans on VHC with one variation in benefit. Because the reflective silver plans do not include funding to offset the loss of the federal cost-sharing reduction payments, they are significantly less expensive than the “silver-loaded” plans. *See* 33 V.S.A. § 1813. Moreover, because subsidies for eligible Vermonters rise relative to the increased cost of the second lowest silver plan on the exchange, subsidized enrollees can apply the larger subsidy to purchase a gold plan, for example, sometimes paying less than they would have paid for a silver plan, or may purchase a bronze plan at little to no cost.

7. As of March 2018, approximately two of every three individuals enrolled through VHC receive federal premium tax credits. Many also receive additional state or federal assistance such as CSRs to reduce their premiums and out-of-pocket costs. *See* Dep’t of Vermont Health Access (DVHA) Health Coverage Map (July 11, 2018), *available at* http://info.healthconnect.vermont.gov/sites/hcexchange/files/Health_Coverage_Map-2018Q1.pdf

² Taxpayers can choose to have the estimated credit computed and paid to the insurance company to lower monthly premiums or can claim the benefit when filing their tax return for the year. APTCs must be reconciled with actual income when the taxpayer files his or her annual tax return. *See* IRS Questions and Answers on the Premium Tax Credit, *available at* <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit>.

8. Central to its reform provisions, the ACA includes an “individual mandate” requiring that individuals and families have qualifying health insurance coverage³ or pay a penalty on their personal income tax returns. *See* 26 U.S.C. § 5000A. The Tax Cuts and Jobs Act (TCJA), enacted by Congress in December 2017, eliminated the imposition of a penalty beginning in plan year 2019 for the failure to purchase qualifying coverage.

9. In February 2018, the Board and the Department of Financial Regulation (DFR) commissioned a study to estimate the impact on the Vermont market of the elimination of the individual mandate penalty. The study, conducted by Lewis & Ellis (L&E), the Board’s contract actuary, estimated that enrollment in the state’s individual and small group market would decrease by approximately 3.5% to 6.0% as fewer younger, healthier individuals purchased insurance, causing an estimated increase in premiums from 1.6% to 2.4%. *See* Individual Mandate Study (Feb. 16, 2018) *available at* <http://ratereview.vermont.gov/sites/dfrr/files/2018/Individual%20Mandate-%20impact%20in%20Vermont.pdf>.

10. To help counteract the elimination of the penalty associated with the federal individual mandate, the Vermont Legislature in its 2018 session enacted Act 182. The Act requires Vermonters to maintain minimum essential health coverage beginning in 2020; establishes a working group to make recommendations and issue a report regarding enforcement of the mandate, with the enforcement mechanism to be enacted by the 2019 Legislature; and requires that DVHA and stakeholders engage in outreach and education to encourage Vermonters to retain insurance for the 2019 and 2020 plan years. Act 182 (2018), *available at* <https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT182/ACT182%20As%20Enacted.pdf>.

11. To help stabilize costs across the market, the ACA includes a risk adjustment program. Under this program, insurers with an enrolled population with lower than average actuarial risk provide payments to insurers whose population has higher than average actuarial risk. The risk adjustment program is intended to reduce incentives for insurers to structure plan offerings to make them most attractive to a healthy, low-risk population, while unattractive to a less healthy population more in need of health care services.

12. Section 1343 of the ACA directs the Department of Health & Human Services (HHS) to develop the methodology for calculating risk adjustment transfers, and in February 2018, the United States District Court for the District of New Mexico found that the HHS risk adjustment formula was “arbitrary and capricious.” *See New Mexico Health Connections v. U.S. Dep’t of Health & Human Services*, No. 16-cv-878, 2018 WL 1136901 (D.N.M. Feb. 28, 2018). On July 7, 2018, the Trump Administration indicated that as a result of the court decision it was suspending the risk adjustment program and withholding risk adjustment payments; the Centers for Medicare & Medicaid Services (CMS) has since announced that the program will continue. *See* CMS Press Release, *CMS Adopts the Methodology for the Permanent Risk Adjustment Program under the Patient Protection and Affordable Care Act for the 2017 Benefit Year* (July

³ Qualifying coverage includes insurance provided by or through an employer, insurance purchased through a health benefit exchange, or government-sponsored coverage that meets federally mandated minimum levels of coverage.

24, 2018) available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-07-24-2.html>.

13. Section 9010 of the ACA also includes a Health Insurance Providers Fee, based on a covered entity's share of net health insurance premium in the prior year, to help fund federal and state marketplaces. See 26 C.F.R. Part 57. Congress imposed a moratorium on collection of the fee for plan year 2017. The fee was resumed for 2018 and has again been suspended for the 2019 calendar year. See Internal Revenue Service, Affordable Care Act Provision 9010 - Health Insurance Providers Fee (June 15, 2018), available at <https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010> (IRS guidance explains fee calculation and moratorium).

14. On October 12, 2017, President Trump issued an Executive Order that called for the Secretary of Labor to consider making access to health care coverage through Association Health Plans (AHPs) less restrictive for small businesses. E.O. 13813; *Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States* (Oct. 12, 2017). The Department of Labor (DOL) issued a final rule on AHPs in June 2018 that expands their availability by adopting a more flexible "commonality of interest" test for employers. 29 C.F.R. 2510 (2018) available at <https://www.gpo.gov/fdsys/pkg/FR-2018-06-21/pdf/2018-12992.pdf>.⁴

15. Based on the federal changes that allow for increased availability of AHPs, the Department of Financial Regulation announced on July 2, 2018 that it was in the process of drafting an emergency rule that would provide regulatory protections for AHP enrollees. DFR filed the emergency regulation and proposed final regulation on August 1, 2018. See <http://www.dfr.vermont.gov/proposed-rules-and-regulations> (links to press release, emergency rule and proposed final regulation).

Procedural History

16. On May 11, 2018, MVP filed its 2019 Individual and Small Group Market Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The filing outlines the development of proposed rates for coverage commencing January 1, 2019 and proposes an average annual rate increase of 10.9% with increases ranging from 4.2% to 30.7%. Exhibit 1 at 3.⁵ Taking into account the increased premium assistance and "silver-loading," as described in ¶ 6, above, the average rate increase that would be felt by policyholders would be 6.4%, with increases ranging from 4.2% to 10.6%. *Id.* at 32.

17. On May 18, 2018, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care services and health insurance, entered a Notice of Appearance as an interested party to the

⁴ On July 26, 2018, a coalition of twelve state attorney generals, led by New York and Massachusetts, filed a legal challenge to the DOL rule. See https://ag.ny.gov/sites/default/files/complaint_as-filed.pdf.

⁵ The exhibits referred to in this decision were stipulated to by the parties, and the page numbers refer to the numbers as shown in the admitted exhibits. All documents, hearing transcript, and public comments referenced in this Decision and Order are available at <http://ratereview.vermont.gov/node/701>.

proceeding. *See* 8 V.S.A. § 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule (Rule) 2.000 §§ 2.105, 2.202, 2.307.

18. From May 11 through July 24, 2018, the Board requested that MVP respond to a series of interrogatories, including two sets of questions provided to the Board by the HCA and forwarded to the company on the HCA's behalf. MVP provided responses to the Board's interrogatories, *see* Exhibits 2-9; but objected to providing responses to several of the HCA's questions. Exhibit 5.

19. On July 10, 2018, DFR issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency. Exhibit 10. Noting that in 2017 MVP's Vermont book of business accounted for approximately 2.9% of its total premiums written, DFR opined that the rates as proposed would not materially impact the company's solvency, but that "adequacy of rates and contribution to surplus are necessary for all health insurers in order to maintain strength of capital that keeps pace with claims trends." *Id.* at 1-2.

20. L&E conducted a review of the filing and on July 10, 2018, issued an actuarial memorandum summarizing its analysis and recommendations. Exhibit 11.

21. On July 10, 2018, the HCA filed an Expert Witness Report of Chief Health Care Advocate Michael Fisher (Fisher Report), who the HCA had previously disclosed as one of its two expert witnesses.⁶ The Fisher Report stated Fisher's view, as a former legislator, of the legislative intent of Act 48 of 2011, supplemented by excerpts from archived legislative records.

22. On July 17, 2018, MVP filed a motion *in limine* to exclude Fisher's report and testimony, and on July 20, 2018, the HCA filed a memorandum in opposition to the motion.

23. In response to a July 16, 2018 L&E interrogatory concerning recently filed Vermont hospital budget submissions, MVP informed the Board on July 17, 2018 that it had revised its unit cost projection based on the submissions, resulting in a 0.5% rate increase. Exhibit 9.

24. The Board held an administrative hearing on the proposed rates on July 24, 2018 at the Vermont State House. General Counsel Judith Henkin served as hearing officer by designation of Chair Kevin Mullin. Gary F. Karnedy, Esq. of Primmer Piper Eggleston & Cramer, P.C. represented MVP and presented testimony from MVP's Director of Actuarial Services, Matthew Lombardo. Jay Angoff, Esq. of Mehri & Skalet in Washington D.C. represented the HCA, assisted by local counsel Kaili Kuiper and Eric Schultheis. Jesse Lussier testified for the Department of Financial Regulation regarding its solvency analysis. Staff Attorney Sebastian Arduengo led the direct testimony of Jackie Lee of L&E, the Board's consulting actuary.

⁶ Although the HCA had disclosed that its Hotline supervising attorney, Marjorie Stinchcombe, would also provide expert testimony, Stinchcombe did not provide an expert report nor appear at the hearing to testify.

25. At the start of the hearing, the HCA withdrew its request that the Fisher Report and related testimony be admitted into evidence. The hearing officer informed the HCA that Fisher could offer factual testimony as a rebuttal witness. Hearing Transcript (TR) at 17-19.

26. During the course of the hearing, the Board requested additional information from MVP concerning the company's consumer website, the status of its negotiations with OneCare Vermont, the success of its fraud, waste, and abuse program and amount of receivables attributed to that program, an explanation of what quality measures are tied to "provider incentives" referenced in its filing, and asked that it calculate a Vermont-specific per-member per-month (PMPM) for administrative costs that reflects the increased membership in Vermont. GMCB Request for Supplemental Information (July 25, 2018) at 1-2. On July 30, 2018, MVP submitted written responses to the Board's requests, but maintained that it needed clarity regarding the question about a state-specific allocation of its administrative costs.

27. The public comment period on the filing began on May 11, 2018 and closed on July 25, 2018. In addition to receiving over 130 written comments, the Board accepted public comment from more than twenty Vermonters who chose to appear in person either at the close of the July 24, 2018 hearing or later that evening at a public comment session.⁷ The commenters overwhelmingly requested that the Board deny any rate increases, stated that health insurance and health care in general is unaffordable for Vermonters—many offered personal accounts of their own or their families' difficulties in accessing or paying for care—and many urged the Board to implement a single payer system.

28. On July 30, 2018, HCA and MVP filed post-hearing memoranda with the Board.

29. On August 1, 2018, L&E issued an addendum to its actuarial memorandum recommending that the Board adopt a 0.2% increase to the rates attributable to the recently-filed hospital budgets, rather than MVP's proposed 0.5% increase. *See* L&E addendum at 1-2.

Findings of Fact

30. MVP Health Plan, Inc. is a non-profit health insurer domiciled in New York State and licensed as a health maintenance organization (HMO) in New York and Vermont. The company is a subsidiary of MVP Health Care, Inc., a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries, and which according to its website, has more than 700,000 members across New York and Vermont. MVP Health Plan, Inc. offers HMO products to individuals in Vermont's large group, individual, and small group health insurance markets.

31. MVP developed the rates in this filing for qualified health plans offered through VHC and for reflective silver plans offered off the exchange, with coverage beginning January 1, 2019

⁷ Because each of the two carriers filing rates for the individual and small group market file on the same date, the public comment periods run simultaneously, and the majority refer to rate increases in general. However, of the overall 173 written comments received, 11 specifically addressed MVP's rate filing, 41 addressed Blue Cross Blue Shield of Vermont's rate filing, and the remainder did not specify a carrier.

and ending December 31, 2019. Based on its February 2018 membership, MVP projects that the filing will cover 8,929 policyholders, 16,360 subscribers and 25,223 members. Exhibit 1 at 32.

32. MVP has garnered an increasing market share in Vermont as a result of its competitive pricing. MVP had 6,614 members as of March 2016, *see* GMCB Docket no. 007-16rr (MVP 2017 Vermont Health Connect rate filing), last year it had over 10,000 members, and this year it has more than doubled last year's membership. TR at 56.

33. MVP's initial rate filing proposed an average annual rate increase of 10.9% across all plans with increases ranging from 4.2% to 30.7%. Exhibit 1 at 32. Because many Vermonters will qualify for additional premium tax credits to offset rate increases "loaded" on silver plans offered through VHC, the average annual rate increase experienced by Vermonters would be 6.4%, with increases ranging from 4.2% to 10.6%. Exhibit 1 at 32.

34. To develop its 2019 rates, MVP used as its base experience period claims incurred between January 1 and December 31, 2017 and paid through February 28, 2018. MVP restated its incurred medical claim estimates to complete the claims through March 31, 2018. Exhibit 1 at 33.

35. In 2017, MVP experienced significantly lower than projected claims due to enrolling a healthier than expected membership. This variation in projected health status of its members is reflected in MVP's risk adjustment calculation, which, using CMS interim data, resulted in a \$50.56 PMPM increase to MVP's projected paid index rate. Exhibit 1 at 38, 73.

36. MVP's rate development assumes that all policies, whether individual or small group, will be active for a full year. This assumption produces a small increase in rates because partial year enrollees, with fewer months to meet their deductibles and out-of-pocket maximum, tend to exhibit lower utilization and claims cost than full-year enrollees. Exhibit 1 at 35.

37. MVP included a 2.0% increase to its experience period claims cost to reflect elimination of the federal individual mandate penalty, increasing the rate by 2.0%. Exhibit 1 at 36. MVP performed its own analysis of the rate impact which showed a slightly higher, 2.2% rate increase, but chose to rely on L&E's best estimate, as reflected in its February 2018 Individual Mandate Study, which incorporated additional considerations such as the federal poverty level and contract tiers. TR at 87-88.

38. MVP projected the experience period claims forward to the rating period using an average annual allowed medical trend factor of 3.2%. The medical trend incorporates a 0.0% utilization trend and a 3.2% unit cost trend. Exhibit 1 at 36-37, 71; TR at 158. In response to an interrogatory requesting that the company demonstrate how the Board's hospital budget orders are reflected in the unit cost trend, MVP provided the information weighted by Vermont facility and physician trends. Exhibit 2A at 3, 4, 5.

39. MVP's unit cost trend of 3.2% incorporated known and expected contractual increases with providers in its network which resulted in a 1.7% unit cost trend increase for Vermont facilities and providers impacted by the Board's hospital budget review, and a 5.0% increase for other facilities and providers. Exhibit 11 at 5. Because at the time it developed its

rates MVP had not finalized its hospital budget negotiations and proposed hospital budgets had not been submitted to the Board, MVP assumed that 2019 hospital budget increases would match 2018 increases. *Id.*

40. MVP's pharmacy benefit manager (PBM) provided the insurer with a pharmacy trend forecast of 13.3%, based on its experience by drug class. Exhibit 1 at 37, 71. MVP expects to receive an increase in pharmacy rebates in 2019, which it has incorporated into its drug trend. TR at 67. Approximately 90% of prescriptions filled by MVP's members are for generic drugs, 9% are for brand name drugs whose prices are increasing most rapidly, *see* Exhibit 1 at 71-72; and 1% are for specialty drugs. TR at 125.

41. MVP included within its rates non-claim expense plan level adjustments that do not vary by plan, including federal and state taxes and fees (\$0.15 and \$0.91 per-member per-month [PMPM], respectively), a 2.0% contribution to reserves (CTR), and a general administrative expense load of \$39.80, \$3.98 of which MVP attributes to quality improvement and cost containment programs. Exhibit 1 at 39-40. Because there is no collection of the Health Insurance Providers fee for plan year 2019, premiums for 2019 will be approximately 1.5% lower than if the tax were collected. Exhibit 11 at 9.

42. MVP adjusted rates at the plan level by 0.2% of premium for an increase in bad debt, based on the assumption that without an individual mandate penalty, some of its members would sign up for coverage and receive covered services, and then later forgo coverage without paying premiums. Exhibit 1 at 40.

43. MVP has targeted a traditional medical loss ratio (MLR) of 89.2% and a federal MLR of 90.2%. Exhibit 1 at 42.

44. MVP has not adjusted its rates upward based on the reintroduction of Association Health Plans into the market because it does not yet have any data to support such an adjustment. MVP expects that migration to AHPs will result in increased rates in its individual and small group market as morbidity increases, however, and will continue to evaluate the potential impact for future plan years. TR at 80-81.

45. Notwithstanding the significant growth of MVP's Vermont membership, Vermonters' PMPM costs for administrative expenses in this year's filing have not declined. MVP spreads its fixed costs "enterprise-wide" across its Vermont and New York business, and many functions, such as the claims operating system, are located and performed in New York where the company is headquartered and where its membership—though still significantly larger than Vermont's—has declined. Although MVP's actuary testified at last year's rate hearing that administrative costs would decline as Vermont membership increased, he had assumed at the time that MVP's New York business and the company's overall membership would also continue to grow. TR at 65-66.

46. MVP proposed a 2.0% CTR to protect itself against unanticipated liabilities and to help meet New York statutory reserve requirements, even though it believes that an approximate 8.5% CTR would be actuarially appropriate for this book of business due to its membership growth and consequent need for more reserves. Exhibit 1 at 40; TR at 57-58. New York

regulators require that the company reserve a minimum of 12.5% of overall premium, and MVP has targeted a range of between 16% and 20%. TR at 59. At approximately 15.4% of premium, MVP is currently below its target range but above the minimum regulatory requirement. TR at 105-06.

47. MVP filed a 1.5% CTR for the individual exchange market in New York, where it anticipates fewer members due to the elimination of the individual mandate penalty, and a 2.0% CTR for its small group market. TR at 96-97. The Board's actuary testified at hearing that she would have found that a 1.5% CTR, had it been submitted by the company in this filing, would be reasonable. TR at 208.

48. Based on its review of the initial filing, L&E recommended three modifications. First, L&E recommended that MVP adjust its claims experience to reflect coverage by individual policyholders lasting less than a full year. This modification would reduce the overall rate increase by approximately 0.3%. Exhibit 11 at 4.

49. Second, L&E recommended that both Vermont carriers in the health benefit exchange revise their risk adjustment calculations based on the final risk adjustment report from CMS, released on July 9, 2017. With the revision, L&E estimates that MVP will make a \$41.21 PMPM 2019 risk adjustment transfer payment, resulting in a 1.9% premium decrease from the company's initial projection. Exhibit 11 at 8.

50. Third, L&E recommended that the Board consider, at the time it issues its decision, the rate impact of any updated information it may receive relating to hospital unit cost trend. Exhibit 11 at 11.

51. After the recommended modifications, L&E projected an average annual rate increase of 8.5% and average increase felt by Vermonters of 3.8%. *Id.* L&E opined that the rates as modified are actuarially sound: They are adequate because they would cover member claims, administrative costs, taxes and fees, and allow for a reasonable CTR; not excessive because they do not exceed the amount needed to pay for such costs; and not unfairly discriminatory because they do not produce impermissible differences in premiums among insureds within similar risk categories. Exhibit 11 at 11; TR at 180-81.

52. MVP does not contest, and incorporated into its rate calculation, L&E's recommended modification to its risk adjustment transfer payment. TR at 23, 36; MVP Post-Hearing Proposed Findings of Fact and Conclusions of Law (MVP Post-Hearing Memo) at 3-4.

53. MVP does not agree with L&E's recommendation that it should modify its claims experience to account for individual members who will not maintain coverage for a twelve-month period. MVP's actuary explained at hearing that although its 2017 experience period data shows that members enrolled at different points throughout the year, the company assumes that for subsequent years individual members will remain enrolled for the full year, and therefore be more likely to meet their deductibles and out-of-pocket maximums, causing an increase in MVP's claims cost. TR at 48-49.

54. In response, the Board's actuary explained that MVP's data provided by the carrier, *see* Exhibit 3 at 6, does not support its assumption that no individual members will enroll for less than a full twelve months. She further explained that even with a shortened open enrollment period in 2018 and 2019 taken into account, some individuals are likely to add or drop their coverage for a number of reasons over the course of the year; for example, individuals might obtain or lose employer-sponsored group coverage or may find coverage too costly and allow their coverage to lapse. TR at 181-84.

55. In response to a question posed by L&E on July 16, 2018, MVP advised the Board on July 17, 2018 that it had recalculated its unit cost trend, based on information in the recent Vermont hospital budget filings, which would require an increase of 0.5% to the rate. Exhibit 9; Exhibit 9A at 14-15 (recalculated hospital unit cost trend). At hearing, actuary Lee declined to provide an opinion about MVP's analysis of the impact of the hospital budgets on rates because she had not yet adequately reviewed MVP's recalculation. TR at 186-87.

56. On August 1, 2018, L&E filed an addendum to its Actuarial Memorandum addressing MVP's proposed 0.5% increase resulting from information in the recent hospital budget filings. Based on an examination of the historical variance between submitted and approved hospital budgets, L&E recommended a 0.2% increase to MVP's proposed rate, rather than 0.5%. L&E addendum (Aug. 1, 2018) at 1-2.

57. MVP has sought to increase member engagement and cost transparency via its website, which for 2018 had approximately 600,000 users logging 2.1 million sessions. MVP also has a Mobile App for Android and iOS applications; combined there have been approximately 9,800 users and 75,000 user sessions. The site includes a "find a doctor" feature (126,422 views), as well as a "treatment cost calculator," which has only experienced light traffic (4,532 views and 3,427 cost estimates). MVP's Vermont-specific landing page, launched in September 2017, received approximately 11,600 page views, 164 lead submissions, and more than 900 plan document downloads between its launch and the end of 2017. MVP Response (July 30, 2018) at 1-2.

58. MVP also implemented a telemedicine benefit for its members that allows access to a health care provider via a computer or smartphone. According to the company, the benefit has shown that it produces savings as an alternative to more costly urgent care visits. TR at 69-70.

59. The percentage of MVP's overall claims attributed to primary care has remained stagnant from 2014 through 2017, with a low in 2016 of 7.9% of claims, and a high of 8.6% in 2014 and 2017. Exhibit 5 at 7; TR at 130-31. The percentage of MVP members without a preventative visit has shown only a slight decline from its high of 65.7% in 2014, to 62.9% in 2017. Exhibit 5 at 7.

60. MVP's special investigations unit recovered \$1,063,063 in claims for fraud, waste, and abuse in 2016; in 2017 it recovered \$973,373. These recoveries amount to less than 0.1% of claims company-wide. MVP Response (July 30, 2018) at 3.

61. In New York State, MVP participates in value-based payment programs with its Medicaid population in the “Roadmap” for Medicaid Payment Reform Program,⁸ TR at 151-54, and to some extent with its commercial population, but does not yet have enough data to adequately analyze the programs’ impact. TR at 128-29.

62. In Vermont, approximately 98.4% of MVP’s claims in its 2017 exchange book of business were processed as fee-for-service. MVP is currently engaged in negotiations with OneCare Vermont to enter into a fixed payment arrangement beginning January 1, 2019, which would include a \$3.25 PMPM payment to OneCare for administrative fees; MVP has not incorporated the payment into its 2019 proposed rates. MVP maintains that it had not sought to implement alternative payment methodologies in Vermont in the past because of its small membership footprint. MVP Response (July 30, 2018) at 3; TR at 106-107.

63. MVP’s New York business is accredited by The National Committee for Quality Assurance (NCQA), which employs a set of more than sixty quality standards and requires reporting in more than forty areas. MVP believes that it offers quality services and that the providers with which it has contracted are high performing, and is currently seeking NCQA certification for its Vermont book of business. TR at 69, 76.

Standard of Review

The Board reviews rate filings to ensure 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 the laws of this State. 8 V.S.A. § 4062(a)(3). In addition, proposed rates cannot be excessive, inadequate, or unfairly discriminatory. Rule 2.000, § 2.301(b). The Board is further required to consider 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.

The Board’s review is plainly not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that several of the Board’s review standards 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. In arriving at its decision, the Board must also consider the Department of Financial Regulation’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), and any public comments received on the 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. Rule 2.000 § 2.104(c).

⁸ In June 2015, the New York State Department of Health released *A Path toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform* (the “Roadmap”). The Roadmap, which was developed primarily for CMS as a condition of the State’s Delivery System Reform Incentive Payment (DSRIP) agreement, is a path for the state to achieve the goal that 80-90% of its Medicaid managed care payments to providers will be value-based by 2020. See https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/vbp_library/docs/2017-11_final_vbp_roadmap.pdf.

Conclusions of Law

I.

We first address an issue on which MVP and our actuaries are in agreement. L&E recommends that the carrier incorporate into its risk adjustment calculation the most recent estimate of its 2017 risk adjustment payment, which was unavailable to MVP on the date of its initial filing. Finding of Fact (Finding) ¶ 49. The company does not oppose the recommendation, which it has since incorporated into its proposed rates. Finding ¶ 52. We agree that the risk adjustment calculation should be made using the most recent and accurate information available, and therefore adopt this recommendation, which reduces the proposed rate increase by approximately 1.9%.

II.

As in last year's Vermont Health Connect rate filing, MVP opposes L&E's recommendation that it should adjust its experience to account for mid-year enrollment in the individual market. See *In re MVP Health Plan Inc.*, Docket No. GMCB-007-17rr, available at <http://ratereview.vermont.gov/sites/dfr/files/2017/MVP%202018%20Exchange%20Decision.pdf>. The company again assumes that because plans in the individual and small group market are offered on a calendar year basis, all individual members will be enrolled for a full year, and are therefore more likely to meet their deductibles and out-of-pocket maximum payments, in turn increasing claims costs for the company. Findings ¶¶ 36, 53.

While we agree that it is reasonable to assume that virtually all small groups will begin coverage at the start of the year and maintain their enrollment for a full twelve months, we again do not agree that this assumption is accurate with respect to individuals. We are instead persuaded by the rationale explained in L&E's Memorandum and amplified by our contract actuary through hearing testimony, that *some* individual members will allow coverage to lapse throughout the year, even if the number of individuals is less than in prior years with longer open enrollment periods. Finding ¶ 48. An enrolled individual may, for example, obtain employer-sponsored insurance mid-year, or decide that the coverage is too costly. *Id.* Accordingly, we require that MVP reduce its rate by approximately 0.3%, as recommended by L&E, to account for mid-year enrollment changes in the individual market.

III.

We next address MVP's request for a 0.5% increase in rate resulting from its recalculation of unit cost trend that incorporates information from the recently filed Vermont hospital budget submissions. We note that the Board has sought to ensure that the two regulatory processes—hospital budget review and insurance rate review—are not conducted in silos, but are integrated, consistent, transparent, and can provide incentives for cost savings and slowed rate growth that will benefit Vermont health care consumers.

Although we encourage the company to use the most recent hospital information to develop its unit cost trends and to negotiate vigorously to keep unit cost trends at their lowest,

the budget submissions received at the start of July are preliminary and untested, and the Board has actively sought to control the growth in hospital spending by consistently ordering reductions to initial budget submissions, in both hospital net patient revenues and commercial rates. Findings ¶¶ 55, 56. We therefore agree with our actuary and allow the insurer to increase its rates by 0.2%, consistent with the aggregate historical reductions the Board has ordered during the hospital budget and budget enforcement processes. *See generally* GMCB Hospital Budget Staff Presentation (prepared for and presented at the Board’s July 18, 2018 public meeting) at slides 10, 11 (tracks disparities between submitted and approved rates), *available at* http://gmcboard.vermont.gov/sites/gmcb/files/B19%20Preliminary_Final%20July%2018%202018%20Hospital%20Budgets.pdf. This modification results in an approximate 0.3% reduction to the rate.

IV.

We next turn to MVP’s assumption, based on the February 2018 Individual Mandate Study commissioned by the Board and DFR, that removal of the individual mandate penalty will have the effect of increasing premiums by 2.0% as healthier individuals drop coverage in the absence of a financial penalty incentivizing them to stay in the market. The study projected an approximate 0.6% increase in Vermont’s uninsured rate, a decrease in the number of healthy, young Vermonters enrolling in the individual and small group market, and an overall increase in premiums in the individual and small group market of between 1.6% and 2.4%. *See* Finding ¶ 9.

Although we agree that the study provides a useful baseline for modeling how the removal of the individual mandate penalty may impact premiums and enrollment, the study is a projection, prepared on the best information that was available at the time. Subsequently, to help counteract the reduction in enrollment as projected in the study, the Vermont legislature passed Act 182 (2018) which 1) creates a state mandate that individuals maintain minimum essential coverage, 2) forms a working group to develop recommendations concerning administration and enforcement of the mandate, with the enforcement mechanism to be enacted by the legislature in 2019, and 3) tasks DVHA, in consultation with the HCA and other stakeholders, with engaging in outreach efforts to educate Vermonters about the importance of, responsibility to maintain, and availability and options for health insurance coverage. *See* Finding ¶ 10. In light of the 2018 legislative action, the ongoing educational efforts by DVHA and community stakeholders, and our obligation to provide Vermonters with the lowest insurance rates feasible, we require that MVP reduce its assumption of rate impact from 2.0% to 1.6%, the low end of the range identified in the Individual Mandate Study, thereby reducing the rate increase by 0.4%.

We further conclude, using much the same rationale, that MVP’s 0.2% rate adjustment to account for an increase in bad debt is overstated. Consistent with our view that elimination of the federal penalty has a less significant impact here in Vermont than it may have elsewhere—Vermont’s uninsured rate prior to enactment of the ACA was low, and some of the ACA’s consumer protections already in place—we are unpersuaded by MVP’s claim that elimination of the individual mandate penalty for a single year, already accounted for as discussed above, will prompt even more members to forgo paying their premiums. We therefore require that the carrier modify its rate downward by an additional 0.2%.

V.

We next reduce the company's proposed CTR from 2.0% to 1.5%, which we conclude will not materially impact or pose a threat to the carrier's solvency. Despite capturing a growing share of the Vermont individual and small group market, the company's Vermont membership remains only a small percentage of its overall business. *See* Finding ¶19. MVP advised the Board that its New York regulators require that the company maintain a minimum of 12.5% of premium in reserves and MVP currently exceeds that threshold. At hearing, the Board's actuary testified that she would have found a 1.5% CTR to be reasonable had it been submitted by the company. Moreover, a 1.5% CTR is consistent with the company's requested CTR in its New York individual market filing. Findings ¶¶ 19, 46, 47.

The reduction in CTR reduces the rate by 0.5%.

VI.

Finally, we address whether the carrier has demonstrated that its rates are affordable and promote access to quality health care. These concepts, unlike our actuarial review standards, are fluid and open-ended, *see In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16, and require a balancing of statutory considerations—unaffordable rates will hamper Vermonters' ability to access quality care, while affordable rates that imperil an insurer's solvency will likewise threaten Vermonters' access to care. At a time when federal changes to health care policy have disrupted the individual and small group health insurance marketplace—the elimination of the individual mandate penalty and the reentry into the market of AHPs are two recent examples—we find that appropriately striking the balance of affordability and solvency has become more difficult, while crucial for Vermonters purchasing health care coverage.

We first acknowledge that MVP's filing, responses to interrogatories, and testimony at hearing demonstrate that the company has implemented programs and initiatives that help further the goal of making high quality, affordable health care accessible to its membership. MVP has priced its plans competitively, grown its Vermont membership, and sought to increase price transparency. Examples of these efforts include the creation of an online portal that allows its members to comparison shop for certain services among providers, and the expanded use of telemedicine which has helped reduce utilization of more expensive urgent care visits. Findings ¶¶ 57, 58. While these initiatives and programs are commendable, as long as health care remains unaffordable, and therefore inaccessible for many Vermonters, they are only a starting point.

During the course of our review process, we received many compelling comments from members of the public, both in writing and in person. Finding ¶ 27. Most all underscore that for many Vermont individuals, families and businesses, health care remains unaffordable under any reasonable standard. We find this is true notwithstanding Vermont's comparatively high grades for its health care system, which include high ratings for access and affordability. *See, e.g.,* The Commonwealth Fund, *2018 Scorecard on State Health System Performance*, (2018 "scorecard" ranks Vermont's system fourth overall, and third for access and affordability) *available at* https://interactives.commonwealthfund.org/2018/state-scorecard/files/Radley_State_Scorecard_2018.pdf.

It is clear to this Board, however, that despite Vermont's favorable comparison to other states, too many Vermonters are spending too much of their incomes on health care.

We therefore require that MVP pursue operational and systemic improvements that will benefit its members. MVP must more vigorously pursue cost containment strategies that move provider payments from a fee-for-service arrangement to reimbursement that is value-based. The company must continue its negotiations with OneCare Vermont, work towards participation in alternative payment arrangements, and help Vermont meet the goals of the All-Payer Model Agreement. And as we have stated before, the company must negotiate favorable pricing with hospitals—both within and outside of Vermont's borders. We further expect that MVP will actively and critically review its policies and procedures and institute best practices that reduce administrative burdens and inefficiencies, provide fair and equitable provider reimbursement, ensure appropriate utilization of services, improve health outcomes, and eliminate fraud and waste from the system; notably, MVP's fraud, waste and abuse program has a recovery rate of less than 0.1% of claims, while national estimates indicate seven percent of health care spending is lost to fraud and abuse alone. Finding ¶ 60; *see generally* N. Sahni *et al.*, *How the U.S. Can Reduce Waste in Health Care by \$1 Trillion*, Harv. Bus. Rev. (Oct. 13, 2015) (discusses reforms that can be implemented to reduce waste in health care spending); J. Martinez *et al.*, *Improving the Health Care System: Seven State Strategies*, Nat'l Conference of State Legislatures (July 2016) (discusses reducing waste and inefficiencies). And despite a broad consensus about the importance of primary care, the percentage of MVP's overall claims attributed to primary care has remained stagnant since 2014, and the percentage of MVP members without a preventative visit has shown only a minimal decline. Finding ¶ 59; *see generally* The Commonwealth Fund, *Primary Care: Our First Line of Defense* (June 12, 2013), available at <https://www.commonwealthfund.org/publications/publication/2013/jun/primary-care-our-first-line-defense>; Mayo Clinic Health System, *Speaking of Health: The Importance of Having a Primary Care Provider* (April 7, 2015) available at <https://mayoclinichealthsystem.org/hometown-health/speaking-of-health/the-importance-of-a-primary-care-provider>; Becker's Hospital Review, *Dr. Atul Gawande on the Importance of Primary Care Physicians* (Oct. 11, 2017) available at <https://www.beckershospitalreview.com/hospital-physician-relationships/dr-atul-gawande-on-the-importance-of-primary-care-physicians.html>. We further note that traffic on the company's cost comparison tool is low and its use should be encouraged and incentivized, Finding ¶ 57, and that while MVP provided testimony at hearing regarding the high quality of providers within its network and advised the Board that it is seeking NCQA certification, *see* Finding ¶ 63, a review of its parent company's 2016-2017 NCQA ratings demonstrates the need for improvement in several key reporting areas, which if achieved can be reasonably expected to foster better health outcomes and reduce health care costs in the long and short term. *See* NCQA Plan Results, <http://healthinsuranceratings.ncqa.org/HprPlanDetails.aspx?id=171> (indicates low scores for mental and behavioral health measures, appropriate antibiotic use for adults with bronchitis, and appropriate use of imaging for lower back pain).

Based on the above, we are convinced that MVP has the ability to become more efficient in its operations and innovative in its policies, with the goal of improving care delivery, health outcomes, and reducing health care costs. Accordingly, to fulfill our statutory charge to ensure

that rates are affordable and quality health care accessible within the bounds of current law,⁹ we require that the company reduce its rate by an additional 1.0%.

Order

For the reasons discussed, we modify and then approve MVP’s 2019 individual and small group market rate filing. Specifically, we order that MVP: 1) reduce the rate by 1.9% based on updated risk adjustment information, as recommended by L&E and agreed to by the insurer; 2) reduce the rate by 0.3% to account for individuals enrolling in plans for less than a full-year period; 3) reduce the rate by 0.3% to account for historical reductions by the Board to proposed hospital budgets; 4) reduce the rate by 0.4% to account for elimination of the individual mandate penalty, and by an additional 0.2% for the increase to bad debt; 5) reduce the CTR to 1.5%, decreasing the rate by 0.5%; and 6) reduce the overall average annual rate increase by 1.0% to make rates more affordable for Vermonters.

As modified, we approve an average annual rate increase of approximately 6.6%. Because many Vermonters will receive larger federal subsidies to cover the increased costs, as explained herein, *the average annual rate increase that will be borne by Vermonters is approximately 1.9%*.

SO ORDERED.

Dated: August 9, 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: August 9, 2018

* *Member Pelham filed a separate concurrence to this decision.*

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

⁹ The majority to this decision do not share the concurring member’s view that appropriating additional funds to DVHA, absent changes to federal or state law, will allow for an increase in the amount of, or eligibility for, subsidies for individuals in the merged market.

Pelham, concurring:

I join the majority in approving the company's individual and small group market rate filing as modified above. I write separately, however, to discuss my deep concern with the evidence presented as to the affordability of the proposed rates.

In testimony, MVP's actuary stated, "cost shifting of costs between Medicare, Medicaid and commercial definitely does have an adverse impact on commercial premium rates." TR at 158. The Board calculated the Medicaid cost shift for hospitals alone in 2017 to be approximately \$210 million. *See* Green Mountain Care Board, Cost Shift for Budget 2018 and Actual 2017 (2018), *available at*

http://gmcboard.vermont.gov/sites/gmcb/files/2018_Act53_Cost_Shift_Trend_PROFILE_Table_7.pdf.

Absent state and federal subsidies, the premium rates proposed by MVP would be unaffordable to many consumers in the Individual market. For example, I estimate that absent subsidies, the annualized 2018 premium for a couple at 250% of poverty (\$41,150) would consume 24.8% of their income for a Standard Bronze plan, one of the least expensive offered, and for a family of four at 250% of poverty, (\$62,250), the 2018 annual Standard Bronze Plan premium is 22.8% percent of income.¹ *See* TR at 155. For a Silver plan, a couple would need to spend 31% of their annual income, and for a family of four, 28.4% of annual income. *Id.* Clearly, such premiums absent subsidies would place many Vermonters in desperate financial and/or health care jeopardy.

But even with federal and state subsidies available through Vermont Health Connect, premium costs are hefty. For example, near or at 400% of poverty I estimate that a couple's Standard Bronze plan consumes 15.6% of their income and the Standard Silver plan for a four-person family consumes 17.7% of their income. *See* TR at 155-156. These ratios do not include the added costs of co-insurance such as copays and deductibles. Now that Vermont remains committed to the Individual Mandate, it's important that the negative effects of the cost shift and rising commercial insurance rates be mitigated so as to not force Vermonters into unacceptable financial and/or health deprivation corners.

To the goal of affordability, the Vermont Premium Assistance Program (VPA) is a state program to help qualified Vermonters, up to 300% of the poverty level, pay insurance premiums. *See* 33 V.S.A. § 1812(a). It is funded both by state general funds and federal global commitment funds. For fiscal year 2018 just ending, the program cost \$6.6 million, comprised of \$3.08 million in state general funds and the balance with federal global commitment funds. For fiscal year 2019 the legislature has appropriated \$7.1 million for this program. Further, after reconciling financial issues with the operations of Vermont Health Connect, the State was able to add \$78.09 million in general funds to the Human Services Caseload Reserve, and thus increase its balance to \$100.09 million. Of this amount the legislature designated \$14.06 million for "A sub-account for Medicaid-related pressures related to caseload, utilization, changes in federal

¹ My estimates are based on published 2018 rates in the company's filing as well as the Vermont Health Connect subsidy estimator. *See* Exhibit 1 at 65; Vermont Health Connect, 2018 Subsidy Estimator, *available at* http://info.healthconnect.vermont.gov/Subsidy_Estimator.

participation in existing human services programs, and settlement cost associated with managing the Global Commitment waiver.” Act 11 (2018 Special Session) § D.104(a)(3). Expenditures from this Reserve can be authorized separately by the General Assembly or by the Emergency Board, which is comprised of the Governor and the Chairs of the House and Senate Appropriations Committees, and the Chairs of the Senate Finance Committee and the House Ways and Means Committee. *See* 32 V.S.A. § 131.

Given the recent elimination of funding for the federal Cost Sharing Reduction and the elimination of the penalty for the Individual Mandate, the Emergency Board should consider at least an interim funding increase to the Department of Vermont Health Access to cushion the impact of these recent federal changes during 2019 on consumers and thus allow time for these changes to be considered and absorbed by Vermont’s health care funders and providers. An allocation of just \$4 million of the \$14.06 million “sub-account” represents nearly a doubling of the premium assistance to consumers in the Individual Market, and possibly the expansion of the program to 400 percent or 500 percent of the federal poverty level.

Dated: August 9, 2018 at Montpelier, Vermont

s/ Tom Pelham
Member, 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 within ten days of the date of this decision and order.