STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.	)	
2019 Individual and Small Group Market	)	GMCB-008-18rr
Rate Filing	)	

OFFICE OF THE HEALTH CARE ADVOCATE POST-HEARING MEMORANDUM

The Office of the Health Care Advocate (HCA) thanks the Green Mountain Care Board (Board) for the opportunity to respond to the MVP Health Plan 2019 Individual and Small Group Rate filing (Filing). MVP Health Plan's proposed increases, in its original filing, range from 4.2% to 30.7%.[1] Because MVP Health Plan (MVP) has failed to submit evidence supporting all factors on which the Board must make a determination, and because MVP has not demonstrated that its proposed increase will produce rates that are affordable and not excessive, the HCA respectfully requests that the Board reduce MVP's proposed rate increase as outlined below.[2]

I. Statutory Background

MVP bears the burden of demonstrating that its proposed premium rate meets the multi-faceted test governing the lawfulness of a proposed rate increase in Vermont.[3] Absent such a demonstration, the Board may, in its discretion, modify the proposed rate or any element of the rate.[4] When "deciding whether to approve, modify, or disapprove each rate request, the Board must make a determination on each of the following criteria:

1) whether the requested rate is affordable;

2) whether it promotes quality care;

[1] GMCB-008-18rr, SERFF Filing at 44.
[2] This post-hearing memo reflects the record as of 2:30pm on July 30, 2018.
[3] GMCB Rule 2.104(c).
[4] E.g., GMCB-007-17rr, Decision; GMCB-004-17rr, Decision at 5 (reducing a proposed rate based on a balancing of the carrier's needs against the needs of Vermonters for affordable rates); GMCB-003-15rr, Decision at 5 (reducing a proposed rate due to a carrier failing to meet its burden of proof).

3) whether it promotes access to health care;

4) whether it protects insurer solvency;

5) whether it is not unjust, unfair, inequitable, misleading, or contrary to law; and

6) whether it is not excessive, inadequate, or unfairly discriminatory.[5]

Vermont law also directs the Board to consider "changes in health care delivery, changes in payment methods and amounts …" and other issues at its discretion.[6]

Additionally, the statute requires the Department of Financial Regulation (DFR) to provide the Board with an "opinion on the impact of the proposed rate on the insurer's solvency and reserves," and it requires the Board to accept comments from both the public and the Office of the Health Care Advocate on MVP's proposed rate increase.[7] The Board may (or may not) choose to contract with an actuary. The Board must consider the views of DFR, the public, and the HCA, but it is not bound by them. The Board may consider its actuary's opinion but is not required to or bound by it.[8]

II. MVP has failed to carry its burden with respect to the criteria on which the Board must make a determination.

A. Affordability

MVP's actuary asserted that the proposed rate is affordable, but that assertion is not within the scope of the MVP actuary's expertise, and it is unsupported by any evidence.[9] Moreover, MVP has acknowledged that it has not implemented any alternative payment methodologies to lessen its need for a rate increase.[10]

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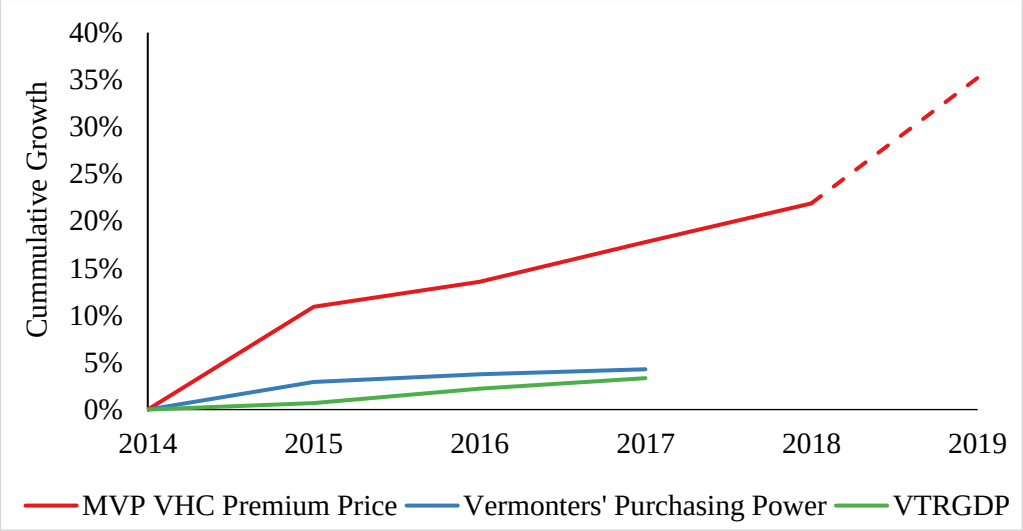
[5] GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 203 Vt. 274 (2016).
[6] 18 V.S.A. §9375(b)(6).
[7] 8 V.S.A §4062(a)(1)(2)(B); 8 V.S.A §4062(c)(1)(B); 8 V.S.A §4062(e)(1)(B).
[8] 8 V.S.A §4062(d)(1).
[9] GMCB-008-18rr, Hr'g Tr. at 107-108 ("Q [Angoff]. Okay. But there is not actuarial standard that qualifies you to render an opinion as to whether a rate is affordable; correct? A [Lombardo]. That is – that's correct. That's not an actuarial opinion."); see also GMCB-008-18rr, Hackett Comment, Hr'g Tr. at 234 (Actuaries "can't tell you what [Vermonters] can afford.").
[10] GMCB-008-18rr, Hr'g Tr. at 106-107.

On the other hand, federal and state statistics demonstrate that MVP's rate increase for this book of business has far outpaced both Vermont GDP and Vermonters' purchasing power. For example, between 2014 and 2017, MVP VHC premium price growth was 538% larger than real Vermont Gross Domestic Product (VTRGDP) growth.[11] During the same period, MVP VHC premium price growth was 413% larger than Vermonter purchasing power (VTPP) growth.[12]

Chart 1. MVP VHC premium price growth compared to VTRGDP and VTPP growth.[13]



In addition, Vermonters' public comments demonstrate the extent to which they struggle to pay premium prices and afford medical care.[14] The ACA premium affordability threshold and Vermont's Household Health Information Survey deductible affordability metric provide a quantitative measure

[11] VTRGDP, as opposed to nominal Vt. gross domestic product, accounts for inflation. U.S. Bureau of Economic Analysis, Vt. Real Gross Domestic Product, https://fred.stlouisfed.org/series/VTNGSP; GMCB-008-18rr, Ex. 1; GMCB-007-17rr, Decision; GMCB-007-16rr, Decision; GMCB-007-15rr, Decision; GMCB-017-14rr, Decision.
[12] VTPP, as opposed to Vt. nominal wages, accounts for inflation. Vt. Dept. of Labor Average Wage Data, http://www.vtlmi.info/indnaics.htm#mqa; U.S. Bureau of Economic Analysis, CPI-U Northeast region, https://data.bls.gov/timeseries/CUUR0100SA0?amp%253bdata; GMCB-008-18rr, Ex. 1; GMCB-007-17rr, Decision; GMCB-007-16rr, Decision; GMCB-007-15rr, Decision; GMCB-017-14rr, Decision.
[13] Fn. 11; Fn. 10.
[14] E.g. Sean Stephens, Pub. Hr'g Tr. at 48 ("My son asked me should I call 911, and as I was writhing around in a pool of my own blood I had to tell him, 'No don't call 911. We can't afford it.'"); Meghan Gardner, Pub. Hr'g Tr. at 11; Avery Brook, Pub. Hr'g Tr. at 15; Christine Birong-Smith, Pub. Comment, July 25, 2018; Samantha Lengevin, Pub. Comment, July 20, 2018.

of the dual burden on Vermonters of paying premium and deductible. Specifically, a plan is affordable if a household (1) does not pay more than 9.56% of their income for premium or (2) have a combined deductible greater than 5% of their income.[15]

Using this test, the current MVP standard Silver plan is unaffordable to large numbers of Vermonters. It is unaffordable, accounting for premium subsidy and cost-sharing benefits, to individuals whose annual income is between $24,121 and $66,466. It is unaffordable to couples whose annual income is between $24,361 and $132,681. And it is unaffordable for families whose annual income is between $36,901 and $186,417.[16] The proposed rate increases will mean that the 2019 MVP standard Silver plan is even more unaffordable.

The plan is particularly unaffordable for Vermonters whose income is slightly above the premium tax credit threshold. For example, in order to pay their premium and meet their deductible, individuals, couples, and families at 401% FPL ($48,361, $65,122, and $98,646, respectively), must pay 19%, 28% and 24%, of their income, respectively.[17]

To be sure, any proposed rate increase will be affordable for some people and unaffordable for others. However, in Vermont, the proposed rate increase would be unaffordable to the 2016 median income individual ($28,069), couple ($67,404), and family of four ($89,824).[18] The proposed rate therefore cannot reasonably be said to be "affordable" within the meaning of the rate review statute.

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[15]Internal Revenue Service, Rev. Proc. 2017-35; Dept. Fin. Regulation, 2014 Vermont Health Insurance Survey Research Findings, 42, http://hcr.vermont.gov/sites/hcr/files/pdfs/survey/2014-VHHIS-Legislative-Presentation.pdf (2015).

[16] The assumed family composition is two adults and two dependent children under 19 years of age. 2017 Federal Poverty Guidelines, 19 Fed. Reg. 82, 8832 (Jan. 3, 2017); 2018 Federal Poverty Guidelines, 12 Fed. Reg. 83, 2643 (Jan. 18, 2018); Vermont Health Connect, 2018 Plan Designs & Monthly Premiums (2017); Vermont Health Connect, 2018 Silver Plan Designs with Cost-Sharing Reduction (2017); Vermont Health Connect, Medicaid & Dr. Dynasaur, http://info.healthconnect.vermont.gov/Medicaid; Vermont Health Connect, 2018 Silver 94 Plans (2017); Vermont Health Connect, 2018 Silver 87 Plans (2017); Vermont Health Connect, 2018 Silver 77 Plans (2017); Vermont Health Connect, 2018 Silver 73 Plans (2017).

[17] Id.

[18] 2016 is the most recent year that the U.S. Census Bureau produces estimates for median household income by household size. U.S Census Bureau, 2016 American Community Survey 1-Year Estimates, Table B19019 – Median Household Income in the Last 12 Months by Household Size.

B. Access to Care

The fundamental measurable indicator of access to care is Vermonters' ability to pay for needed care. The evidence in the record indicates that Vermonters cannot afford premiums, and many Vermonters, even when insured, cannot afford medical care.[19] Such a lack of affordability directly impedes Vermonters' access to care.

MVP has asserted that some of the initiatives it is undertaking, such as telemedicine, improve access to care.[20] However, it has failed to show how the rate increase will enhance its ability to provide such programs, and it has failed to offer any evidence that telemedicine, or any of its other initiatives, measurably improve access to care.

C. Quality Care

MVP's actuary testified that he did not know whether MVP tracks whether its strategies for improving health and wellness improve health outcomes.[21] MVP also provided data showing that less than 9% of its claims costs go towards primary care and that over 60% of its consumers do not have a preventative visit each year.[22] MVP's evidence and argument relating to quality care do not demonstrate that the proposed rate promotes quality care.

D. Solvency

DFR noted in its report on this filing that "MVPHP's Vermont operations pose little risk to its solvency."[23] No evidence was introduced supporting a contrary position. Because its Vermont

[19] E.g. GMCB-008-18rr, HCA Post-Hr'g Mem. at 3; Kevin Wagner, Pub. Tr. at 36 ("The high deductible we pay for our plan like every time we need care it's a matter of we're going to be paying for it for months in the future, and that's – it's definitely a barrier for us and it does cause us to like restrict the care that we seek…"); Grace Beninson, Pub. Hr'g Tr. at 29 ("I had a high deductible plan and wasn't able to afford to go to the doctor… "); Cathy Steven, Pub. Comment, July 23, 2018 ("We have had to make decisions to not go for care because we couldn't afford it, even on a nice income.").
[20] GMCB-008-18rr, Hr'g Tr. at 69-71.
[21] GMCB-008-18rr, Hr'g Tr. at 123-125; see also GMCB-008-18rr, Hr'g Tr. at 109-110 (Lombardo statement that actuaries have no expertise in evaluating quality of medical care.).
[22] GMCB 08-18rr, Ex. 5 - MVP Responses to HCA Non-Actuarial Questions at 7.
[23] GMCB 08-18rr, Ex. 10 - Dep't Fin. Regulation Solvency Op. at 2.

premium constitutes such a small percentage of its written premium, 2.9%, it is undisputed that the rates MVP charges in Vermont will not materially affect MVP's solvency.[24]

E. Not Unjust, Unfair, Inequitable, or Misleading

MVP introduced no evidence tending to demonstrate that the proposed increase is not unjust, unfair, inequitable, or misleading. To the contrary, the evidence before the Board indicates that the proposed increase is unjust, unfair and inequitable, because it discriminates against Vermonters. First, although the Board allowed MVP a 2% CTR for 2018 and MVP has asked for a 2% CTR in Vermont for 2019,[25] the New York Insurance Department allowed MVP a 1.5% CTR for 2018, and MVP has asked for a 1.5% CTR in New York for 2019.[26] There is no principled justification for MVP requiring Vermont residents to pay rates which incorporate a higher underwriting profit factor than its New York rates. This disparate treatment is especially unfair, unjust and inequitable because it forces the few Vermont members to subsidize the many New York members.

Similarly, MVP has assumed higher administrative costs for 2019, even though last year the Board told MVP that it expected MVP to reduce its costs, and MVP has more than doubled the number of Vermonters it is insuring this year and therefore can spread those costs over a wider base.[27] MVP seeks to justify using a higher administrative cost factor in its proposed Vermont rates on the grounds that it has lost more members in New York than it has gained in Vermont, and it spreads its administrative costs over its entire enrollment, rather than allocating them by state.[28] Once again, however, MVP's methodology disadvantages Vermonters.

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[24] Id.
[25] GMCB-008-18rr, Ex. 1 – MVP Actuarial Mem.; GMCB-007-17rr, MVP Actuarial Mem.
[26] GMCB-008-18rr, Hr'g Tr. at 95-97.
[27] GMCB 07-17rr, Decision at 9.
[28] GMCB-008-18rr, Hr'g Tr. at 94-95; see also GMCB-007-17rr, Decision at 9 ("Should MVP realize its projected VHC membership growth for 2018, however, we expect that MVP will further reduce its administrative expenses in next year's filing, as its administrative costs will be spread across a larger population and may reflect a reduction in the expanded sales and marketing efforts incorporated in the 2018 rate.").

F. Not Excessive, Inadequate, or Unfairly Discriminatory

1. The effect of the repeal of the federal individual mandate penalty

MVP asks for a 2% rate increase due to the federal individual mandate penalty being set to $0.[29] As became clear at hearing, MVP's adjustment is neither adequately supported nor reasonable. For example, MVP's actuary stated that MVP's assumption was not based on empirical market research or whether Vermonters were aware of and motivated by the penalty;[30] that MVP's analysis of the actuarial study it adopted only involved reading through "the slide deck…";[31] and that MVP did not incorporate the passage of the Vermont individual mandate legislation in its adjustment despite the fact that the Vermont individual mandate became law prior to the Filing.[32] In addition, MVP's analysis ignores the fact that Vermont's uninsured rate was low (3.7%) when the penalty was $95. MVP's actuary admitted that the $95 penalty was too low to incent Vermonters to purchase insurance.[33]

2. A 0.6% increase for bad debt on top of an assumed 2% for repeal of the individual mandate

In addition to assuming a 2% increase for repeal of the individual mandate penalty, MVP seeks to increase the rate by an additional 0.6% for bad debt allegedly caused by such a repeal.[34] MVP argues that people will drop coverage during the year because they know that they won't have to pay a penalty for not having coverage.[35] That argument, however, contradicts MVP's claim that all its insureds will stay with it throughout the year.[36] Further, MVP's 0.6% assumption for bad debt is six times BCBSVT's 0.1% bad debt assumption.[37]

[29] GMCB-008-18rr, Ex. 1 – MVP Actuarial Mem. at 36(6).
[30] GMCB-008-18rr, Hr'g Tr. at 92-94, 111-12.
[31] GMCB-008-18rr, Hr'g Tr. at 112.
[32] GMCB-008-18rr, Hr'g Tr. at 110.
[33] GMCB-008-18rr, Hr'g Tr. at 92; Robertson and Noyes, 14.
[34] GMCB-008-18rr, Hr'g Tr. at 142-144.
[35] GMCB-008-18rr, Hr'g Tr. at 143, 147.
[36] GMCB-008-18rr, Hr'g Tr. at 204.
[37] GMCB-009-18rr, Ex. 13 at 305(4).

3. MVP's assumption of no mid-year enrollment

MVP's failure to account for mid-year enrollment was settled last year when the Board ordered it to include an assumption for mid-year enrollment in its 2018 filing.[38] MVP has not provided new evidence to show that last year's Board decision was incorrect. Further, although the Board is not bound by L&E's conclusions, L&E has found that MVP's assumption on this point is unreasonable.[39]

4. Updated risk adjustment data

The most recent available data show that MVP will owe less money for risk adjustment than it estimated in the Filing. L&E recommends a rate reduction of 1.9% to correct for this.[40] MVP has agreed to this modification.[41]

5. Hospital Budgets

MVP requests an additional 0.5% adjustment due to the proposed hospital budgets. The Board can reasonably be expected to adequately address affordability in the hospital budget process, thus negating any need for MVP to increase its rates due to the proposed hospital budgets. Further, MVP's argument that the Board must incorporate proposed hospital budget increases into its rates demonstrates that MVP is acting as a passive price-taker instead of aggressively negotiating with providers.

6. Disadvantaging Vermonters vis-a-vis New Yorkers

The evidence before the Board indicates that the proposed increase is excessive for the same reasons that it is unfair, unjust, and inequitable: it discriminates against Vermonters by incorporating a higher CTR in its Vermont rates than in its New York rates, and it requires Vermonters to pay for

[38] GMCB-007-17rr, Decision at 9.
[39] GMCB 08-18rr, Ex. 11 - L&E Op. at 11.
[40] Id.
[41] GMCB 08-18rr, Hr'g Tr. at 36.

higher per-capita administrative costs caused by MVP's loss of New York enrollees notwithstanding its dramatic increase in Vermont enrollment.[42]

III. Conclusion

MVP has not demonstrated that the proposed rate is affordable; promotes access to care; promotes quality care; is not unfair, unjust, inequitable, or misleading; and is not excessive, inadequate, or unfairly discriminatory. As a result, the HCA respectfully requests that the Board recalculate the proposed rate as follows:

- Adopt L&E's recommendation on mid-year enrollment and reduce MVP's rate by 0.3%;[43]
- Adopt L&E's recommendation to correct for updated risk adjustment data and reduce MVP's rate by 1.9%;[44]
- Reduce MVP's assumption regarding the impact of the repeal of the federal individual mandate penalty to account for recent changes in Vermont law and to the extent to which MVP's assumptions are not backed by sufficient data;
- Reduce MVP's bad debt factor from 0.6% to 0.1%;
- Reduce MVP's CTR from 2% to no higher than 1.5%;
- Correct MVP's unfair treatment of Vermonters by incorporating in the proposed rate administrative costs that reflect the administrative cost reduction due to the increase of the Vermont member population;
- Increase affordability and access to care by setting MVP's medical, prescription, and utilization trends at the 25th percentile of L&E's assumed actuarially reasonable ranges;

[42] GMCB-008-18rr, Hr'g Tr. at 94-95; GMCB-008-18rr, HCA Post-Hr'g Mem. at 6-7.
[43] GMCB 08-18rr, Ex. 11 - L&E Op. at 11.
[44] Id.

- Incentivize MVP to negotiate stringently with providers by reducing the proposed rate increase by an additional 1%. The Board may also wish to consider limiting hospital budget increases in recognition that both insurers and providers share the responsibility for cost reduction/containment.

Recalculating the rates as proposed will not fully address the challenges Vermonters face due to rising premium prices and deductibles. However, the recalculation will mitigate the harm to Vermonters of the proposed rate increase. Further, such a recalculation would reflect a reasonable balancing among all the factors the Board is statutorily charged to consider. In addition, such a recalculation would better align MVP's rate growth with Vermont's 3.5% ceiling for annual health care cost growth under the all-payer model.

Dated at Montpelier, Vermont this 30th Day of July, 2018.

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CERTIFICATE OF SERVICE

I, Eric Schultheis, hereby certify that I have served the above Office of the Health Care Advocate Post-Hearing Memorandum on Judith Henkin, Green Mountain Care Board General Counsel; Sebastian Arduengo, Green Mountain Care Board Staff Attorney; Agatha Kessler, Green Mountain Care Board Health Policy Director; and Gary Karnedy, MVP's designated representative, by electronic mail, return receipt requested, this 30th day of July, 2018.

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