

STATE OF VERMONT  
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Insurance Company	)	GMCB-012-15rr
December 2015 Agriservices	)	
Association Rate Filing	)	SERFF No.: MVPH-130236588
	)	
	)	

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**DECISION & ORDER ON MOTION FOR RECONSIDERATION**

On December 24, 2015, the Green Mountain Care Board issued a decision in the above-captioned rate review proceeding denying MVP Health Insurance Company’s (MVPHIC) request for a 27.4% average annual rate increase. *See* Decision & Order, *available at* [http://ratereview.vermont.gov/sites/dfr/files/GMCB\\_012\\_15rr\\_Decision.pdf](http://ratereview.vermont.gov/sites/dfr/files/GMCB_012_15rr_Decision.pdf). MVPHIC moved for reconsideration on January 11, 2016. The Office of the Health Care Advocate (HCA), a party to this matter, filed a response to the motion on January 19, 2016 opposing the reconsideration request. For the reasons outlined below, we deny MVPHIC’s motion.

MVPHIC raises three bases for reconsideration. First, the company states that the record does not support the Board’s decision. MVPHIC argues that L&E “unequivocally” determined that the rate increase is needed to ensure adequacy, that the HCA “did not recommend such an outright disapproval,” and that the Department of Financial Regulation’s (Department) solvency opinion does not opine on whether disapproving the filing, which results in a zero rate increase, will maintain the insurer’s solvency.

The Board’s decision denying the rate request is amply supported by the evidence. Contrary to MVPHIC’s claim and as explained in our decision, the Board’s review is not limited to an actuarial analysis of the filing. Rather, the legislature conferred broad authority to the Board to take into account considerations not subject to mathematical calculation and certitude. *See* 8 V.S.A. § 4062(a)(3) (Board determines whether rates are affordable, promote quality care and access to health care, protect insurer solvency and are not unjust, unfair, inequitable, misleading or contrary to Vermont law); 18 V.S.A. 9375(b)(6) (enlarges authority beyond 8 V.S.A. § 4062 criteria to allow for consideration of changes in health care delivery, payment methods or amounts, and other issues at the Board’s discretion); *accord* GMCB Rule 2.000, *Rate Review*, § 2.401. If the Board were restricted to a narrow, actuarial review of the filing as advocated by the carrier, the Board’s rate making authority would be superfluous. *Cf.* *Insurance Com’r of State v. CareFirst of Maryland, Inc.*, 816 A.2d 126, 140 (2003) (regulator’s

consideration of “other relevant factors” when setting insurance rates extends beyond actuarial considerations); *see also In re: Blue Cross Blue Shield of Vt. ’s Appeal of Denial of Nov. 2009 Rate Filing for the Vt. Veterinary Medical Assoc.*, Vt. Dep’t of Banking, Insurance, Securities and Health Care Admin., Docket No. 0111-I (Oct. 22, 2009) available at <http://www.dfr.vermont.gov/reg-bul-ord/blue-cross-blue-shield-vermonts-appeal-denial-november-2009-rate-filing-vermont-veterina> (Commissioner could disapprove insurance rate based on factors beyond actuarial soundness; if actuarial analysis “were the beginning and the end of the Commissioner’s rate inquiry, there would be no need for the Commissioner to exercise her rate-setting authority, a policy-making function of government that is properly characterized as ‘legislative’”).

As we previously explained, our decision is based on the totality of facts and circumstances which together support disapproval of the filing. The 27.4% requested rate increase is undeniably large and impactful on renewing members. MVPHIC’s operations in Vermont—of which this book of business is but one small segment—comprise only a small percentage of its overall operations, minimizing any potential threat to the insurer’s solvency. The filing was submitted with insufficient time prior to its effective date for a 90-day Board review as provided for by statute, was filed purportedly under the authority of inapplicable federal guidance, and contained an error in calculation that caused further delay in our review and issuance of a decision. Finally, when we approved Agriservices’ previous rate request, we did so with the expressly stated understanding—based on Agriservices’ representations—that the filing was its last and that members would be so notified to enable them to obtain alternative health care coverage. Given this backdrop, we reject MVPHIC’s argument that the record does not support our decision.

Second, the company asserts that Agriservices is a grandfathered plan, is not a transitional plan, and that MVPHIC’s reliance on federal guidance from March 2014 is appropriate. This argument misses the point. We did not deny this rate request because of its filing status, nor did we conclude that this filing is a transitional plan. To the contrary, our decision to disapprove the filing rests on a convergence of issues, inaccuracies and inconsistencies with the filing, coupled with the magnitude of the proposed increase. Whether or not MVPHIC expressly referred to this filing as a transitional plan is immaterial; MVPHIC has repeatedly stated—in its filing, in its memorandum, and now on reconsideration—that it derives its authority for continuation of this plan from federal guidance issued in March 2014. As we have already explained, the guidance relied on by the carrier pertains solely to non-grandfathered, transitional plans. *See* Finding of Fact ¶ 7; Conclusion of Law ¶ 3. MVPHIC’s continued assertion

otherwise, whether express or implied, is without merit and lends no credence to its request for reconsideration.

Next, MVPHIC states that the decision “sets a dangerous precedent” because our review is limited to “sound actuarial principles,” that insurers should be able to rely on the opinion of the Board’s actuary, and that it is inappropriate for the Board “to attempt to force discontinuance of a product offering by denying a needed rate increase.”

Stated again, the Board is not limited to mathematical calculation and actuarial analysis when reviewing rates; the legislature conferred broad authority to this Board that includes considerations of fairness, affordability, and equity. Thus, we reasonably expect that our regulated entities will accurately portray the insurance plans they offer so we can afford them a thorough and fair review. As discussed above and in our initial decision, MVPHIC did not provide this Board with an accurate filing and made representations concerning the continued availability of this product—on which we relied in approving last year’s rate increase—which proved to be incorrect. Although we acknowledge MVPHIC’s ability to file as long as this grandfathered plan meets federal requirements, the onus is squarely on the carrier to submit accurate filings that produce rates that are affordable, fair, and equitable to its members. The Board cannot, and will not, approve a substantial rate increase if MVPHIC fails to meet this burden. Indeed, our approval of a filing that does not comport with our statutory responsibilities would “set a dangerous precedent.”

Order

For the reasons discussed above, the Board denies MVP Health Insurance Company’s Motion for Reconsideration.

**So ordered.**

s/ Alfred Gobeille	)	
	)	
s/ Cornelius Hogan	)	GREEN MOUNTAIN
	)	CARE BOARD
s/ Jessica Holmes	)	OF VERMONT
	)	
s/ Betty Rambur	)	
	)	
s/ Allan Ramsay	)	

Filed: January 21, 2016

Attest: s/ Janet Richard  
Green Mountain Care Board, Administrative Services Coordinator