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July 29, 2016

VIA E-MAIL - Noel.Hudson@vermont.gov
AND FIRST CLASS MAIL

Noel Hudson, Esq.
Health Policy Director
Green Mountain Care Board
89 Main Street, Third Floor
City Center
Montpelier, VT 05620

Re: MVP Health Care 2017 Vermont Health Connect
Rate Filing – Docket No. GMCB-007-16rr

Dear Mr. Hudson:

On behalf of MVP Health Plan, Inc. enclosed please find ***MVP Insurance Company's Post-Hearing Findings of Fact and Conclusions of Law*** along with a ***Certificate of Service***.

Respectfully submitted,

Gary F. Karnedy

Enclosures

Cc: Marisa Melamed (via e-mail Marisa.Melamed@vermont.gov)
Service List

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Vermont Health Connect 2017 Rate filing SERFF No. MVPH-130558905	)))))	GMCB-07-16-rr

MVP POST-HEARING PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

MVP Health Plan, Inc. ("MVP"), by and through its counsel, Primmer Piper Eggleston & Cramer PC, submits this Post-Hearing Memorandum to the Green Mountain Care Board (the "Board"), pursuant to Board Rule 2.307(g), in support of its 2017 Vermont Exchange Rate Filing, requesting a rate increase by an average of 6.3% across all MVP products.

Findings of Fact

1. On July 13, 2016 MVP modified its rate reduction request, reduced the requested rate increase from 8.8% to 6.3%, a reduction of 2.3%. *Exs. 1, 11, 15; Lombardo Testimony* (hereinafter "Lombardo"), p. 20-21. The 6.3% increase is relatively modest compared to 2017 rate increases approved in other states across the country. MVP's book of business affected by this rate filing is 2,987 policyholders, 4,354 subscribers, and 6,614 members based on March 2016 Membership. *Ex. 1, p. 19.* MVP has seen a slight growth in membership over the last year. *Lombardo, p. 49.*

2. This reduction addressed both of the two Lewis & Ellis ("L&E") recommended adjustments. *Ex. 11; Lombardo, p. 21.* MVP accepted L&E's first recommendation to modify the inforce actuarial value and induced demand factor which reduced the initially proposed premium rate by .5%. *Ex. 9, p. 10; Ex. 11, p. 1; Lee Testimony* (hereinafter "Lee"), *p. 84-85, 94.*

3. Risk Adjustment Program. MVP did not agree with L&E's second recommendation, to reduce premium rates by 4.2% (as a result of L&E modifying the assumed risk adjustment payment reflected in MVP's 2017 premium rates). MVP's enrollment represents less than 10% of the VT Exchange market, and therefore MVP's risk scores as well as realized profit margins are going to be much more volatile than Blue Cross Blue Shield's ("BCBS") assuming both plans are pricing rationally. *Ex. 11, p. 2; Lee, p.99-101.* To illustrate, between 2014 and 2015, MVP's risk score increased by 20.1% while the statewide average risk score only increased by 6.4% yet MVP's membership was largely unchanged (80% retention). *Ex. 11, p. 2.* Since MVP's membership in ACA compliant plans has not changed materially and the total market membership has not changed substantially between 2014 and 2015, MVP does not anticipate its relative risk position to change from being a payer to a receiver. *Ex. 1, p. 25.*

Because the Risk Adjustment Program is a zero sum game, MVP has substantially more pricing risk than BCBS and MVP's realized profit margins are far more significantly impacted by the results of the Risk Adjustment formula. A $1 million miss on the assumed risk adjustment receipt/payment would impact MVP's profits by approximately $12.60 PMPM or about 2.5-3.0% of premium. yet impact BCBS's profits by only $1.15 PMPM or 0.3% of premium. *Ex.11, p. 2.*

L&E's refusal to consider 2014 data that it admits is relevant, and fully rely only the 2015 Risk Adjustment results exposes MVP to excessive pricing risk given the known imperfections of the CMS Risk Adjustment program. *Ex. 11, p.2.; Lee, p. 103-104, 106, 108; Lombardo, p. 30, 49.*[1] MVP's request reflects a refined estimate of the expected Risk

[1] The testifying actuaries agreed that more credible data is better than less credible data, preferring to base opinions on a range of information rather than one year pinpoint data. *Lee, p. 96-97; Lombardo, p. 29.* Ms. Lee admitted that in this very filing, on multiple occasions

Adjustment liability for 2017 given that there are now two data points to take into consideration. *Lombardo, p. 33-34; Ex. 14.* MVP is revising the rates to reflect a weighting of the 2014 and 2015 RA results, one-third and two-thirds respectively. This split is actuarial art, not science, based on the greater quantity of reliable and trustworthy data. *Lombardo, p. 49; Ex. 11, p.2.* MVP's weighting acknowledges that MVP places more credibility on the 2015 results, while not ignoring the 2014 results as valid, real and reflective of the potential for large swings in risk scores that do not necessarily reflect corresponding changes in claim costs. *Ex. 1, p. 2; Ex. 14; Lombardo, p. 56-57.* It will be very hard to pinpoint the future risk adjustments. *Lombardo, p. 29.* MVP built volatility into the risk adjustment program. The Department of Financial Regulation ("DFR") also saw volatility from 2014 to 2015. *Chieffo, p. 68-69.* Unfortunately, MVP is at the mercy of BCBS. To the extent that BCBS's actions cause its risk score to increase, and MVP's risk score stays the same, MVP's payment will continue to grow. *Lombardo, p. 54-55.* Although BCBS may be relatively stable going forward, MVP could have volatile movement throughout its rates. *Lee, p. 88.*[2]

(medical trend and pharmacy trend), she used more than one year of data, more than one data point, and considered volatility. *Lee, p. 99-101, 104-105.* Actuaries often exercise their professional views and weight data from different years. *Lombardo, p. 57; Lee p. 97.* Reliability of data is not black and white, it is gray. *Lee, p. 102.*

[2] MVP did not include a risk adjustment payment in its 2016 rate filing because it wanted to offer very competitive premium rates, an inclusion would have caused approximately a 12% premium increase. *Lombardo, p. 31, 44.* Also, MVP only had the one year of less than perfect data in 2016, and the State of Vermont had not yet completed a market simulation. *Lombardo, p. 32.*

MVP's original May 11 filing treated the risk adjustment program differently than in its amended filing. *Ex. 1, p. 25.* CMS issued an interim risk adjustment for 2015 about a month before MVP filed its rates. That information indicated that MVP would go from paying $2.7M to receiving almost $2M in the risk adjustment program. Consequently, MVP had two data points but did not have trust in the interim result. Rather than building in the full amount of the 2014 risk adjustment payment, MVP applied two-thirds of its 2014 payment. *Lombardo, p. 32-33.* MVP

MVP's risk score changed by almost four times more than BCBS's between 2014 and 2015. *Lombardo, p. 28-29.* MVP is more confident in using 2014 data for 2017 than in 2016 because it also now has 2015 results. [3] In both years, MVP was a payer and had a healthier population than the statewide average. MVP also did more research which indicated that a carrier with a small market share is subject to significant volatility in the risk adjustment results from year-to-year. Having the second year of data this year amounted to two data points, and MVP could then use 2014 to some degree to estimate the best number possible. *Lombardo, p. 56-57.*

CMS publishes statewide risk scores and general information on the web about the Vermont population. MVP reviewed the 2014 and 2015 risk score information for the statewide average. Because there were only two carriers in the state, MVP was able to use simple algebra to back into and calculate BCBS's risk score. *Lombardo, p. 25-28; Ex. 13.*

In contrast, L&E indicated that it relied on confidential information, but no such information was submitted as evidence, or is part of the record. *Lee, p. 81.* Furthermore, L&E was not privy to confidential information that would cause their risk adjustment opinion to be superior to MVP's. Although L&E did have more information on both carriers' risk scores by

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then made its final rate amendment after receiving the final 2015 adjustment, as did L&E. *Lombardo, p. 33-34.*

[3] A risk score is generated by the demographic profile as well as utilization of health care services that a population has throughout a given year. Essentially, MVP's population in 2014 was healthier than the statewide average, and healthier than BCBS's population. In 2014 MVP's PMPM payment amount (which translated to $44 on a PMPM basis) represented about 12% of MVP's overall premium. The statewide average risk score was 1.462. MVP's risk score was a 1.187. *Lombardo, p. 24; Ex. 12.* MVP's risk adjustment payment in 2015 dropped substantially, to $581,000 from $44 PMPM to $9.55, down to a little over 2% of premium, driven by the change in MVP's risk score. *Lombardo, p. 25.*

metal level and by plan, both L&E and MVP witnesses agreed that metal level information was not needed for the aggregate risk factor calculation. MVP is using the same aggregate information, and applying simple math and algebra. *Lombardo, p. 27-28, Lee, p. 106-107.*

4. MVP's 1.8% reduction on this issue compares to the 4.2% reduction recommended by L&E. *Ex. 11, p. 2.* The Ex. 15 table compares the initially proposed rate change and the modified rate change, based on metal level. The range of increase has varied based on metal level. In general, all the reductions are between 2.1% and 2.3%. *Lombardo, p. 34-35; Ex. 15.* In summary:

MVP Initial Filed Rate Proposal	8.8%
Two Items Reduced	
Risk Adjustment Payment	(1.8%)
Normalization for AV	(0.5%)
MVP Revised Rate Proposed	**6.3%**
L&E Recommended Rate	**3.7%**

Ex. 15.

5. Solvency. L&E, DFR and MVP are all of the opinion that the 6.3% average rate proposed will have the impact of sustaining the current level of solvency of MVPHP, and the 1% contribution to revenues was reasonable. *Ex. 8, p. 1; Lombardo, p. 37-38; Chieffo Testimony, p. 62* (hereinafter "Chieffo")*; Lee, p. 86, 104-105.* In seeking no contribution to revenues in 2016, MVP was trying to offer the most competitive rate possible to gain market share. MVP did not think that was a sustainable method, so it reverted back to one percent of the premium in the 2017 filing which is consistent with other MVP filings, and L&E agreed. *Lombardo, p. 35; Ex. 9, p. 9.* Each product, each line, and each filing really does need to stand on its own. *Chieffo, p. 67.*

6. Administrative Costs / Expenses. MVP's general administrative expense load includes $1.50 PMPM to provide an expanded network to members purchasing exchange products in Vermont through a partnership with PHCS. *Ex. 1, p. 26.* $3.51 PMPM is attributable to Quality Improvement/Cost Containment Programs. *Id.* MVP will also be

responsible for approximately $70,000 assessment to fund the Health Care Advocate. *Ex. 1, p. 26.* MVP has also been working on quality improvement, administrative, and special project expenses for long term efficiencies and savings. MVP participates in the Vermont Blueprint for Health, as well as a number of other programs that are proposed to help promote affordability and access to care. *Lombardo, p. 40-42.* The Vermont Blueprint is a statewide initiative to have community health teams and patients in medical homes where other providers of health care coverage can actually visit with them to help create efficiency and reduce costs. MVP is also participating in Health First IPAQI program, which provides a reward back to providers for finding efficiencies of care. *Ex. 5, p. 4.*

L&E generally accepts the steps MVP's taken on administrative costs. *Lombardo, p. 42; Ex. 9, p. 9.* MVP's administrative costs are basically unchanged from 2016 and that MVP's assumptions are based on actual 2015 MVP expenses, and they found it reasonable and appropriate. *Ex. 9, p. 9.* The administrative expense as a percent of premium is decreasing, that costs have fallen substantially since 2013, the historic reductions could not continue indefinitely. *Id.*

7. Statutory Criteria. Based on all of the evidence, MVP's rates are not excessive or unfairly discriminatory - they are reasonable relative to the benefits that are offered. The rates are not inadequate because MVP did a thorough analysis of its data and projected it forward and is comfortable that the premiums that it is offering or proposing are reasonable relative to the benefits that are included in the filing. They cover MVP claims cost to its best estimate, and the expected cost of the delivery of health care for these products. The rates are not unjust, unfair, inequitable, misleading, or contrary to Vermont law because they promote all of Vermont statutes, quality of care, and affordability and the rates are reasonable based on MVP's data, and

are actuarially sound. MVP rates promote quality of care and access to health care through its substantial credentialing work with its providers and also through NCQA accreditation. It also offers an expanded network benefit for Vermonters purchasing MVP products so that insureds can seek care outside of Vermont. MVP is responsible for an approximate $70,000 payment towards the Health Care Advocate ("HCA"). The HCA speaks on behalf of consumers and has a free consumer hotline. This fee is going to be used to help fund the HCA efforts to help Vermonters. The MVP rates meet the standard of affordability because they are actuarially justified. *Lombardo generally p. 38-40, Exs. 1-15, Chieffo generally, Lee generally.*

Conclusions of Law

1. Based on the only *reliable* evidence received at the July 21st MVP hearing, the Board should find that MVP's Risk Adjustment Data and Methodology was superior, and approve MVP's 6.3% rate request. *See Findings 1-7.*

2. Health insurance rates in Vermont must be approved before they are implemented. *See* 8 V.S.A. § 4062(a) and § 5104(a). The Board is empowered to approve, modify, or disapprove requests for health insurance rates. *See* 18 V.S.A. § 9375(b)(6); 8 V.S.A. § 4062(a). MVP bears the burden of demonstrating that its rates satisfy the statutory standards. *See* Board Rule 2.104(c). The Board must take into consideration the requirements of the underlying statutes; changes in health care delivery; changes in payment methods and amounts; DFR's solvency analysis; and other issues at the discretion of the Board. *Board Rule 2.401.* The Board shall modify or disapprove a rate request only if it is "unjust, inequitable, misleading, or contrary to law of the State or plan of operations, or if the rates are excessive, inadequate or unfairly discriminatory, fail to protect the organization's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access." 8 V.S.A. § 5104(a)(2).

3. MVP's 6.3% rate increase best meets the statutory standards, because it is adequate, fair, just, equitable, affordable, promotes quality of care, access to health care, and is not excessive, unfairly discriminatory or misleading. *Findings 1-7, see Ex. 1-15; Lombardo, Chieffo, and Lee.* The 6.3% rate increase is superior to L&E's recommended 3.7% increase because MVP's consideration and weighting of both 2014 and 2015 risk adjustment information resulted in a superior estimate of the 2017 Risk Adjustment. *Findings 3 and 4.* L&E and MVP agreed that 2014 data was relevant, but L&E did not consider it, even in the face of admitted volatility and a high risk score change from year to year of 20.1%. *Id.*

4. The Board's decision must be based solely on the evidence contained in the Record. *GMCB Rule 2.403(a).* The General Counsel offered evidence at hearing through L&E testimony, and cross-examination of MVP's witness. However, there was no foundation or documentation evidence submitted by the HCA or the General Counsel to support L&E's general conclusory testimony on the 2017 Risk Adjustment Program, which was admittedly based solely on generally referenced "confidential information." *Finding 3.* None of that referenced information was contained in L&E's actuarial memorandum or any other exhibit because L&E said it was confidential. *Id.* Without that foundation evidence, the Board cannot rely on L&E conclusory opinions that lack any evidentiary foundation. Furthermore, MVP was left with no opportunity to challenge the basis of those secret expert opinions.

"Expert testimony must rest on a reliable foundation." *Moffitt v. Icynene, Inc.*, 407 F. Supp.2d 591, 606 (D. Vt. 2005) (internal quotations omitted); *See also Trotier v. Bassett*, 174 Vt. 520, 523, 811 A.2d 166, 170 (2002) ("An opinion cannot be based upon speculation."). A party seeking to present expert testimony has the burden of establishing that the witness' opinion is foundationally reliable. *See Plourde v. Gladstone,* 190 F. Supp. 2d 708, 718 (D. Vt.

2002). Based on the content of this incomplete Record, the Board cannot establish a reliable basis to consider Ms. Lee's testimony.

There are a variety of ways that confidential information can be shared and submitted as evidence at hearing and still maintain confidentiality. *See, e.g. Schmitt v. Lalancette,* 2003 VT 24, ¶ 10, 175 Vt. 284, 830 A.2d 16 (protective orders); *Rutland Herald v. City of Rutland,* 191 Vt. 387, 48 A.3d 568 (2012) (in camera review of confidential documents); *In re Sealed Documents*, 172 Vt. 152, 772 A.2d 518 (2001) (filings under seal)*; Bernstein v. On-Line Software Intern., Inc.*, 232 A.D.2d 336, 337 (N.Y. App. Div. 1996) ("attorney eyes only"). The General Counsel and the Health Care Advocate failed to meet their burden. The record is now closed. It is reversible error for the Board to consider L&E's testimony on the 2017 risk adjustment in the absence of this foundation evidence. Ms. Lee's conclusory statements are purportedly based on mystery confidential information not contained in the Record. Further, HCA proffered no expert testimony from Donna Novak. Given her role in advocating for reductions in MVP rates, the Board can fairly infer that her "empty chair" meant that she could not support L&E's recommendation on the 2017 risk adjustment. The Record simply contains no reliable expert evidence on the risk adjustment contrary to MVP.

5. MVP's 2017 1% contribution to reserves is appropriate, and undisputed. *Findings 5 and 6.*

6. Given MVP's importance to a fair competitive Vermont marketplace, the Board should not be increasing BCBS proposed rate and correspondingly cutting MVP's. L&E recommends that the Board increase BCBS's rate to 8.24%, which would result in a reduction of MVP's proposed rate from 6.3% to 3.7%. BCBS holds approximately 90% of market share to MVP's 10%. A decision favoring BCBS will have a greater adverse financial impact on more

Vermont ratepayers overall. To approve L&E's increase for 90% of Vermonters in conjunction with its decrease for 10% of Vermonters is not fair, just, equitable, or affordable. It is unfairly discriminatory, and does not promote quality of care or access to healthcare in Vermont.

In its closing argument, the HCA argued that the Board needs to enforce L&E's method because it will make the rates more affordable for Vermonters. The HCA appears to be advocating for only 10% of Vermonters, ignoring 90%, and ignoring its statutory charge.

Dated at Burlington, Vermont, this 29th day of July, 2016.

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By: _____

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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	)	
MVP Vermont Health Connect	)	
2017 Rate filing	)	GMCB-07-16-rr
	)	
SERFF No. MVPH-130558905	)	

CERTIFICATE OF SERVICE

I, Gary F. Karnedy, Esq., hereby certify that I have served the above MVP's Post-Hearing Proposed Findings of Fact and Conclusions of Law, via electronic mail and U.S. mail, was served via U.S. Mail, postage prepaid, upon the following:

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Dated: July 29, 2016

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