STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2018 Vermont Health Connect Rate Filing	)))))	GMCB-07-17-rr

HCA POST-HEARING MEMORANDUM

I. Introduction

The Office of the Health Care Advocate (HCA) asks the Green Mountain Care Board (Board) to review and modify MVP Health Plan, Inc.'s (MVP) exchange filing. The Board's statutory authority charges it to evaluate both the actuarial soundness of MVP's exchange filing and the filing's impact on affordability and access to health care. MVP's exchange filing negatively impacts affordability, does not promote access to health care, and is actuarially excessive.

II. Standard of Review

Health insurance organizations in Vermont must submit rate changes to the Board for review.[1] Insurers bear the burden to justify their proposed rates to the Board.[2] The Board can modify, approve, or disapprove requests for rate changes to ensure that public health objectives are realized and or to ensure that the proposed rates are actuarially sound.[3]

The Board must, when "deciding whether to approve, modify, or disapprove each rate request, … determine whether the requested rate is *affordable*, promotes quality care, *promotes access to health care*, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory."[4]

[1] 8 V.S.A. §4062 (a); 8 V.S.A. §5104(a).
[2] GMCB Rule §2.104(c).
[3] 18 V.S.A. §9375(b)(6); 8 V.S.A. §4062(a).
[4] GMCB Rule §2.301(b) (*emphasis added*); GMCB Rule §2.401; *see also* 8 V.S.A. §4062(a)(3).

The Board must evaluate rates using two interrelated criteria sets. The first criteria set relates to public health objectives: affordability, quality of care, and access to care. The second criteria set relates to the insurer's solvency and the actuarial soundness of the proposed rates. Both criteria sets are necessary and essential components of the Board's review. For instance, affordability means little if an insurer is not solvent. At the same time, insurer solvency means little if Vermonters cannot afford insurance or access health care services. Also, a lack of affordability and access will negatively impact market participation and thus negatively impact insurer solvency.

It is critical that the Board reviews rates both in terms of (1) public health objectives and (2) their actuarial soundness. Only by applying these two criteria sets can the Board ensure the proper functioning of Vermont's health care system.

III. Background

On May 12, 2018, MVP submitted its 2018 Exchange filing and requested an average rate increase of 6.74%. The proposed rate increase, if implemented, would increase the average annual cost of MVP's exchange plan to $5,700.18. This increase would impact over 10,300 Vermonters.[5]

On July 11, 2017, the Vermont Department of Financial Regulation (DFR) submitted its solvency analysis of MVP's Exchange filing. DFR determined "that [MVP's] Vermont operations pose little risk to [MVP's] solvency."[6]

On July 11, 2017, Lewis & Ellis (L&E), the actuarial firm retained by the Board, submitted its actuarial recommendations related to MVP's Exchange filing. L&E found that MVP's

[5] GMCB-07-17-rr, Exhibit 1: May 12, 2017 VT 2018 Exchange Filing Rates, p. 4.
[6] GMCB-07-17-rr, Exhibit 9: July 11, 2017 Department of Financial Regulation Solvency Letter, p. 2.

proposed VHC rate was actuarially excessive, inadequate, or unfairly discriminatory.[7] L&E's findings relate to only one criteria set that the Board must consider when setting rates. It must be noted that L&E stated that they did not examine whether the proposed rates realized public health objectives or even "assess [the] affordability of the premiums."[8]

On July 19, 2017, at hearing, MVP agreed with two of L&E's four recommendations. In particular, MVP agreed to change its risk adjustment and a trend calculation resulting in an amended proposed rate of 5.1%.[9] However, MVP continues to assert that their method of calculating the 2016 actual/projected claims experience is reasonable despite L&E's position, with which HCA agrees, that it leads to an actuarially excessive rate.[10]

On July 24, 2017, MVP filed a response to Board questions posed at hearing. In this response, MVP stated that "should MVP adopt the 2018 budgets as submitted to the GMCB by Vermont facilities, the resulting rate would be 1.1% lower than the 5.1% rate increase proposed by MVP at the rate hearing."[11]

IV. The Proposed Rate Is Not Affordable

As a part of the Board's public comment process, one Vermonter commented, "At some point it will no longer be a choice for us as to whether or not we buy insurance, it will simply be beyond our financial means. The current trend is not sustainable."[12] Setting individual hardship on Vermonters aside, on a macro-level, unaffordable rates will undermine household solvency and cause plan participation to fall thus impacting MVP's solvency.

[7] GMCB-07-17-rr, Exhibit 10: July 11, 2017 Lewis & Ellis Actuarial Opinion, p. 10.
[8] GMCB-07-17-rr, MVP Rate Review Hearing Transcript, p. 147, line 24.
[9] GMCB-07-17-rr, MVP Rate Review Hearing Transcript, p. 21, line 1.
[10] GMCB-07-17-rr, MVP Rate Review Hearing Transcript, p. 20, lines 11-16.
[11] GMCB-07-17-rr, July 24, 2017 MVP Letter to Judy Henkin, p. 2.
[12] Green Mountain Care Board Public Comments: John Dunham, July 19, 2017.

This section first examines MVP's proposed rate in light of macroeconomic indicators. Next, this section examines how MVP's proposed rate increase will be detrimental to individual-level affordability. Both the macro- and individual-level analyses show that MVP's proposed rates will exacerbate Vermont's health care affordability crisis. The rate of Vermont health care cost growth is unsustainable and without the Board's intervention will undermine insurer solvency and the solvency and health of Vermonters.

1 The Proposed Rate is not Affordable at the Macro-Level

The comparative growth of MVP's VHC premiums to Vermont's Gross Domestic Product (VTGDP) exposes the excessive cost growth of MVP's VHC premiums. Between 2014 and 2016, the period starting at the beginning of VHC and ending at the most recent year for which VTGDP data is available, MVP's cumulative premium growth was 230% of cumulative VTGDP growth. [13]

MVP's cumulative VHC premium growth also outpaced cumulative Vermont wage growth (VTWG) during the period from 2014 to 2016. This period starts at the beginning of VHC and ends at the most recent year for which VTWG data is available. During this period, MVP's cumulative premium growth was 283% of cumulative VTWG.[14] Table 3 shows that cumulative MVP VHC premium costs have increased more than two times cumulative VTGDP growth and VTWG.

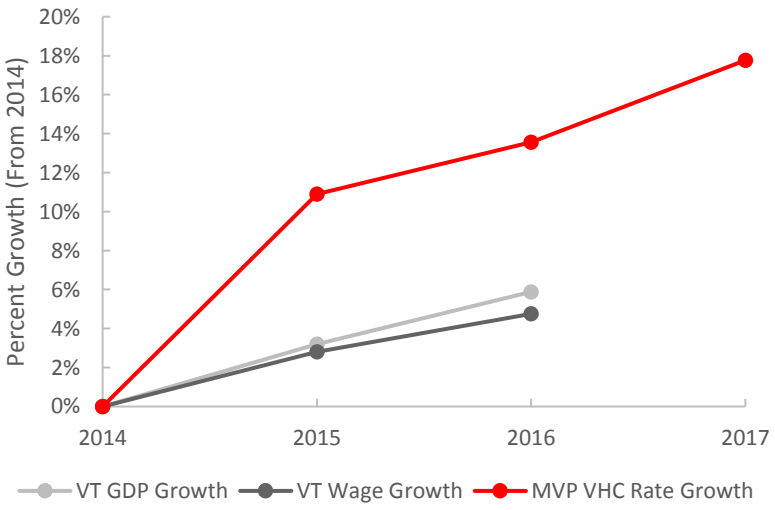
[13] U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Vt., retrieved from FRED, Federal Reserve Bank of St. Louis, https://fred.stlouisfed.org/series/VTNGSP; GMCB-07-17-rr, Exhibit 1: May 12, 2017 VT 2018 Exchange Filing Rates; August 9, 2016 State of Vt. MVP Rate Review Decision; August 13, 2015 State of Vt. MVP Rate Review Decision; September 2, 2014 State of Vt. MVP Rate Review Decision.
[14] Vt. Dept. of Labor, Year to Date Wage tables, http://www.vtlmi.info/indnaics.htm#mqa; Fn. 13.

Table 3. MVP VHC premium growth compared to VTGDP growth and VTWG.

	Cumulative MVP VHC Premium Growth	Cumulative VTGDP growth as a percent of cumulative MVP VHC Premium Growth	Cumulative VTWG as a percent of cumulative MVP VHC Premium Growth
2014-2016	13.6%	230%	283%

The proposed increases would be less troubling if MVP's VHC premiums had not continued to increase at an alarming premium since 2016. Between 2014 and 2017, MVP's VHC premium has cumulatively grown by 17.8%.[15] Chart 1 presents the macro-level, unsustainable trend of MVP VHC premium growth compared to VTGDP growth and VTWG.

Chart 1. Cumulative MVP VHC premium growth compared to cumulative VTGDP growth and cumulative VTWG. [16]



[15] *See* Fn. 13.
[16] *See* Fns. 13, 14, and 15.

Macro indicators only tell part of the story of the affordability. The impact of MVP's VHC premium growth on Vermont households must also be considered.

2 The Proposed Rate is not Affordable at the Individual-Level

The Affordable Care Act (ACA) provides one method for measuring individual-level premium affordability. Under the ACA, a 2017 premium is unaffordable if an individual would be required to pay more than 9.69% of their income towards the premium.[17]

The ACA standard does not take into account the substantial financial burden of a plan's deductible on a Vermonter. The State of Vermont, however, provides a measure for deductible affordability. Specifically, Vermont defines a deductible as unaffordable if a household would have to pay more than 5% of their income towards the deductible.[18]

One way to begin to analyze individual-level affordability is to combine the ACA premium affordability and Vermont's deductible affordability standards thus creating a method to measure plan affordability. Using this method, a plan is affordable only if a household (1) does not pay more than 9.69% of their income for the premium or (2) have a deductible greater than 5% of their income.

The most popular MVP VHC plan is the Silver High Deductible Health Plan (FRVT-HMOH-S-001-S (2017)) (Silver HDHP).[19] This plan is unaffordable to large swaths of Vermonters using the above-described, two part affordability test. The plan is unaffordable,

[17]26 U.S.C § 5000A(e)(1), 26 U.S.C. §36B. The 9.69% captures the top end of premium cost burden for individuals who qualify for premium subsidies and is the metric for assessing affordability of employer based coverage.
[18]Robertson and Noyes (2015), 2014 Vermont Health Insurance Survey Research Findings, p. 79, http://hcr.vermont.gov/sites/hcr/files/pdfs/survey/2014-VHHIS-Legislative-Presentation.pdf. Note: We only use the first prong of affordability test used in the Vermont Health Insurance Survey. The complete affordability test looks at the ratio of deductible to income and the ratio of experienced out-of-pocket expenses to income. The use of just the ratio of income to deductible can only undercount whether a specific plan is affordable and is appropriate when examining specific plan affordability as opposed to making a population estimate of health care affordability.
[19]GMCB-07-17-rr, Exhibit 1: May 12, 2017 VT 2018 Exchange Filing Rates, p. 158.

accounting for subsidy and cost-sharing benefits, to individuals whose annual income is (1) between $17,820 and $32,000 and (2) between $47,638.80 and $60,896.59.[20] The plan is unaffordable to couples whose annual income is between $24,000 and $121,793.19.[21] The plan is unaffordable for families[22] whose annual income is between $97,433 and $171,119.50.[23]

The 2017 Silver HDHP is particularly unaffordable for households at 401% of the Federal Poverty Level (FPL) whose incomes are slightly above what is required to receive a premium tax credit. Individuals, couples, and families at 401% FPL have to pay 15.75%, 23.35% and 20.30% of their income respectively to maintain coverage for a year and reach their deductible. If an individual, couple, or family at 401% FPL has to pay both their premium and the maximum yearly out of pocket costs they would have to pay 25.83%, 38.30%, and 30.16% of their incomes respectively.

An individual-level affordability measure must be ground-truthed with the lived-experience of Vermonters. Overwhelmingly, public comments submitted to the Board, received as of August 19, 2017, called attention to VHC plan unaffordability.

- "I'm a freelance writer and I pay $408 a month for the very cheapest plan available with a huge deductible and very few things covered, that means my insurance is so expensive that I can't afford to go to the doctor."[24]

[20] VHC Subsidy Estimator, http://info.healthconnect.vermont.gov/Subsidy_Estimator. Note, at some lower incomes, a household is eligible for high deductible silver plans with a smaller deductible than the Silver HDHP. In these instances, we used the lower deductible plan to calculate plan affordability. Also, the subsidy calculator does not correctly account for the fact that some lower income families may be eligible to purchase a couple plan due to Dr. Dynasaur eligibility. In instances where a family would be eligible to purchase a couple plan to insure their entire family, we assumed that the family purchased a couple plan. It is worth noting that both of the above-detailed assumptions result in a greater level of MVP VHC plan affordability.
[21] *Id.*
[22] We assumed that a family consists of two adults and two children under 19 years of age.
[23] Fn. 21.
[24] Green Mountain Care Board Public Comments: Jen Rose Smith, May 15, 2017.

- "As a self-employed clinical social worker I am paying almost $600/month for coverage for myself. This is already outrageous. If the rates rise I will be forced to go without insurance, taking another healthy Vermonter (who supports the unhealthy population) out of the system." [25]
- "Last week, I cancelled an MRI that my neurologist ordered because I just can't afford it, even with insurance. It is outrageous that an insurance plan that already costs 10% of my income doesn't provide the coverage I need to make important procedures affordable. An increase in rates would also increase the burden on my family as we struggle to pay for our medical care." [26]
- "Though I do not make much and work two jobs, I don't qualify for much of a subsidy and currently pay a lot for health insurance -1/4 of my monthly mortgage. A rate hike would make it impossible for me to continue to have health insurance."[27]

The Board should either disapprove or modify MVP's proposed rate downward to address the above-documented health care affordability crisis.

[25] Green Mountain Care Board Public Comments: Joanne Case, July 17, 2017.
[26] Green Mountain Care Board Public Comments: Caitlin Gildrien, July 19, 2017.
[27] Green Mountain Care Board Public Comments: Samantha Langevin, July 19, 2017.

V. The Proposed Rate Does Not Promote Access To Health Care

The Board must set rates to promote access to health care.[28] At a basic level, access to health care has two necessary components. The first component relates to the adequacy of the provider network which has not been an issue for Vermont Qualified Health Plans. Plan affordability is the second component of access to health care.

It makes no difference how adequate MVP's provider network is if Vermonters cannot afford to use it. As we argue above, MVP's current VHC plans are unaffordable for too many Vermonters. The documented lack of affordability directly and negatively impacts access to health care.

The Board should either disapprove or modify MVP's proposed rate downward to promote access to healthcare.

VI. The Proposed Rate is Excessive, Inadequate, or Unfairly Discriminatory

Statutory authority requires that an insurer's proposed rates not be actuarially excessive, inadequate, or unfairly discriminatory.[29] The HCA agrees with L&E's recommendation that MVP should properly calculate actual/projected claims experience to account for mid-year enrollment/termination and that the Board should consider the impact of 2018 hospital budgets on unit cost trends. [30]

It is patently unreasonable to assume no mid-year enrollment/termination given that the data demonstrates (1) that mid-year enrollment/termination occurs and (2) that this phenomenon substantially reduces the claims that MVP must pay. Further, it is irrelevant that MVP agreed to two adjustments that L&E found necessary to correct the proposed rates. MVP's rates must, in their totality, be actuarially sound. MVP's mid-year enrollment/termination assumption is both

[28] GMCB Rule §2.301(b); GMCB Rule §2.401; *see also* 8 V.S.A. §4062(a)(3).
[29] *Id*.
[30] *See* GMCB-07-17-rr, Exhibit 10: July 11, 2017 Lewis & Ellis Actuarial Opinion, p. 10.

self-serving and negatively impacts Vermonters. In addition, updating the unit cost trends related to hospital budgets will increase the reliability of MVP's cost projections.

The Board should disapprove or modify MVP's proposed rate downward to correct for MVP's faulty method of accounting for mid-year enrollment/termination and they should incorporate updated hospital budget information.

VII. Conclusion

MVP has failed to adequately justify its proposed rates. HCA asks the Board to modify the proposed rate to correct for MVP's failure to properly account for mid-year enrollment/termination and to incorporate updated hospital budget information. Further, HCA asks the Board to disapprove or modify MVP's proposed rates downward to account for the lack of affordability of the rates, to promote access to healthcare, and to ensure the solvency of both MVP and Vermont households.

Dated at Montpelier, Vermont this 27th Day of July, 2017.

/s/ Kaili Kuiper
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CERTIFICATE OF SERVICE

I, Kaili Kuiper, hereby certify that I have served the above Memorandum on Judith Henkin, General Counsel to the Green Mountain Care Board; Noel Hudson, Health Policy Director of the Green Mountain Care Board; and Gary Karnedy, MVP Health Plan representative, by electronic mail, return receipt requested, this 27th day of July, 2017.

/s/ Kaili Kuiper
Kaili Kuiper
Staff Attorney
Office of the Health Care Advocate