GARY F. KARNEDY
ADMITTED IN VT, NH AND DC
gkarnedy@primmer.com
TEL: 802-864-0880
FAX: 802-864-0328

PRIMMER PIPER EGGLESTON & CRAMER PC
ATTORNEYS AT LAW

July 27, 2017

VIA E-MAIL ONLY - Noel.Hudson@vermont.gov

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

Re: In re: MVP Health Care 2018 Vermont Health Connect Rate Filing
Docket No. GMCB-007-17rr

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***.

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 Health Care 2018 Vermont Health Connect Rate Filing	)	DOCKET NO. GMCB-007-17rr
SERFF No. MVPH-131034103	)	

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 2018 Vermont Exchange Rate Filing, requesting a rate increase by an average of 5.1% across all MVP products.

Findings of Fact

1. **L&E Agrees With MVP in 2018**. MVP seeks a 2018 rate increase as amended, of 5.1%. *Lombardo Testimony (hereinafter "Lombardo"), p. 17; Ex. 8; Ex. 10.* After a vigorous and rigorous 60-day review by Board actuary Lewis and Ellis ("L&E"), and agreed upon modifications, L&E and MVP have broad agreement on all aspects of the 2018 rate filing, with the exception of only one issue regarding mid-year enrollment. Consequently, only a .3% difference remains, with L&E's recommending a 4.8% rate increase. *Lombardo, p. 21, Lee Testimony (hereinafter "Lee"), p.147; Ex. 8; Ex 10, p. 10.* Although there is sufficient evidence to find that the statutory criteria have been met for a rate increase of either 5.1% or 4.8%, MVP requests that the Board find MVP's 5.1% rate increase is superior.

2. **MVP's 2% Contribution to Reserves is Statutorily Required.** MVP's proposed 2% contribution to reserves ("CTR") was supported not just by MVP's actuaries, but also by L&E and the Vermont Department of Financial Regulation ("DFR"). *Lombardo, p. 55; Lee, p. 147, 156-157; Lussier Testimony (hereinafter "Lussier"), p. 133; Ex. 8; Ex. 9; Ex. 10, p. 8.* In fact,

L&E requested and considered data from MVP on a 1% CTR alternative on June 24th, but still concluded that the 2% contribution was reasonable and appropriate in its July 11th final report. *Ex. 4, p. 6; Ex. 10, p. 8, Lee, p. 157.* DFR witness Lussier confirmed that the 2% surplus, in light of MVP's reduced 5.1% rate increase, would still have the impact of sustaining the current solvency of MVP. *Lussier, p. 125.*

Board Member Holmes asked Lussier directly whether MVP could reduce the contribution from 2% to 1%. *Lussier, p. 128.* Lussier responded that such downward adjustments should not be made unless actuarially supported. *Id.* Since neither Lombardo nor Lee opined that such a reduction was supported, there is no actuarial support in evidence to support the 1% reduction. Such a reduction would therefore be contrary to the direction of the DFR.

Trying to justify a reduction from 2% to 1% by relying on the reserves of MVP's New York book of business (and the relatively small portion the Vermont business attributable to the total MVP business), is not an actuarially sound approach to measuring the necessary contribution to surplus. *Lombardo, p. 50.* The DFR believes that the filings should stand on their own. *Lussier, p. 128.* The surplus should be measured based on the individual lines. *Lombardo, p. 50; Lussier, p. 128.* It is not actuarially sound to measure the adequacy of a rate by assuming New York line reserves may be raided to prop-up Vermont lines. *Lombardo, p. 50.* New York state regulators require that "each state's book of business in its corporate structure should be self-supporting and MVPHP would not meet this criteria" with a 1% contribution to surplus. *July 24, 2017 MVP Response Letter* (hereinafter "*Response Letter*").

The Board should carefully read MVP's July 24, 2017 detailed response to the Board's written follow-up of the CTR question, and take stock in the financial folly created by such a reduction:

8. If the Board were to reduce the CTR for this specific filing from 2.0% to 1.0%, would the company remain in compliance with New York State's solvency requirement?

Response: Although a reduction in CTR from 2% to 1% would not impact MVP's compliance with New York's solvency requirement, MVPHP's VT block of business would not meet this requirement at current membership levels. MVP has several concerns with reducing CTR which are outlined below:

1) Reserve requirements are in place to maintain stability in the market to ensure that a carrier can absorb adverse financial risk from higher than anticipated claims experience and unforeseen regulatory assessments.

a. NYS introduced enterprise risk management requirements as another method to review solvency and financial risks that insurers face. MVP's enterprise risk management program requires the plan to maintain reserves in excess of the statutorily required reserves in order to ensure that the plan has adequate reserves in the case of unforeseen adverse events. MVP's target minimum reserve percentage to absorb unanticipated financial risks is 16% with a target amount equal to 20% of premium (see Exhibit 4, page 3).

b. MVP was assessed a $735,000 fee in 2017 to support an under-reserved long-term care insurance company in VT. Similarly, MVP was assessed $113,000 to cover the same under-reserved long term care insurance company in New Hampshire. To pay this fee, MVP had to utilize its reserves which weakened our financial strength.

c. As MVPHP's VT block continues to grow at a rapid pace, we have significant concerns that the membership we acquire from BCBSVT will result in adverse claim experience and therefore lead to financial losses. Since VT's hospital budgets are dictated by the Board, MVP does not estimate a significant spread in provider reimbursement rates. If rates are approved consistent with L&E's actuarial opinion, MVP's premium rates will be 6% - 15% lower than BCBSVT's in 2018. Given that claims account for approximately 90% of the premium and the Board is setting the hospital budgets, MVP is of the opinion that a premium spread of 6% - 15% is outside the range of reasonableness. As MVP gains market-share from BCBSVT, we project our claims experience to align closer with the market average resulting in inadequate premium rates.

2) As MVPHP's VT block grows, the reserve requirement to maintain solvency will also grow. Based on current premium levels, MVPHP projects its VT block to have reserves equal to $6.3M, or 11.5% of premium, at year-end 2017 which is below NYS' minimum threshold (see Exhibit 4, page 6). If MVP's block of business were to grow by 5,000 members in 2018 to 15,300 members, we forecast approximately $7.3M in reserves using a 1% CTR on projected annual revenue of $85.0M, or 8.6% of premium, which is well below the minimum reserve requirement. NYS' regulators have communicated to MVP that each state's block of business in its corporate structure should be self-supporting and MVPHP would not meet this criteria. As MVPHP's VT business continues to grow, reductions to CTR and other rate cuts that are not actuarially justified will lead to financial harm.

3) MVP has proposed lower CTR percentages in recent years to become more competitive in VT and gain membership, but these reduced CTR figures are

not sustainable, especially given MVP's recent membership growth in the VT Exchange. Response Letter, p. 4-5.

The notion that Vermont members need not contribute 2% to reserves because the Vermont business line is only 3% of MVP's overall business subverts NY regulator (and the Vermont DFR) opinions and requirements. Furthermore, reserves should be substantial enough so that if an actuarially sound assumption in a 2018 rate filing turns out to be incorrect, MVP is not required to undertake significant replenishment via even higher rates in its 2019 rate filing. *Lussier, p. 128*; *Lee p. 155.*

3. **L&E's Mid-Year Enrollment Analysis Is Too Speculative.** MVP disagrees with L&E's proposed .3% reduction in MVP's 2018 rate increase relating to mid-year enrollments. *Lombardo, p. 20*; *Ex. 3, p. 2; Ex. 6, p. 2; Ex. 10, p. 10.* Federal law required a forty-five day reduction in the open enrollment period for 2018, from November 1 – January 31 for 2017 to November 1 - December 15 for 2018. L&E agreed with MVP that individuals on small group plans who enroll for a full year are now more likely to use up their deductible during the entire 12-month period, resulting in MVP paying more claims. *Lee, p. 153, 155; Ex. 10, p. 3.*

Lee admitted on cross examination that L&E is making additional assumptions about 2018 enrollment patterns which MVP actuaries felt were too speculative. *Lee, p. 154, 155.* Lee agreed on cross examination that her assumptions are based on prior year data where the enrollment period was totally different: longer (90 rather than 45 days) and spilling into the covered year by 45 days. *Lee, p. 167.* She is predicting apples with oranges. Lee agreed that MVP does not think there is reliable data to predict the extent of partial year enrollment for individual plans in this very different enrollment period. *Lee, p. 153-154; Lombardo, p. 39.*

Lee agreed with MVP that if more individuals on individual plans did in fact sign up for the whole year rather than mid-year, to the extent that they have claims, they are more likely to

use up their deductibles over that longer period of time, and MVP will pay more for claims. *Lee, p. 153, 155.* Lee also agreed that if an insurance company guesses wrong, it will likely have to charge higher rates in later years to make up the difference. *Lee, p. 155.*

Board Member Hogan asked a common sense question at the hearing, whether a difference of .3% in a rate filing on $90 million in business is just "noise." *Hearing Transcript, p. 103.* However, Lombardo confirmed that a rigorous rate filing needs to consider every nickel, up or down, to ensure that the premium charged aligns with the product and services purchased, and meets the statutory criteria. *Lombardo, p. 118.*

4. 2018 Final Hospital Budgets Are Uncertain At This Time. One of the Board's statutory charges is to ensure that MVP's rates are adequate. This task is particularly difficult in the context of the horse before the cart calendaring of the hospital budget approval hearings, which take place after the Board's statutory deadline for a final decision on this rate filing (final decision due on August 10, *Pre-Hearing Order, p.2*). Since the 2018 hospital budgets are not yet finalized, MVP has assumed the hospital increases will match 2017 increases. *Ex. 8; Ex. 6, p. 4; Ex. 10, p. 4.* The Board has historically issued budgetary instructions to hospitals, and then later approved some hospital budgets that have exceeded those instructions. Several of the hospitals have again this year submitted 2018 budgets that exceed those instructions with detailed explanations why, so it remains to be seen what budget increases the Board will approve. *Response Letter, p. 2-3.* It remains to be seen what the Board will decide on these hospital budgets after it fairly considers evidence at the budget hearings. It would be improper for the Board to pre-determine those final hospital budget numbers in this insurance rate hearing, before considering the explanatory evidence in the hospital budget hearings. *Id.*

Similarly, L&E testified that it would not be prudent, and would be speculative to attribute a percent increase to the as of yet undetermined hospital budget increases, and declined

in its report to attribute any number to the uncertainty of the hospital budget status. *Lee, p. 150-151; Ex. 10, p. 10.* Furthermore, if the hospitals are constrained by the budgets approved by the Board, they will not negotiate a further decrease with MVP. *Lombardo, 47-48.*

5. <u>2018 Administrative Costs Estimates Are Reasonable.</u> MVP increased its Exchange market share from 10-15% in 2017. *Lombardo, p. 16-17.* MVP included a membership increase of 3,500 Exchange members in 2018 and in sales and marketing/administrative costs in its rate increase analysis. *Lombardo, p. 109; Ex. 8, p. 16-17.*

> *MVP's fixed expenses account for 59%-63% of administrative costs over the past three years in VT which is slightly lower than its corporate wide distribution of fixed vs variable administrative costs. MVP's cost to administer its other commercial products is higher than its cost to administer its Exchange business which is driving the discrepancy between the projected 2017 administrative expense in the attached file compared to MVP's Exchange rate filing. Response Letter at 4, and confidential Expense Summary at 6.*

The calculation of overall administrative expenses is not as simple as dividing a total cost by the number of members. Not all administrative costs are fixed, and particular administrative efforts and initiatives can change from year to year. "Administrative expenses are not fixed year over year and changes to these costs must be reflected in projected expenses to provide an actuarially sound premium rate." *Id.* One example is MVP intending to increase its marketing efforts in an attempt to increase market share for 2018. *Lombardo, p. 109.*

Only about 10% of the proposed rate increase is attributable to overhead and contribution of reserves. *Lombardo, p. 46.* Consequently, even a 10% further reduction in administrative costs would result in only a 1% reduction in this rate filing. *Lombardo, p. 48-49.* Importantly, 10% of the general administrative expense load is used to cover Quality Improvement/Cost Containment Programs in the 2018 Rate Filing. *Ex. 8, p. 16; Ex. 10, p. 8.* Both MVP and L&E actuaries agreed that MVP's Administrative Load is actuarially prudent, and should not be fodder for additional cuts by the GMCB. *Ex. 8, p. 16-17; Response Letter, p. 4; Ex. 10, p. 8.*

Over the last five years, MVP has succeeded in keeping administrative costs flat. *Lombardo, p. 105-106.* MVP's finance team meets with MVP department heads about every six months, to assess cost drivers for MVP's expenses and work with the teams to understand how these costs should be allocated. *Lombardo, p. 46-47.* MVP also has a contracting team that works with hospitals and providers to negotiate for a decrease in their rates. *Lombardo, p. 47.* Furthermore, as MVP anticipates the exchange business to grow, it anticipates losing large group members. *Lombardo, p. 97.* The Board should rely on L&E's conclusion regarding administrative costs based on its exhaustive 60-day review:

> *This historical reduction in administrative costs cannot continue indefinitely, and the projected administrative costs appear to be reasonable. In light of the steps taken by MVP in reducing administrative costs over the recent years, the assumed administrative 2017 costs appear to be reasonable and appropriate. Ex. 10, p. 8.*

6. **Statutory Criteria.** In light of all of the evidence, MVP's 5.1% increase meets all of the statutory criteria. The rates are affordable because the premium fairly equates with the products and services covered, and are actuarially justified. *Lombardo, p. 60-61.* By contributing to reserves, MVP addresses affordability by maintaining a stable market. *Id.* The press of competition by a viable second carrier in the marketplace makes rates more affordable. *Lombardo, p. 54-55.* MVP works with its providers to obtain the lowest contract cost possible, along with the GMCB. *Lombardo, p. 61.* MVP is continually analyzing its administrative expenses as discussed *supra*, also trying to reduce costs as much as possible. *Id.* By reducing costs, MVP is constantly trying to offer the most competitive premium rate, and as it increases market share, bend the cost curve. *Lombardo, p. 107-108.* The actuarial goal of affordability is to try to produce a sustainable rate that will meet MVP reserve requirements and maintain market stability. *Lombardo, p. 118.*

MVP's New York rates are increasing approximately 12-13%. *Lombardo, p. 77.* Based on L&E's work on rate filings in seven states, it estimates that Vermont's rate increases have been at the lower level. *Lee, p. 136, 148.* Per its Report, L&E reviewed all of the statutory criteria, including whether the rate is statutorily "affordable." *Ex. 10, p. 2.* L&E concluded that the 4.8% increase was affordable. *Ex. 10, p. 2; Lee, p. 158.* [1]

MVP promotes quality of care and access to health care by: (1) providing more options for insureds with a second carrier in the marketplace with a proven track record; (2) providing an online cost calculation tool; (3) offering a telemedicine benefit and 24/7 access for routine health questions; (4) contracting with CIGNA, a national network of providers, to ensure their members access treatment; (5) providing MVP's network across the borders of New York (e.g. Bennington members going to Albany) and New Hampshire (e.g. Rutland members going Dartmouth Hitchcock); (6) credentialing providers associated with their network to ensure the national quality standards; (7) providing a comprehensive case management and medical management team for members with chronic conditions; (8) providing nurse outreach to help members navigate the health care system; and (9) contributing to the budget of the Health Care Advocate, by funding the HCA's efforts including its 24/7 toll-free line. *Lombardo, p. 51-55, 61-62.*

The rates are not unjust, unfair, inequitable, misleading, or contrary to Vermont law because they promote quality of care and affordability and are reasonable based on the data that MVP analyzed. They are actuarially sound and fairly charge for premium for services covered.

[1] The HCA's philosophical inquiry into what is affordable for Vermonters goes outside the relevant statutory inquiry. Furthermore, the HCA failed to properly offer or admit any evidence of anticipated wage growth for 2018. The statements of the HCA attorney in her opening and cross-examination regarding wage growth were not evidence, lacked any evidentiary foundation, and should not be considered by the Board. *Hearing Transcript, Hearing Officer Ruling on Objection, p. 68-71.* The Board should reject any attempt to offer new evidence in briefing that was not submitted at hearing.

The rates are not inadequate, excessive or unfairly discriminatory. *Lombardo, p. 63; Lee, p. 147 (at 4.8).* The rates are not inadequate because MVP conducted a thorough analysis of its data, projected it forward, and is comfortable that the premiums that it is offering are reasonable relative to the benefits that are included in the filing. They are not higher than necessary to cover claims, or too low to cover claims and the expected cost of the delivery of health care for these products, and will maintain minimum solvency requirements in 2018. *Lombardo, p. 61, 62; Lee, p. 147 (at 4.8).* The rates as filed do not discriminate against individuals who have similar risk profiles. *Ex. 8.* DFR has found the rates adequate. *Ex. 9; Lussier, p. 123.*

Conclusions of Law

1. 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, unfair, inequitable, misleading, or contrary to law, or if the rates are excessive, inadequate or unfairly discriminatory, fail to protect the insurer's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access. *8 V.S.A. §§ 4512(b); 4062 (a)(2),(3); Board Rule 2.0.*

2. MVP's 5.1% rate increase best meets these statutory standards. *Findings 1-6, Ex. 1-11; Response Letter; Lombardo, Lee and Lussier.* The 5.1% rate increase is superior to L&E's recommended 4.8% increase because it does not speculate on the impact of 2018 enrollment changes, and ensures that the rate will be adequate. As a matter of law, carriers are not

statutorily allowed to seek a rate increase, even one of only .3%, without actuarial justification. The same should hold true for any proposed rate reduction.

3. The HCA's philosophical inquiry into what is affordable for Vermonters goes outside the frame of the statutory inquiry. Any increase in taxes, college tuition, housing, daycare, or even the price of a movie ticket could be argued to be unaffordable to a Vermonter with a fixed income. Statutory "affordability" of the health insurance rate increase should not be considered in such simple isolation. Affordability is based on comparing the relative costs of the services and products and the premiums offered, in conjunction with the other statutory criteria.

4. The danger of statutorily inadequate rates for this 2018 filing is a clear and present. If the Board fails to allow the 2% contribution to surplus that has been clearly supported by all of the evidence, and all of the witnesses who testified, the Board will be left playing catch-up in future years through inflated rates. Such consequences are playing out in the BCBS filing this year. The Board is well-advised by DFR to rely on the actuaries, and approve a 2% contribution to surplus, which is supported by the evidence, and undisputed.

Dated at Burlington, Vermont, this 27th day of July, 2017.

PRIMMER PIPER EGGLESTON & CRAMER PC

By: _____

Gary F. Karnedy, Esq.
30 Main Street, Suite 500, P.O. Box 1489
Burlington, VT 05402-1489
(802) 864-0880
gkarnedy@primmer.com

Attorney for MVP Health Plan, Inc.

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

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CERTIFICATE OF SERVICE

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

Kaili Kuipier, Esq.
Staff Attorney
Office of the Health Care Advocate
P.O. Box 606
Montpelier, VT 05601
KKuiper@vtlegalaid.org

Judith Henkin, Esq.
Green Mountain Care Board
89 Main Street, Third Floor
Montpelier, VT 05620
Judy.Henkin@vermont.gov

Dated: July 27, 2017.

PRIMMER PIPER EGGLESTON & CRAMER PC

By: _____

Gary F. Karnedy, Esq.
30 Main Street, Suite 500
P.O. Box 1489
Burlington, VT 05602-1489
(802) 864-0880
gkarnedy@primmer.com

Attorneys for MVP Health Insurance Company