STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Plan, Inc. Third Quarter 2018 and Fourth Quarter 2018 Large Group HMO Rate Filing	))))	GMCB-007-18rr SERFF No.: MVPH-131435335
In re:	MVP Health Insurance Company, Third Quarter 2018 and Fourth Quarter 2018 Large Group Point of Service Rider	))))	GMCB-006-18rr SERFF No.: MVPH-131435409

DECISION AND ORDER

Introduction

Vermont law requires that health insurers submit major medical rate filings to the Green Mountain Care Board, which shall approve, modify, or disapprove the filing within 90 calendar days of its receipt. 8 V.S.A. § 4062(a)(2)(A). On review, the Board must determine whether the proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. § 4062(a)(3).

Procedural History

On March 23, 2018, MVP Health Plan, Inc. (MVPHP or "the carrier") submitted its Third Quarter 2018 (3Q18) and Fourth Quarter 2018 (4Q18) Large Group HMO Rate Filing and MVP Health Insurance Company (MVPHIC) submitted its Third Quarter 2018 and Fourth Quarter 2018 Large Group Point of Service (POS) Rider to the Board via the System for Electronic Rate and Form Filing (SERFF).[1] On April 3, 2018, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid representing the interests of Vermont health insurance consumers, entered an appearance as a party to this filing. On March 29, 2018, the carrier amended the filings, making a number of technical corrections for clarity and completeness.

On May 11, 2018, the Board posted to the web the Department of Financial Regulation's (DFR) analysis regarding this filing's impact on the insurer's solvency. On May 22, 2018, the Board posted to the web an actuarial memorandum provided by its contract actuaries, Lewis & Ellis (L&E). The Board solicited written public comments on this filing through June 6, 2018. No members of the public provided comment. The parties waived hearing in this matter and filed memoranda in lieu thereof. *See* GMCB Rule 2.000, § 2.309(a)(1).

[1] Because the POS Rider is directly associated with MVPHP's Large Group HMO line of business, we review both filings concurrently. The contents of the SERFF filing and all documents referenced in this Decision and Order can be found at http://ratereview.vermont.gov/node/699 (Large Group HMO Rate Filing) and http://ratereview.vermont.gov/node/698 (Large Group POS Rider).

Findings of Fact

1. MVPHP is a non-profit New York health insurer licensed as a health maintenance organization (HMO) in New York and Vermont. MVPHP is owned by MVP Health Care, Inc. (MVP), a New York corporation that transacts health insurance business in New York and Vermont through a variety of for-profit and non-profit subsidiaries. MVPHP provides EPO and PPO products to individuals and employers in the small and large group markets in New York and Vermont. L&E Memo at 1.

2. This filing proposes rates and demonstrates premium development for MVPHP's large group HMO product for policies beginning 3Q18 and 4Q18. MVP has migrated its entire large group business to this product and retired the large group PPO product previously offered by MVP Health Insurance Company (MVPHIC). Where applicable, both the old and new product names have been displayed in the filing, and the proposed rate increases compare the MVPHP product to the previous MVPHIC PPO product. SERFF Filings (Actuarial Memoranda)[2] at 1.

3. In an amendment to this filing, MVPHP added a wellness program and a discount program for services such as acupuncture, chiropractic, dietetic, and massage therapy to every group's base benefit. The cost of these services is reflected within the medical claim cost presented in the experience period and comes at no additional cost to members. Amendment to Rate Filing at 1.

4. This filing is supplemented by a POS Rider that provides out-of-network coverage to the base major medical offering. The POS Rider is not a standalone product and must be purchased in conjunction with MVPHP's large group HMO product. Rates for the POS Rider are set as a percentage of premium to the combined medical and pharmacy rates for MVPHP's large group HMO product. L&E Memo at 1.

5. As of January 2018, there were approximately 2,275 members enrolled in MVP large group plans in Vermont. Of these, 155 (7.0%) have a 3Q18 effective date and none have a 4Q18 effective date. The remaining members have effective dates in the first or second quarter. *Id.* at 1.

6. MVPHP proposes a 3.8% average annual rate increase for members renewing in 3Q18 and a 1.9% average annual increase for those renewing in 4Q18. On a quarterly basis, the carrier proposes a 2.6% increase from 2Q18 to 3Q18, and a 0.8% increase from 3Q18 to 4Q18. *Id.* at 2.

7. To form a credible experience base for projecting its 3Q18 and 4Q18 rates, MVPHP used large group MVPHIC claims incurred between November 2016 and October 2017 and paid through January 2018 (with incurred estimates updated through February 2018). MVPHP adjusted the data to reflect incurred but not reported paid claims (IBNR) and replaced high-cost claims (in excess of $100,000) with a pooling charge. MVPHP Memo at 2-3.

8. MVPHP adjusted its rating methodology to account for the demographics of the covered population, which have deviated from past expectations. The carrier re-normalized the

[2] We refer to these documents collectively as the MVPHP Memo.

demographic factors to reflect its updated experience, resulting in a 1.0% decrease. L&E Memo at 3.

9. MVPHP projected its experience forward using an annual paid medical trend assumption of 2.8%, derived from its proposed allowed cost trend rates and the impact of leveraging.[3] The assumed unit cost trends for Vermont hospitals reflect the FY2018 budgets each hospital proposed to the Board. MVPHP Memo at 5. Due to its concerns about the impact of membership growth in its other blocks of business on the total utilization trend, MVPHP incorporated a 0.0% utilization trend. L&E Memo at 3-4.

10. The carrier projects an annualized effective paid pharmacy trend of 14.7%, based on allowed pharmacy trends provided by its pharmacy benefits manager (PBM). L&E Memo at 4; MVPHP Memo at 5-6.

11. MVPHP assumes a general administrative expense load of 9.7% of premium, including an assumption of 2.0% contribution to reserves (CTR). L&E Memo at 4; MVPHP Memo at 6.

12. MVPHP anticipates that the proposed rates would generate a traditional loss ratio of 84.8%, and a federal loss ratio of 86.6%.[4] L&E Memo at 4. The carrier did not implement the Board's order in Docket No. GMCB-012-17rr to count the billback imposed by 18 V.S.A. § 9374(h)(1) and the HCA assessment as administrative expenses for loss ratio purposes. *Id.* at 7.

13. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR assessed the impact of the proposed filing on the carrier's solvency. Noting that it is not MVPHP's primary regulator, that New York State regulators have expressed no concerns about the carrier's solvency, and that all of MVPHP's health operations in Vermont account for approximately 2.9% of its total premiums written in 2017, DFR determined that the carrier's Vermont operations pose little threat to the carrier's solvency. DFR nonetheless opined that the rates as filed will promote MVPHP's solvency absent a finding by L&E that they are inadequate. *See* Solvency Analysis at 2.

14. Based on its independent review and analysis, L&E opines that the filings do not produce rates that are excessive, inadequate, or unfairly discriminatory, and therefore recommends that the Board approve them without modification. L&E Memo at 8.

15. The carrier and the HCA each provided legal memorandum to the Board. The HCA asserts that MVPHP failed to address statutory criteria such as affordability or systemic cost reduction efforts, and requests that the Board reduce its requested premium increase by a minimum of one percent. HCA Memo in Lieu of Hearing at 6-7, 10. MVPHP requests that the Board approve the filing without modification. MVPHP Memo in Lieu of Hearing at 4.

[3] Leveraging is the result of the fixed nature of deductibles and copays causing the carrier to bear a greater portion of the cost of medical inflation.

[4] As opposed to calculation of the traditional loss ratio, calculation of the federal minimum loss ratio under the ACA allows insurers to adjust for quality improvement activities and expenditures on taxes, licensing and regulatory fees.

Standard of Review

The Board reviews rate filings to ensure that a proposed rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust unfair inequitable, misleading, or contrary to the laws of this State." 8 V.S.A. § 4062(a)(3); GMCB Rule (Rule) 2.000, § 2.301(b). Although the first several terms—excessive, inadequate, or unfairly discriminatory—are defined actuarial standards, other standards by which the Board reviews rate filings are "general and open-ended," the result of "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16. The Board additionally takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); Rule 2.000, § 2.401.

In arriving at its decision, the Board must consider the Department's analysis and opinion of the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2)(B), (3). The Board must also consider any public comments received on a rate filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id.* § 2.104(c).

Conclusions of Law

With this filing, MVPHP has completed the transition of members from MVPHIC's PPO product to the MVPHP product discussed herein. The carrier's proposed medical and pharmacy trend assumptions, including a 0.0% medical utilization trend, are comparable to the prior MVPHIC product, and we agree with and adopt our actuary's opinion that the MVPHP's assumptions are appropriate and actuarially reasonable. Findings of Fact (Findings) ¶¶ 9, 10, 14. The carrier's 2018 unit cost trends incorporate our regulated hospitals' budget submissions, and the resulting annual paid medical trend of 2.8% represents a downward trend that, if continued, will help Vermont meet its obligations under the All-Payer ACO Model Agreement with the federal government. Findings ¶ 9; *see also* Docket Nos. 011-17rr (1Q/2Q18 Large Group PPO, 3.9% paid medical trend); GMCB-003-17rr (3Q/4Q 2017 Large Group PPO, 4.7% paid medical trend). While encouraged by the downward trend, we remind the carrier of our reasonable expectation that it engage in vigorous contract negotiations with providers—within and outside of our borders—in a way that promotes parity between academic medical centers, community hospitals and independent practices, and the resulting reimbursement levels that reflect actual costs of care, rather than site of service.

We next order a minimal administrative cost reduction, lowering the carrier's proposed 9.7% administrative expense load to 9.5%. In doing so, we encourage the company to find innovative ways to increase efficiencies and to review internal policies and practices that, for example, may unnecessarily require providers to obtain prior authorizations for patient referrals, while increasing the financial burdens on members via premiums that are rising at an unsustainable pace. We additionally note the carrier's failure to implement our order to treat billback expenditures as administrative, rather than claims expenses for the purpose of calculating its loss ratio. At this juncture, we caution the carrier that we will not approve future filings without this change.

Last, we reduce the proposed CTR from 2.0% to 1.0%. This reduction helps address valid concerns raised by the HCA regarding affordability of the proposed rates, while maintaining the carrier's reserve level above the 12.5% minimum threshold required by its New York State regulator.

Order

For the reasons discussed above, the Board modifies MVPHP's Third Quarter 2018 and Fourth Quarter 2018 Large Group HMO and Large Group Point of Service (POS) Rider rate filings by reducing CTR from 2.0% to 1.0% and administrative expenses from 9.7% to 9.5%. We then approve the filing.

SO ORDERED.

Dated: June 20, 2018 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Tom Pelham)
)
s/ Maureen Usifer)

Filed: June 20, 2018

Attest: s/ Jean Stetter, Administrative Services Director
Green Mountain Care Board

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (email address: Agatha.Kessler@vermont.gov). Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further Order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed with the Clerk of the Board within ten days of the date of this decision and order.