STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Large Group Point of Service (POS) Rider	)	GMCB-006-18rr
	)	
In re: MVP Large Group HMO 3Q/4Q 2018	)	GMCB-007-18rr

OFFICE OF THE HEALTH CARE ADVOCATE MEMORANDUM IN LIEU OF HEARING

We thank the Green Mountain Care Board (Board) for the opportunity to respond to the MVP Large Group Point of Service Rider filing and the MVP Large Group HMO 3Q/4Q 2018 filing (collectively, Filings). We also thank the Board for its commitment to containing health care costs and making quality health care accessible for Vermonters. In this memorandum, we respond to both filings together as the POS rider is only available to customers of MVP's Large Group HMO product.

The Office of the Health Care Advocate (HCA) submits the following Memorandum in Lieu of Hearing in opposition to MVP's proposed 3.8% annualized rate increase for coverage renewal in 3Q 2018 and 2.8% annualized rate increase for coverage renewal in 4Q 2018. MVP failed to meet its burden of proof to justify the proposed rate. Further, the Filings are not affordable because they (a) fail to adequately demonstrate system cost containment efforts and (b) unreasonably exacerbate the health insurance affordability crisis experienced by Vermonters. Therefore, MVP's proposed rate fails to conform to the applicable statutory standard for health insurance rate changes and should be modified.

We respectfully ask the Board to reduce the total proposed premium by, at a minimum, one percent. Such Board action will motivate MVP to submit filings that adequately address the relevant statutory criteria while simultaneously encouraging meaningful participation in Vermont's efforts to contain cost, provide quality medical care, and ensure an accessible and affordable health care system.

We also ask the Board to define rate filing guidance such that carriers are explicitly instructed to address the relevant statutory criteria in future filings. Regulated entities will only pay lip service to cost containment and affordability until the Board mandates new processes and holds the regulated entities accountable to conform to the applicable statutory and/or regulatory standard(s).

Lastly, we note that the proposed rate increase will apply in the first year of Vermont's all-payer model (APM) agreement. The Board endorsed this agreement as an "opportunity to move forward

towards a more efficient health care system that rewards quality care and positive health outcomes."[1] Further, in that agreement, the Board noted that continuing health system cost growth will place "unsustainable financial burdens on Vermonters and their families…" and it will "cripple [Vermont's] economy."[2] The Board must apply its regulatory oversight to ensure carriers are doing everything they can to lower costs while maintaining quality care and access to care if the Board wishes for Vermont to meet the APM targets. A downward reduction of the proposed premium and the imposition of filing standards that track the statutory criteria would advance the Board's stated goals.

Before proceeding to the substantive sections of this memorandum, we first detail the applicable standard of review and the procedural history of the Filings.

STANDARD OF REVIEW

The insurer bears the burden of justifying the rate change when filing a proposed rate.[3] Neither the Board nor the HCA must present an alternative rate scheme to remedy a deficient proposed rate. Absent an adequate justification for the proposed rate, the rate scheme, or an element thereof, should be disproved or the Board may, in its discretion, modify the proposed rate or rate element.[4]

When "deciding whether to approve, modify, or disapprove each rate request," the Board is charged to "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."[5] The Board must also take into consideration "changes in health care delivery, changes in payment methods and amounts …" and other issues at its discretion.[6]

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[1] GMCB Decision, In re Vermont All-Payer Accountable Care Organization Model Agreement (Oct. 26, 2016) at 11.
[2] Id. at 1.
[3] GMCB Rule 2.104(c).
[4] E.g., GMCB-04-17rr, Decision at 5 (reducing a proposed rate for a large group filing based on a balancing of the carrier's needs against the needs of Vermonters for affordable rates); GMCB-03-15rr, Decision at 5 (reducing a proposed rate for a large group filing due to a carrier failing to meet its burden of proof); GMCB-016-14rr, Decision at 4 (disapproving an insurer's proposed administrative costs and contribution to surplus based on the insurer failing to meet "its burden for the requested increase…").
[5] GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 155 A. 3d 1207 (Vt. 2016).
[6] 18 V.S.A. §9375(b)(6).

Procedural History

On March 29, 2018, the Filings were submitted to SERFF. The Fillings request a 3.8% annualized rate increase for coverage renewal in 3Q 2018 and a 2.8% annualized rate increase for coverage renewal in 4Q 2018.[7] This proposed rate increase would impact 2,275 Vermonters.[8]

On April 3, 2018, the HCA filed notices of appearance to represent the public's interests.[9]

On May 11, 2018, the Vermont Department of Financial Regulation (DFR) submitted a solvency opinion regarding the Filings. DFR noted that "MVPHP's Vermont operations pose little risk to its solvency."[10]

On May 22, 2018, Lewis & Ellis (L&E), the actuarial firm retained by the Board, submitted actuarial recommendations related to the Filings.[11] L&E's recommendations, consistent with its charge and expertise, relate only to the actuarial soundness of the proposed rate and not the full set of statutorily-defined criteria that the Board is charged to weigh when reviewing proposed rate changes.[12]

ARGUMENT

MVP HAS FAILED TO MEET ITS STATUTORILY DEFINED BURDEN OF PROOF BECAUSE THE FILINGS ONLY ADDRESS WHETHER THE PROPOSED RATE IS ACTUARIALLY JUSTIFIED.

MVP has failed to offer any evidence other than an actuarial justification for the proposed rate. MVP chose such a course of action despite (1) clear statutory language that actuarial justification is only a subset of the criteria that the Board is charged to consider when evaluating proposed rates and (2) the unambiguous rule that MVP bears the burden of proof to justify the proposed rate. Absent an adequate justification for the proposed rate by the insurer, the rate scheme, or an element thereof, must be modified by the Board.[13]

The legislature mandated that the Board review a proposed rate in terms of the rate's system impact, actuarial soundness, and its impact on Vermonters. As stated above in the Standard of Review section,

[7] GMCB-007-18rr, SERFF Filing.
[8] GMCB-007-18rr, Lewis & Ellis Actuarial Opinion at 2.
[9] GMCB-006-18rr, HCA Notice of Appearance; GMCB-007-18rr, HCA Notice of Appearance.
[10] GMCB-006-18rr, Department of Financial Regulation Solvency Opinion at 2; GMCB-007-18rr, May 15, Department of Financial Regulation Solvency Opinion at 2.
[11] GMCB-006-18rr, Lewis & Ellis Actuarial Opinion; GMCB-007-18rr, Lewis & Ellis Actuarial Opinion.
[12] GMCB Rule 2.301(b); GMCB Rule 2.401; 18 V.S.A. §9375(b)(6); see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 155 A. 3d 1207.
[13] E.g., GMCB-04-17rr, Decision at 5; GMCB-03-15rr, Decision at 5; GMCB-016-14rr, Decision at 4.

the legislature charged the Board to "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."[14] The Board must also take into consideration "changes in health care delivery, changes in payment methods and amounts …" and other issues at its discretion.[15] We recognize the difficulty of executing this mandate. Regardless, the proper execution of the mandate lies at the heart of Vermont's future.

Here, MVP failed to adequately address multiple criteria that the Board must evaluate when reviewing a proposed rate. Specifically, the Filings do not address affordability, the promotion of quality care, the promotion of access to health care, or whether the rate is misleading, unjust, unfair, or inequitable.

Although MVP has, in the past, only offered actuarial justification for proposed rates, such past practices do not negate the underlying statutory and regulatory frameworks that set out the criteria and burden of proof that a carrier proposing a rate must meet. Further, MVP's practice of only offering actuarial justification for the proposed rates focuses the Board's evaluation towards a narrow subset of actuarial criteria that best justify the proposed rate. The Vermont Supreme Court, however, has made clear that affordability and other non-actuarial criteria that take into account health system function and the needs of Vermonters are mandated components of the Board's rate review.[16]

Below, we discuss one statutory criterion that the Filing fails to adequately address, namely, affordability.

1. MVP did not Adequately Address Affordability Because It Failed to Demonstrate how it is Makings Reasonable Efforts to Reduce Costs for Vermonters

The legislature charged the Board to "determine whether a proposed rate is affordable…"[17] In cases such as this where there is no statutory or regulatory definition of a term and the statute deals with a specialized subject, the meaning ascribed to the term should be that meaning which is used in the relevant technical field or policy community.[18] Here, the relevant policy community the Board should look to in ascribing meaning to the word "affordability" are similarly situated state actors.

[14] Id.; GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3).
[15] 18 V.S.A. §9375(b)(6).
[16] See, In re MVP Health Insurance Company, 155 A. 3d at 1214.
[17] GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 155 A. 3d 1207.
[18] E.g., William N. Eskridge, Jr., Philip P. Frickey, & Elizabeth Garret, Cases and Materials on Legislation: Statutes and the Creation of Public Policy (3d. ed. 2001).

We are aware of only one other state that defines affordability in its health insurance rate review process, namely, Rhode Island.[19] In broad terms, Rhode Island applies a two-prong affordability test. The first prong of the affordability test is that a carrier must demonstrate that it is working to reduce health care costs by undertaking cost containment and system reform activities. [20] The second prong of the affordability test is that a carrier must demonstrate that lower-income consumers have "the ability … to pay for health insurance." Both prongs are necessary because carriers lack a financial incentive to reduce system costs or premiums. [21] Neither prong, however, is sufficient; premium reductions absent system reform will risk carrier insolvency and ever increasing premiums will place ever greater financial burdens on Vermonters absent system reforms. MVP failed to adequately addresses either affordability prong.

a. MVP is not engaging in adequate cost containment and system reform efforts.

In its actuarial memorandum, MVP offers no evidence that the proposed rates are affordable in terms of implementing cost containment or system reform activities. MVP does not even discuss potential or early-stage health system reform efforts such as the implementation of cost containment activities or alternative payment methodologies that have the potential to reduce system costs in the Filing.

As part of the filing review process, the HCA asked MVP to explain how it is controlling costs for this book of business through alternative payment methodologies with or outside of OneCare Vermont. We asked for this explanation both because of the relevant statutory criteria and the Board's statement that Act 48 "makes clear that health insurers, Medicaid, Medicare, and other payers should reimburse health care professionals with consistent payment methodologies that provide incentives to coordinate care and control cost growth."[22]

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[19] R.I. Gen, Laws § 42-14.5-2 (the Rhode Island legislature created a regulatory entity, the Office of the Health Insurance Commissioner (OHIC), with numerous charges including the review of proposed health insurance rates); Office of the Health Insurance Commissioner Regulation 2 (Originally Effective December 15, 2006) at 14-16 (regulations defining the technical usage of the word "affordable."), available at http://www.ohic.ri.gov/documents/2016-OHIC-Regulation-2-amendments-2016-12-12-Effective-2017-1-1.pdf.

[20] Id. at 15 (activities examined under this prong include reform efforts such as improved primary care supply, reduced emergency room visit incidence, reduced re-hospitalization, and the "implementation of effective strategies by the health insurer to enhance the affordability of its products").

[21] Marshall Allen, Why Your Health Insurer Doesn't Care About Your Big Bills, NPR (May 25, 2015) (describing how health insurance carriers lack incentives to reduce system costs), available at https://www.npr.org/sections/health-shots/2018/05/25/613685732/why-your-health-insurer-doesnt-care-about-your-big-bills,

[22] GMCB Decision, In re Vermont All-Payer Accountable Care Organization Model Agreement at 2.

MVP, in response to the HCA's question, stated that, "at this time, MVP has not incorporated alternative payment methodologies into its direct contracts in Vermont."[23] MVP did note that OneCare Vermont has reached out to it but that these discussion were "too preliminary to provide any details."[24] Even accounting for MVP's response to the HCA's questions, MVP failed to demonstrate that it is engaging in adequate cost containment and system reform activities.

Because MVP has offered insufficient evidence that they are making adequate efforts to control costs for the population in this book of business, the Filing is, by definition, not affordable. In light of this fact, the Board must engage in the difficult task of balancing the carrier's needs against Vermonters need for health care cost containment and health care system reform. The result of this balancing should be a reduction of the proposed rates.

b. MVP failed to adequately address whether its proposed rates place an unreasonable financial burden on Vermonters.

Affordability, as discussed above, contains a second component, namely, whether Vermonters can afford the premium charged. This second component is a necessary but insufficient component of affordability meaning that an affordable rate must incorporate both cost containment and system reform activities and the proposed rate must align with Vermonters' ability to purchase health insurance.

Many Vermonters, whether employers or employees, cannot afford the premium increase proposed in the Filing. We note that, for this book of business, an employee will likely pay a share of the increased premium. In light of this fact, an observer might conclude that the primary burden of the proposed rate will be on Vermont employers. This conclusion is incorrect.

Vermont employees will also significantly bear the burden of the proposed rate increase. Substantial evidence shows that employers view an employee's total compensation as a whole when setting wages. Thus, if the employer premium share increases the employee's wage is offset by the increased employer premium share.[25] Wage suppression due to premium growth also likely impacts employers insofar as they are unable to offer a competitive wage. Increases in the rates for these books of

[23] GMCB-007-18rr, MVP Response to Objection Letter #2 at 3 (Q6).
[24] Id.
[25] E.g., Gary Burtless & Sveta Milusheva, Effects of Employer-Sponsored Health Insurance on Social Security Taxable Wage, Social Security Bulletin, 73(1), 83-107 (2013); But see, Priyanka Anand, Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey, Health Economics, 26(12) (2017) (describing that a $1 increase in health care costs causes a larger than $1 decrease in total hourly compensation).

business thus have the dual effect of placing Vermont employers at a competitive disadvantage and creating an unsustainable financial burden for Vermont employees.

We note that a trend of premium growth outpacing economic growth has multiple possible effects. First, the growth of premium substitutes for wage. Premium growth thus suppresses wage growth leaving Vermonters both paying more premium and having less money to purchase health care and other necessities. [26] Wage suppression due to premium growth also likely inhibits Vermont employers' ability to offer a competitive wage.

Second, the increasing share of a household's income paid towards health insurance premium may influence a household's decision to not participate in the health insurance market. The result of such a decision undermines the risk pool and, if it happens at scale, leads to higher health insurance premiums for those remaining in the risk pool. Further, if a household chooses to forgo health insurance, this may increase the incidence and amount of bad debt that hospitals experience serving the uninsured. The incidence of bad debt may in turn increase the unit cost for health care services, increase the medical trend, and further increase premium cost.

In the Filings, MVP fails to offer adequate proof that the proposed rate is affordable to Vermonters. Therefore the Board should exercise its discretion to modify the rate downward.

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[26] See, Burtless & Milusheva, supra note 28.

CONCLUSION

MVP has failed to meet its burden of proof for the proposed rate increase because it has failed to adequately address the statutory criteria that the Board is statutorily mandated to use when evaluating rate changes. These criteria help advance the goals of the APM and ensure that health insurance rates are affordable for Vermonters. In fact, MVP failed to even minimally address a substantial portion of the relevant statutory criteria in the Filings including affordability, the promotion of quality care, the promotion of access to health care, or whether the rate is misleading, unjust, unfair, or inequitable.

Therefore, we respectfully ask the Board to define rate filing guidance such that carriers are explicitly instructed to address the relevant statutory criteria. Regulated entities will only pay lip service to cost containment and affordability until the Board holds them to be accountable for their actions.

Further, we respectfully request that the Board reduce the total premium by, at a minimum, one percent based on an analysis of MVP's failure to meet its burden of proof and on a balancing of the statutorily mandated factors the Board is charged with evaluating when exercising its authority related to rate modification.[27]

Dated at Montpelier, Vermont this 6th Day of June, 2018.

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[27] E.g., GMCB-04-17rr, Decision at 5 (reducing a proposed rate for a large group filing based on a balancing of the carrier's needs against the needs of Vermonters for affordable rates); GMCB-03-15rr, Decision at 5 (reducing a proposed rate for a large group filing due to a carrier failing to meet its burden of proof); GMCB-016-14rr, Decision at 4 (disapproving an insurer's proposed administrative costs and contribution to surplus based on the insurer failing to meet "its burden for the requested increase…").

CERTIFICATE OF SERVICE

I, Eric Schultheis, hereby certify that I have served the above Memorandum in Lieu of Hearing on Judith Henkin, Green Mountain Care Board General Counsel; Sebastian Arduengo, Green Mountain Care Board Staff Attorney; Agatha Kessler, Green Mountain Care Board Health Policy Director; and Susan Gretkowski, MVP's designated representative, by electronic mail, return receipt requested, this 6th day of June, 2018.

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