STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP 2019 Large Group HMO	)	GMCB-010-18rr
	)	
In re: MVP 2019 Large Group Point of Service (POS) Rider	)	GMCB-011-18rr

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 Health Plan, Inc. (MVP) 2019 Large Group Point of Service Rider filing and the MVP 2019 Large Group HMO filing (collectively, Filings). In this memorandum, we respond to the Filings together as the POS rider is only available to customers of MVP's Large Group HMO product.

Because MVP has failed to submit evidence supporting all factors on which the Board must make a determination, and because MVP has not demonstrated that its proposed premium increase will produce rates that are affordable and not unfair, the HCA respectfully requests that the Board reduce MVP's proposed rate as outlined below.

STATUTORY BACKGROUND

MVP bears the burden of demonstrating that its proposed premium increase meets the multi-faceted test governing the lawfulness of a proposed rate increase in Vermont.[1] Absent such a demonstration, the Board may, in its discretion, modify the proposed rate or any element of the rate.[2] When deciding whether to approve, modify, or disapprove each rate request, the Board must determine whether the requested rate meets each of the following criteria:

1) affordable;
2) promotes quality care;
3) promotes access to health care;
4) protects insurer solvency;
5) not unjust, unfair, inequitable, misleading, or contrary to law; and
6) not excessive, inadequate, or unfairly discriminatory.[3]

[1] GMCB Rule 2.104(c).
[2] E.g., GMCB-008-18rr, Decision at 16 (reducing a proposed rate to "make rates more affordable to Vermonters"); GMCB-006-18rr, Decision at 5 (reducing a proposed rate to increase affordability to Vermonters); GMCB-003-15rr, Decision at 5 (reducing a proposed rate due to a carrier failing to meet its burden of proof).
[3] GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 203 Vt. 274 (2016).

Vermont law also directs the Board to consider "changes in health care delivery, changes in payment methods and amounts" and other issues at its discretion.[4]

Additionally, the statute requires the Department of Financial Regulation (DFR) to provide the Board with an "opinion on the impact of the proposed rate on the insurer's solvency and reserves," and it requires the Board to accept comments from both the public and the Office of the Health Care Advocate on MVP's proposed rate increase.[5] The Board may (or may not) choose to contract with an actuary. The Board must consider the views of DFR, the public, and the Office of the Health Care Advocate (HCA), but it is not bound by them. The Board may consider its actuary's opinion but is not required to or bound by it.[6]

ARGUMENT

MVP has failed to carry its burden with respect to the criteria on which the Board must make a determination.

A. Affordability

One state that defines affordability in its health insurance rate review process is Rhode Island.[7] In broad terms, Rhode Island's affordability test asks two questions. The first question asks whether a carrier is working to reduce health care costs by undertaking cost containment and system reform activities.[8] The second question asks whether lower-income consumers have "the ability … to pay for health insurance." Both inquiries are necessary because insurance carriers lack a financial incentive to reduce system costs or premiums.[9] Neither inquiry, however, is sufficient: premium reductions absent system reform will be unsustainable and risk carrier insolvency, and system reforms absent checks on premium prices will not ensure that Vermonters have the financial ability to purchase available plans. MVP failed to show that its proposed rates are affordable under either analysis.

[4] 18 V.S.A. §9375(b)(6).
[5] 8 V.S.A. §4062(a)(1)(2)(B); 8 V.S.A. §4062(c)(1)(B); 8 V.S.A. §4062(e)(1)(B).
[6] 8 V.S.A. §4062(d)(1).
[7] 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."), http://www.ohic.ri.gov/documents/2016-OHIC-Regulation-2-amendments-2016-12-12-Effective-2017-1-1.pdf.
[8] Id. at 15 (activities examined 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").
[9] 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), https://www.npr.org/sections/health-shots/2018/05/25/613685732/why-your-health-insurer-doesnt-care-about-your-big-bills.

MVP's failure to implement system reforms to lessen the need for a premium price increase is demonstrated by the absence of any discussion of system reform initiatives. MVP failed to describe any efforts to move from traditional payment methodologies to alternative payment methodologies.[10] Further, MVP does not mention any other health system reform efforts in the Filings.[11] Lastly, MVP's continued non-participation in OneCare Vermont could indicate that MVP is not sufficiently supporting Vermont's efforts to bend the health care cost curve downward while maintaining quality of care.[12]

Affordability, as discussed above, also contains a second component, namely, whether Vermonters can afford the premium charged. Many Vermonters, whether employers or employees, cannot afford the premium increase requested. 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 premium price increase. Evidence shows that employers view an employee's total compensation as a whole when setting wages; if the employer's premium share increases, the employee's wage is offset by the increased employer premium share.[13] Wage suppression due to premium growth also likely impacts employers insofar as they are unable to offer a competitive wage. Increases in the premium price for this book of business thus have the dual effect of placing Vermont employers at a competitive disadvantage and creating an unsustainable financial burden for Vermont employees.

The burden the proposed premium increase places on Vermonters is particularly worrisome given stagnant Vermont real wage growth. The proposed annualized premium price increase ranges from 13.8 percent to 16.2 percent depending on each member's renewal quarter.[14] In contrast, Vermonters'

[10] GMCB-010-18rr, MVP Actuarial Mem.
[11] Id.
[12] See 2019 OneCare Vermont ACO Budget Submission, https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB%20ACO%20Budget%20Submission%202019%20Final%20%28Supplemental%20Attachment%29.pdf.
[13] 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).
[14] GMCB-010-18rr, L&E Actuarial Mem.

real wages grew by less than 1 percent (0.7%) between 2016 and 2017, the most recent year for which data is available.[15]

Premium growth outpacing wage growth has effects both for individuals and the healthcare system as a whole. First, the growth of premium substitutes for wages. Premium growth thus suppresses wage growth leaving Vermonters both paying more premium and having less income to purchase health care and other necessities.[16] 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 premiums may influence a household's decision to not participate in the health insurance market, especially for healthier households. 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 and free care that hospitals experience. The incidence of bad debt and free care may in turn increase the unit cost for health care services, increase the medical trend, and further increase premium cost.

These outcomes will undermine the long-term economic health of Vermonters, Vermont businesses, and the Vermont healthcare system.

B. Access to Care

The proposed rates do not promote access to care. The fundamental measurable indicator of access to care is Vermonters' ability to pay for needed care. The lack of an affordable premium price directly impedes Vermonters' access to care.[17] Further, MVP has failed to show how the rate increase will enhance its ability to provide services to increase access to care.

[15] Real wage growth, as opposed to nominal wage growth, accounts for inflation. Vt. Dept. of Labor, QCEW Average Wage Data, http://www.vtlmi.info/indnaics.htm#mqa; U.S. Bureau of Economic Analysis, CPI-U Northeast region, https://data.bls.gov/timeseries/CUUR0100SA0?amp%253bdata.

[16] See, Burtless & Milusheva, supra note 13.

[17] Vt. Agency of Human Services, Vermont Household Health Insurance Survey (2014) (According to the 2014 Vermont Household Health Information Survey, the most recent survey available, 13.3% of Vermonters did not seek medical care due to cost in 2014).

C. Quality Care

The proposed rates do no promote quality care. MVP provided no evidence of strategies for improving health and wellness or to improve health outcomes.[18] No evidence was even provided related to fundamental indicators of quality care such as primary care spend and preventative visits.

D. Solvency

The proposed rate unreasonably increases surplus at the expense of Vermonters. As DFR noted in its report on the Filings, "MVPHP's Vermont operations pose little risk to its solvency."[19] No evidence was introduced supporting a contrary position. Because MVP's Vermont premium constitutes such a small percentage of its written premium, 2.9%, it is undisputed that the rates MVP charges in Vermont will not materially affect MVP's solvency.[20]

Despite the lack of concern regarding solvency, the filings propose a 2% CTR. The 2% CTR is not in line with the Board's recently ordered CTR for this book of business.[21] Charging Vermonters for such a large CTR is excessive and unnecessary in light of DFR's statement that MVP's Vermont operations pose little risk to MVP's solvency.

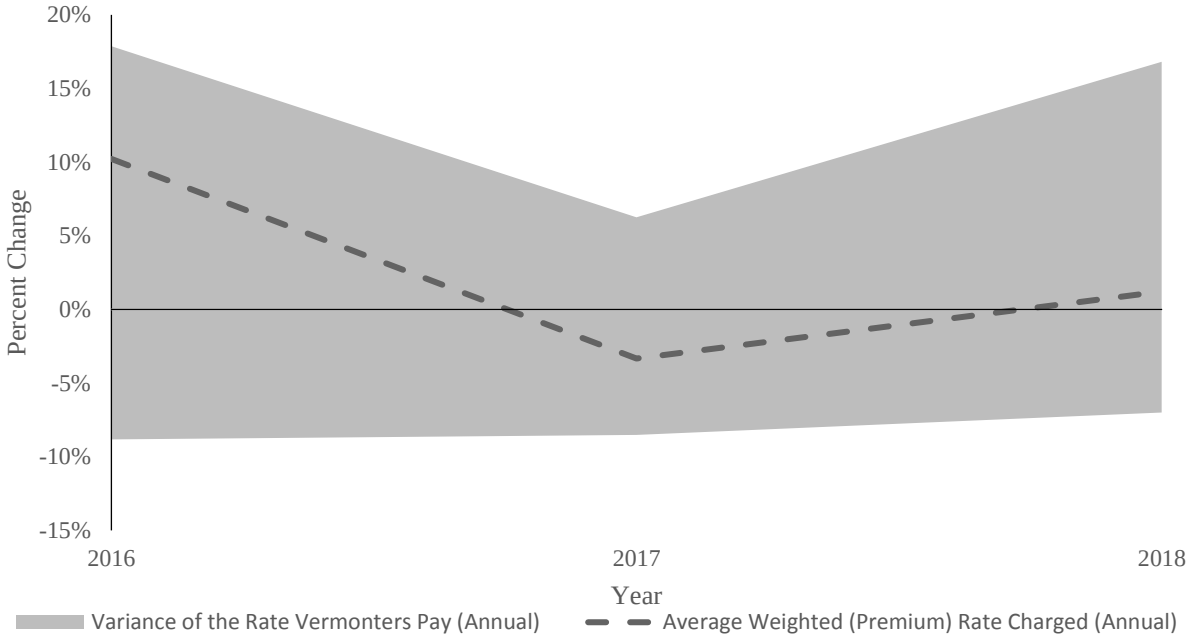
E. Not Unjust, Unfair, Inequitable, or Misleading

The proposed rates are not fair due to the large variance of the actual rates MVP charges Vermonters compared to the Board ordered rates. As this book of business is experience rated, there will always be some variance of the actual rates charged from the approved rates due to the characteristics and experience of the specific groups and the exercise of underwriting discretion when setting specific rates. That being said, variance of more than 10% to 15% from the average premium-weighted rate change should raise concerns about both the carriers' use of excessive underwriting judgement to effectively nullify the Board's regulation and MVP's potentially unfair and inequitable treatment of Vermont policy holders.

[18] GMCB-010-18rr, MVP Actuarial Mem.
[19] GMCB-010-18rr, Dep't Fin. Regulation Solvency Op. at 2.
[20] Id.
[21] GMCB-006-18rr, Decision at 5.

In Figure 1, we graph the average premium-weighted rate change charged and the spread of rate changes charged.

Figure 1. Average premium-weighted rate charged and the rates Vermonters pay.[22]



The size of the variance shows both that the ordered rate only loosely conforms to the actual rate charged and that Vermont policy holders pay substantially different premiums.

F. Not Excessive, Inadequate, or Unfairly Discriminatory

MVP's medical trend, as proposed, is excessive. MVP did not have access to the Green Mountain Care Board's final decisions regarding the 2019 hospital budgets at the time MVP submitted these filings.[23] The final hospital budget cost increases were lower than what MVP had originally projected.[24] Lewis and Ellis, the Board's contracted actuarial firm, recommends that the Board reduce MVP's rates to correct this issue.[25]

[22] GMCB-10-18rr, MVP Answer to Obj. Letter #3.
[23] GMCB-010-18rr, L&E Actuarial Mem., 6-7.
[24] GMCB-010-18rr, L&E Actuarial Mem., 6-7.
[25] GMCB-010-18rr, L&E Actuarial Mem., 6-7.

CONCLUSION

MVP has not demonstrated that the proposed rate is affordable; promotes access to care; promotes quality care; is not unfair, unjust, inequitable, or misleading; is needed to protect insurer solvency; and is not excessive, inadequate, or unfairly discriminatory. As a result, the HCA respectfully requests that the Board recalculate the proposed rate as follows:

- Adopt the Board's actuary's recommendation to incorporate the recent hospital budget orders into the rate;[26]
- Limit the allowed variance from the Board's ordered rate and the rates Vermonters pay to a reasonable amount;
- Incentivize MVP to negotiate stringently with providers by reducing the requested rate increase by 0.5%;
- Incentivize MVP to increase administrative efficiencies and reduce organizational waste by reducing the requested administrate costs by 0.5%;
- Reduce MVP's CTR from 2% to no higher than 1.5%;
- Increase affordability by reducing the requested rate increase by at least 1%.

Recalculating the rates as proposed will not fully address the challenges Vermonters face due to rising premium prices and deductibles. Vermont employers and employees will continue to bear the financial burden of unsustainable premium growth. However, the recalculation will mitigate the harm to Vermonters of the proposed rate increase. Further, such a recalculation would reflect a reasonable balancing among all the factors the Board is statutorily charged to consider. In addition, such a recalculation would better align MVP's rate growth with Vermont's 3.5% ceiling for annual health care cost growth under the all-payer model.

Dated at Montpelier, Vermont this 19th Day of October, 2018.

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[26] GMCB-010-18rr, L&E Actuarial Mem. at 10.

CERTIFICATE OF SERVICE

I, Kaili Kuiper, 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 19th day of October, 2018.

/s/ Kaili Kuiper

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