STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Care 2019 Vermont Health Connect Rate Filing	)	DOCKET NO. GMCB-008-18rr
SERFF No. MVPH-131497138	)	

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 2019 Vermont Exchange Rate Filing, requesting a rate increase by an average of 4.6% across all MVP products.

Findings of Fact

1. **MVP's Amended Rate Increase Request from 6.4% to 4.6% is reasonable and appropriate.** MVP's May 11, 2019 rate filing sought an average rate increase of 6.4%. *See Exhibit 1, MVP Rate Filing, p. 32*; *Matt Lombardo Testimony ("Lombardo"), pp. 32-35.* Lewis & Ellis ("L&E") found MVP's rate request to be adequate and appropriate with three recommended modifications, and an adjustment addressing silver loaded plans. *See Exhibit 11, July 10, 2018 L&E Actuarial Opinion, p. 11*; *Jacqueline Lee Testimony ("Lee"), p. 203.* MVP adjusted its proposed rate from 6.4% to 6.1% to address the silver loaded plans in a manner consistent with L&E (-.3%), modified the impact of the projected risk adjustment to reflect the most recent data available (L&E Recommendation #2) (-1.9%), and considered updated information on hospital budgets (L&E Recommendation #3) (+.5%), to amend its proposed rates to 4.6%. *Ex. 11, p. 11*; *Lombardo, pp. 35-36.* MVP did not adopt L&E's Recommendation #1, a .3% reduction regarding mid-year enrollment. *Ex. 11, p. 11*; *Lombardo, p. 36.* L&E recommends that the Board reduce MVP's rate increase to 3.8%. *Ex. 11, p. 11*; *Lee, p. 203.* Although there is

sufficient evidence to find that the statutory criteria have been met for a rate increase of either 4.6% or 3.8%, MVP requests that the Board find that MVP's 4.6% proposed rate increase is superior.

2. **MVP's adjusted rate increase of .5% for the hospital budgets proposal is reasonable and appropriate.** Vermont hospitals submitted fiscal year 2019 individual hospital budget information to the Board after L&E had completed and filed its July 10 Report. On July 16, L&E asked MVP whether it anticipated that the recent information regarding hospital unit cost increases for 2019 would have an impact on proposed rates, and if so, to provide updated trend build-up by facility, which MVP promptly provided on July 17. *Exhibit 9, 7/17/18 Response Letter #6, p. 1.* MVP found that the effect of those proposed trends on the premium rates in this filing would increase the proposed rate by .5% to be adequate. *Ex. 9, p. 1*; *Lombardo, pp. 54-55.* L&E believes that it is appropriate for MVP to incorporate the updated hospital budget information, and request an increase in rate, but as of July 24, had not yet determined the exact amount of increase it would recommend, wanting to compare prior budget proposals and ultimate approvals. *Ex. 11, pp. 5-7*; *Lee, pp. 195-197.*

In its 2018 Rate decision, the Board established the precedent of considering evidence of the budget proposals of the hospitals, even though hospital budget hearings had not yet been held, and final budget increases had not been approved by the Board. "(T)he hospital budget and insurance rate processes should not be siloed, and the information before us at this time, prior to approving insurance rate increases, should be used to maximize consistency." *2018 Vermont Health Connect Rate Filing, SERFF No. MVPH – 131034103, pp. 8-9.* In its conclusions of law, the Board compared each of the hospitals' proposed to approved rates from 2013-2017 and indicated that the hospital "budget submissions have not deviated substantially from what we have approved." *Id.* In some years, hospital budget proposals could result in a reduction in an

initially proposed insurance rate request, but in other years, an increase. The Board's own actuary stressed the importance of the Board's consistency in considering the hospital budget information. *Lee, p. 192.*

3. **MVP's treatment of mid-year enrollment and terminations is superior to L&E's recommendation.** The benefits offered in the exchange are calendar year benefits, reset on January 1 of each year. Members enroll and terminate throughout the year. A mid-year enrollee would presumably have fewer claims, and be less likely to meet their deductible; however both actuaries acknowledged the uncertainty. *Lee, p. 199*; *Lombardo, pp. 48-50.* To better ensure that it will have sufficient premiums to cover possible claims for mid-year enrollees, MVP takes a more conservative approach than L&E, and assumes members will enroll for a full year for this rate filing. *Ex. 1, p. 27*; *Ex. 11, p. 4*; *Lombardo, p. 50.* L&E projects month-by-month enrollment and termination patterns, however, and if it is incorrect in its assumptions, MVP would need to make up for that difference in its 2020 rate filing. *Lee, pp. 200-201*; *Lombardo, p. 50.* Both L&E and MVP agreed as actuaries that they would prefer to address mid-year enrollment and termination issues for 2019 in this 2019 rate filing rather than a later rate filing. *Lee, p. 201*; *Lombardo, p. 50.* Accordingly, the Board should adopt MVP's approach and decline to reduce the rate by .3% as suggested by L&E. [1]

4. **MVP & L&E's treatment of the federal risk adjustment is reasonable and appropriate.** Both L&E and MVP concur that a reduction of MVP's rate by 1.9% to properly reflect the federal risk adjustment program is reasonable and appropriate for 2019 based on the July 9 final risk transfer results. Recent court decisions that question the use of the risk

[1] Separate and distinct from mid-year enrollment, MVP increased its bad debt expense by .2% of premium, on the assumption that the lack of an individual mandate will incentivize members to stop making payments in the last few months of the policy year, knowing that MVP will still cover claims during this grace period, and also knowing that the member will no longer be penalized for dropping coverage. *Ex. 1, p. 40; Lombardo, pp. 142-44.* L&E did not find this assumption unreasonable or inappropriate. *Ex. 11.*

adjustment at the federal level will not affect this year's filing. *Ex.11, p. 8; Lombardo, pp. 51-53*; *Lee, pp. 184-185.*

5. **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"). *Ex. 1, p. 83*; *Exhibit 10, 7/10/18 DFR Solvency Opinion, p. 2*; *Ex. 11, p. 9; Lombardo, p. 60-64*; *Lee, p. 203*; *Jesse Lussier Testimony ("Lussier"), p. 170.* MVP's proposed 2% CTR is significantly lower than the 8.5%-9% of premium MVP would need to build into its rate to meet minimum reserve requirements for 2019. *Lombardo, p. 59.* All but one of MVP's multiple 2019 commercial rate filings in New York includes a 2% CTR. *Lombardo, pp. 96, 139.* Insurance companies that offer health insurance in multiple states routinely and appropriately calculate CTR based on the block of business in that state and on state specific factors. *See Lee, p. 208*; *See Lussier, pp. 166-67*; *See Lombardo, p. 63.* The same is true for calculating appropriate CTRs for Vermont and for New York due to different circumstances in each state. *See Lombardo, 96-97.* Consequently, CTR of 1.5% for *one* rate filing in New York says nothing about the propriety of a 2% CTR in Vermont. *See Lombardo, p. 63.* Importantly, DFR witness Jesse Lussier was not asked and did not indicate that a 1.5% contribution to reserves would be found adequate by the DFR. *Ex. 10; Lussier, pp. 165-73.*

Even though Vermont is a smaller percentage of MVP's total premium (2.9%), DFR and the Board should look at Vermont specific premiums and this rate filing to determine adequacy. *Ex. 1, Ex. 10, pp. 1-2; Lussier, pp. 168-171*; *Lombardo, p. 62.* The notion that Vermont members need not contribute 2% to reserves because the Vermont business line is only 2.9% of MVP's overall business subverts New York regulator (and the Vermont DFR) opinions and requirements. Furthermore, reserves should be substantial enough so that if an actuarially sound

assumption in a 2019 rate filing turns out to be incorrect, MVP is not required to undertake significant replenishment via even higher rates in its 2020 rate filing. *Lee, pp. 200-01*; *Lussier, p. 169-70.* This Board should not "kick the can" to 2020, and the contributions to reserves for this year should align with the rate filing for this year, so that MVP maintains strength of capital that keeps pace with claim trends. *Ex. 10, p. 2*; *Lee, pp. 200-01*; *Lussier, pp. 169-70.*

6. **MVP is lowering costs, promoting quality care and access, and affordability in this rate filing.** Only about 10% of MVP's proposed rate increase is attributable to overhead and contribution to reserves. *Lombardo, pp. 72, 118.* Furthermore, 10% of the general administrative expense load is used to cover Quality Improvement/Cost Containment Programs in the 2019 Rate Filing. *Ex. 1, p. 83; See Lombardo, pp. 47-48.* 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 Board. *Ex. 1, pp. 30, 43, 85*; *Ex. 11, p. 9; Lombardo, pp. 63-64.* 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 for this population. . . . 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. 11, p. 9.*

MVP increased its Exchange market share from 11-12,000 members (13%) in 2017 to 25,000 members (approximately 30%) of market share. *Lombardo, p. 56.* MVP has fixed and variable administrative costs, which are analyzed on an enterprise-wide level. *Ex. 1*; *Lombardo, pp. 65-66.* Although MVP's membership has grown in Vermont in 2018, its membership in New York has declined, resulting in an overall reduction in members, thus, it is splitting fixed costs over fewer members. MVP's goal is to lower costs. *Lombardo, pp. 66-67.* Any sort of formula or calculus to separate out and allocate Vermont administrative costs might benefit Vermonters

in one year where it has an increase in membership, but could also cause Vermonters to pay higher premium in years where its membership decreases, but the overall membership of MVP increases.

MVP reduces costs, promotes an affordable health benefit, and promotes access and quality of care through: (1) competitive bid processes with its vendors to keep down administrative costs; (2) promoting an affordable rate with a quality product; (3) undertaking an annual initiative focused on reducing administrative costs; (4) its pharmacy team managing costs down as much as possible; (5) analyzing formularies and lower cost generic drug availability; (6) keeping rates affordable and maintaining MVP's premium rate advantage against BCBS; (7) online price comparisons for members to compare providers in their area for access and quality, as well as costs to mitigate out-of-pocket costs; (8) telemedicine – members can use a smartphone or computer to meet with a doctor 24/7 to receive a diagnosis and treatment, fill a prescription, replacing a more costly $150 - $300 urgent care visit with a $40 telemedicine interaction, and the member also saves on gas and avoids travelling in inclement weather; (9) welcome packets to help members understand benefits, to increase utilization and make members healthier; (10) IT improvements; (11) online health and wellness tools, to help members quit smoking and personal health assessments, which include guidance on healthy eating; (12) health care and management programs including helping members to manage their chronic conditions, make sure they are taking their prescriptions, and avoiding higher cost hospitalizations; (13) aligning fees to increase access to primary care physicians in the community, efforts to direct more care to PCPs increasing quality care and access; (14) including credentialing and accreditations in administrative costs; (15) a nationwide network of providers, contracted with CIGNA; (16) keeping indirect costs down (90 cents out of every premium dollar goes to health care expenses) through contract negotiations with doctors, hospitals, and pharmacies; (17)

participating in silver reflective plan efforts to help mitigate loss of the subsidy eliminated by the federal government; (18) offering both standard and non-standard plans so members can compare plans and choose the one that lines up with the benefits they want; (19) the Quality Improvement initiative to reduce costs, reduce inpatient readmissions, reduce medical errors, and include health and wellness initiatives; (20) MVP's special investigation unit monitoring and addressing fraudulent and wasteful claims; (21) coordinating regular meetings with Vermont Health Connect and Blue Cross Blue Shield of Vermont to discuss and create outreach programs and communications to encourage consumers to maintain coverage and make educated decisions in light of CSR defunding and the introduction of the silver reflective plans; (22) creating special enrollment period guidelines and a user-friendly website to help Vermonters who did not start coverage during the open enrollment period determine if they are eligible for a special enrollment period and how they can obtain coverage outside of open enrollment; (23) negotiating rates that reflect appropriate reimbursement levels across all provider types in MVP's network; (24) providing access to health care case managers to help members navigate the health care system and coordinate the member's providers during the decision making process; (25) developing robust evidence-based guidelines such as MVP's Medical Policies and Utilization Management Program designed to decrease unwarranted variations in care and support appropriate utilization. *Exhibit 6, 6/26/18 Response Letter #4*; *Exhibit 7, 7/6/18 Response Letter #5*; *Exhibit 8, 7/6/2018 Response to the Board's Non-Actuarial Questions; Lombardo, pp. 40-41, 59-60, 66-77, 131.*

7. **The likely increase in morbidity on the exchange caused by association health plans should be considered by the Board.** After MVP filed its original rates on May 11, federal law was changed to allow association health plans to purchase insurance outside the Exchange. Although MVP did not adjust its rates to address the effects of this recent change in

the federal law, it anticipates that overall morbidity of exchange members will increase as members exit the Exchange and join these plans. *Lombardo, pp. 79-80.* The MVP rates do not reflect this selection risk, and MVP does not yet have an estimate of the number of MVP members that may exit the Exchange and purchase insurance with an association. MVP is working with stakeholders in Vermont to understand the risks posed. *Lombardo, pp. 112-14.* Although MVP has not amended its rate filing to request an increase for this issue, the Board should consider these ramifications in its overall decision on the MVP rate increase.

8. **The rates are not excessive, inadequate, or unfairly discriminatory, nor are they unjust, inequitable, misleading or contrary to Vermont law.** Pursuant to Actuarial Standards of Practice No. 8 (*rev'd* 2014) ("ASOP 8"), MVP's proposed rate increase as modified is adequate and not excessive because it provides for and does not exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees and have reasonable contingency and profit margins. *Lombardo, p. 78*; *Lee, p. 191. ASOP 8, p. 8.* Pursuant to ASOP 8, MVP's proposed rate increase is not unfairly discriminatory because it does not result in premium differences among the insured within similar risk categories that are not permissible under applicable law, or do not reasonably correspond to differences in expected costs. *Lombardo, pp. 78-79*; *Lee, p. 191.* MVP conducted a thorough analysis of its data, and is comfortable that the premiums that it is offering are reasonable relative to the benefits that are included in the filing, and will maintain minimum solvency requirements in 2019. *Lombardo, p. 76-79*; *Lee, p. 191.* DFR has found the rates adequate. *Ex. 10, pp. 1-2*; *Lussier, pp. 166-167.* Based on the rate filing and all the other evidence submitted at the hearing, including testimony, the rates are not unjust, inequitable, misleading, or contrary to Vermont law because they are actuarially sound and fairly charge premium for services covered, and are reasonable based on the data that MVP analyzed. *Lombardo, p. 77.*

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.* Each piece of evidence in the record could apply to one, multiple, or all of these statutory criteria.

2. The Board must exercise its discretion to consider the affordability, the promotion of care and access to care of this rate filing in a "fair, predictable, transparent, [and] sustainable" manner. *In Re MVP Health Insurance Company*, 203 Vt. 274, 284 (2016). For example, it would be unfair and unpredictable if the Board ignored its precedent and changed its approach year to year in its consideration of hospital budget proposals: considering proposed hospital budgets in MVP's 2018 filing, but ignoring proposed budgets in MVP's 2019 filing.

3. Furthermore, the Board must consider the analysis and opinion of the DFR in making its solvency determination. *8 V.S.A. § 4062(a)(3).* A reduction to a 1.5% contribution to reserves is not supported by DFR in this closed record and the Board may not consider a reduction to 1.5% in the absence of DFR's analysis or opinion on that reduction.

4. Based on all of the evidence, which was substantial, the Board should find that MVP has met its burden of proving that the rate filing, as amended to an average of 4.6%, meets all of the statutory criteria. *8 V.S.A. §§ 4062(a); 5104(a); and, 18 V.S.A. § 9375(b); Exs. 1-14; Lombardo, pp. 29-164; Lussier, pp. 165-173; Lee, pp. 174-217.*

Dated at Burlington, Vermont this 30th day of July, 2018.

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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 upon the following:

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