**STATE OF VERMONT**
**GREEN MOUNTAIN CARE BOARD**

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| In re: MVP Health Plan's 2019 Large Group HMO Rate Filing | ) | Docket #: GMCB-10-18rr |
| In re: MVP Health Insurance Company's 2019 Large Group Point of Service Rate Filing | ) | Docket #: GMCB-11-18rr |

## MVP Health Care's and MVP Health Insurance Company's Combined Memorandum in Lieu of Hearing

MVP Health Plan (MVPHP) and MVP Health Insurance Company (MVPHIC) (referred to as MVP) hereby submit this Memorandum requesting that the Green Mountain Care Board (GMCB) approve the rates as recommended by the Board's actuary, Lewis and Ellis (L&E). MVP is willing to accept the modification recommended by L&E. MVP and the Health Care Advocate have agreed to waive the hearing before the GMCB in this proceeding.

The present filing is the manual and factor rate filing for MVP's large group HMO line of business. Note that MVP has migrated its entire product portfolio sold on the MVPHIC license to MVPHP, and retired the entire portfolio previously sold on MVPHIC. Additionally, MVP has filed several "point of service" optional riders (under the MVPHIC license) that will be offered in connection with the MVPHP products (they are not stand alone products). MVP is proposing these riders to provide out of network coverage as a supplement to the in-network benefit. MVP also added optional riders for wellness and a discount program for various other services, such as acupuncture, exercise centers, fitness clubs and massage therapy. L&E reviewed both filings together and issued one actuarial opinion addressing both filings. Therefore, this Memorandum will cover both product filings.

MVP has proposed annual premium rate changes for manually rated groups of 13.8% for 1Q2019, 14.4% for 2Q2019, 14.8% for 3Q2019 and 16.2% for 4Q2019 for medical and prescription drug coverage. The manually rated group rates are composed

of a manual rate change, an age/gender factor change and a change in retention. MVP has proposed rates for the POS riders that are a percentage of premium to the combined medical and pharmacy manual rates under the group's plan. (See L&E opinion, dated October 5, 2018, paragraph 3 on page one for an example of how this would work). For the wellness and other riders, the rate added was $0.00.

As of May 2018, there were approximately 2,171 members enrolled in these plans. Of these members 85% will renew in 1Q2019.

**L&E Recommendation**

L&E recommends that the rates be approved as filed with one change – the unit cost trends be modified to reflect the Board's orders for 2019 hospital budgets. Notably, they found the rate development methodology for *each* element of the filing (including overall rate development, age/gender factor changes, medical trend, Rx trend, and administrative expenses) to be reasonable and appropriate. The following is a summary of L&E's findings.

Rate development methodology: L&E looked at the medical loss ratio experience, and found that claims in this book have increased rapidly recently. *This has led to a loss ratio of 96.2% in FY 2017, and they are expecting higher loss ratios likely in 2018, possibly approaching 100% and causing MVP to tap into reserves*. They found MVP is taking steps to mitigate the volatility in premiums by increasing its pooling charge assumption to 9.9% from 9.2%. This is expected to reduce projected claims by approximately 15%. Overall, they found MVP's rate development methodology to be reasonable and appropriate.

Age and gender factor changes: L&E found that MVP appropriately corrected for the average age/gender changes in its population, which has been increasing by .6%. If MVP had not corrected for this, it would have resulted in excess revenue being collected. Therefore, MVP decreased its age/gender factors by what L&E said was a necessary .6%. Therefore, they found the normalization methodology to be reasonable and appropriate.

Medical trend: L&E found MVP's use of an annual effective paid medical trend of 4.3% to reflect their most current provider contracting information, resulting in a slight change from prior filings. However, L&E noted that since this filing was made, the Board has made its final decisions regarding the 2019 hospital budgets, and the budgeted cost increases are lower than anticipated at the time the filing was made. They therefore recommended (and this is the only change recommended) the filing be modified to reflect the lower hospital budget amounts. The impact of this recommendation is contained in a chart on page 7, paragraph 3, of the L&E opinion dated October 5, 2018. Finally they noted MVP's planned use of a 0.0% utilization trend to be reasonable and appropriate.

Rx trend: The annualized effective paid trend is 14.6% which blends the allowed trends to get to the projection period and accounts for cost sharing by plan members. MVP used Vermont specific book of business data from its PBM, CVS/Caremark. L&E found MVP's assumptions to be reasonable and appropriate.

Administrative expenses: L&E found MVP's assumption for its general administrative load of 8.9% to be lower than previous filings and is equal to actual 2017 expenses. Some of this is due to a change in the targeted loss ratio (from 86.3% to 86.4%) and other miscellaneous changes. Overall, MVP's general administrative load has decreased by .6% of premium. MVP is proposing to increase its contribution to reserves to 2.0%. L&E did not recommend any decrease in this increased reserve contribution.

Summary: the one change recommended by L&E will result in annual rate changes of 13.2% for 1Q2019, 13.8% for 2Q2019, 14/1 for 3Q2019 and 15.3% for 4Q2019, each slightly lower than what MVP is requesting. L&E found all of MVP's assumptions to be reasonable and appropriate.

**MVP is lowering costs, promoting quality care and access, and affordability in this rate filing**

In addition to the actuarial standard L&E opined on above, 8 VSA 4512(b) and 4062(a)(2)-(3) say the Board shall modify or disapprove a rate request only if it is unjust,

unfair, inequitable, misleading or contrary to law, or …fails to meet the standards of affordability, promoting quality of care and promotion of access.

As noted above. MVP has taken a number of actions in this filing to keep rates as low as possible: 1) steps to mitigate the volatility in premiums by increasing its pooling charge assumption to 9.9% from 9.2% which will prevent any excess revenue from being earned; 2) appropriately corrected for the average age/gender changes in its population, which has been increasing by .6% which will also prevent excess revenue from being earned; 3) agreeing to accept L&E's recommendation to incorporate the actual hospital budget orders from the Board which will lower the increases; and 4) working over the past several years to reduce its administrative expenses, and in this filing the general administrative load has decreased by .6% of premium.

As detailed in its 2019 QHP Rate Filing and detailed at the Hearing (GMCB Docket #008-18rr), MVP further 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) participation in the Blueprint, and in the upcoming MAT pilot programs; (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 and lifestyles; (12) health care and case management programs including helping members 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 (89 cents out of every premium dollar goes for direct 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) 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; (22) negotiating rates that reflect appropriate reimbursement levels across all provider types in MVP's network; (23) 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; (24) 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.

**Conclusion**

Based on the above, MVP asks the Board to approve the filing as recommended by L&E. L&E opined that "the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory" (L&E Actuarial Analysis, October 5, 2018, page 10). Any further modifications made by the Board would not be supported by anything in the record, nor have any actuarial support.

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**Certificate of Service**

I, Susan Gretkowski, hereby certify that I have served the above Memorandum on Judy Henkin, General Counsel to the Green Mountain Care Board, and Kaili Kuiper, Office of the Health Care Advocate, by electronic mail this 19th day of October, 2018.

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