STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2019 Large Group HMO Rate Filing	))))	GMCB-010-18rr SERFF No.: MVPH-131604445
In re: MVP Health Insurance Company 2019 Large Group Point of Service Rider	))))	GMCB-011-18rr SERFF No.: MVPH-131604447

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 August 6, 2018, MVP Health Plan, Inc. (MVPHP) submitted its 2019 Large Group HMO Rate Filing and MVP Health Insurance Company (MVPHIC) submitted its 2019 Large Group Point of Service (POS) Rider to the Board via the System for Electronic Rate and Form Filing (SERFF).[1] On August 14, 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 its appearance as a party to these filings.

On October 5, 2018, the Board posted to the web the Department of Financial Regulation's (DFR) analysis regarding these filings' impact on the insurer's solvency and an actuarial memorandum provided by the Board's contract actuaries, Lewis & Ellis (L&E). The Board solicited written public comments through October 20, 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).

Findings of Fact

1. MVPHP is a nonprofit New York health insurer licensed as a health maintenance organization (HMO) in New York and Vermont. MVPHP is owned by MVP Health Care, Inc.

[1] Because the POS Rider is directly associated with MVPHP's Large Group HMO line of business, we jointly review the filings. The contents of the SERFF filing and documents referenced in this Decision and Order can be found at https://ratereview.vermont.gov/MVP-131604445 (Large Group HMO) and https://ratereview.vermont.gov/node/704 (POS Rider). The rate review website also includes links to past rate decisions cited herein.

(MVP), a New York corporation that offers health insurance plans in New York and Vermont. MVPHP provides large group coverage in Vermont, as well as individual and small group coverage sold on Vermont Health Connect. L&E Actuarial Memorandum (L&E Memo) at 1.

2. This filing demonstrates premium development for MVPHP's large group HMO product for policies beginning January 1, 2019 and ending December 31, 2019. MVP recently migrated its entire large group business to this product and retired the large group Preferred Provider Organization (PPO) product previously offered by MVPHIC. *Id.*

3. MVPHP's large group 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 stand-alone 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. *Id.*

4. As of May 2018, there were 2,171 members enrolled in MVPHP large group plans in Vermont. Of these, 1,853 have a first quarter (1Q19) renewal, 167 have a second quarter (2Q19) renewal, and 151 have a third quarter (3Q19) renewal. No members have renewals in the fourth quarter (4Q19). SERFF Filing, MVPHP Actuarial Memo (MVP Memo) at 1.

5. MVPHP proposes a 13.8% average annual rate increase for members renewing in 1Q19, a 14.4% increase for 2Q19 renewals, a 14.8% increase for 3Q19 renewals, and a 16.2% increase for 4Q19 renewals.[2] On a quarterly basis, the carrier proposes a 9.9% increase from 4Q18 to 1Q19, a 2.0% increase from 1Q19 to 2Q19, a 1.6% increase from 2Q19 to 3Q19, and a 2.1% increase from 3Q19 to 4Q19. L&E Memo at 2.

6. MVPHP used large group claims incurred from May 2017 through April 2018 and paid through May 2018, with incurred estimates updated through June 2018. MVPHP's claims experience increased rapidly during this period, with claims exceeding $100,000 making up 25.3% of the base period experience. L&E Memo at 3-4, 6. MVPHP's projected rates in this filing assume that the recent poor claims experience will not continue. *Id.* at 2-3 .

7. To help mitigate the impact of high cost claims, MVPHP replaced claims in excess of $100,000 with a pooling charge equal to 9.9%, up from 9.2% in the previous filing. *Id.* at 3-4.

8. MVPHP has increased its traditional medical loss ratio (MLR) target from 81.2% in its 1Q18 filing to 86.4% in this filing. For calendar year 2017, the actual loss ratio for this book of business was 96.2%. MVP Memo at 1; L&E Memo at 6.[3]

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[2] MVPHP's initial filing reflected slightly lower proposed increases, which were the result of errors in calculation. The errors were discovered and corrected during the course of our review.

[3] The ACA requires insurers providing large group coverage to spend at least 85% of premium dollars on medical care (an 85% MLR) or provide rebates to their customers. Traditionally, insurers could only include the portion of premium they paid out in health care claims within the MLR. Under the ACA, however, insurers are allowed to include expenditures for quality improvement activities, taxes, fees, and regulatory costs within the calculation. *See generally* https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (Kaiser Family Foundation MLR Fact Sheet).

9. MVPHP adjusted its age/gender factor, resulting in a revenue decrease of 1.6% from the 1Q19 manual rate of 22.9%. Changes to its retention costs/target loss ratio further reduced the 1Q19 revenue change by 6.0%. MVP Memo at 1-2; L&E Memo at 5, 8-9.

10. MVPHP projected its experience forward using an annual paid medical trend assumption of 4.3%, which incorporated a 0.0% utilization trend. L&E Memo at 4-5.

11. Based on allowed pharmacy trends provided by its pharmacy benefits manager (PBM) and reflecting the company's Vermont book of business, MVPHP projects an annualized effective paid pharmacy trend of 14.6%. MVPHP projects increases in unit cost and utilization for Generic and Specialty drugs, and that Brand drugs will increase in unit cost but decrease in utilization. L&E Memo at 5; 7-8.

12. MVPHP assumes a general administrative expense load of 8.9% of premium, which is lower than the assumption used in its previous large group filing, *see* Docket no. 007-18rr (the Board reduced proposed 9.7% trend to 9.5%) and equal to its 2017 calendar year expenses. The filing assumes a 2.0% contribution to reserves (CTR). L&E Memo at 8.

13. Because there is a moratorium on collection of the ACA Health Insurer Provider Fee for calendar year 2019, MVPHP did not include the fee in its annual rates for members renewing in 1Q19. Assuming that the fee will be reinstituted for 2020, however, MVPHP included its cost in rates for members renewing in 2Q19, 3Q19, and 4Q19, based on the portion of the enrollees' plan year falling within 2020. *Id.*

14. On September 5, 2018, the HCA filed suggested questions for the Board to ask the insurer. Based on the HCA's submission, the Board asked the insurer two questions relating to underwriter's judgment, and the rate variance among the large groups. The insurer's September 26, 2018 response to the questions referenced its Experience Rating Addendum which outlines relevant factors—which it summarized in the response—that may be considered in the underwriting process. *See* Objection Letter #3.

15. 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 New York State, MVP's primary regulator, has not expressed any 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 MVPHP's Vermont operations pose little threat to the company's solvency. DFR opined that the rates as filed will promote MVPHP's solvency, absent a finding by L&E that they are inadequate. DFR Solvency Analysis at 2.

16. L&E reviewed the filing and recommends that the Board adjust the unit cost trend to reflect the hospital budgets established by the Board while this filing was pending. The

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For 2016, the average federal MLR in the large group market was 90.3%. *See* Center for Consumer Information & Insurance Oversight, *Summary of 2016 Medical Loss Ratio Results* (Dec. 28, 2017) at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html. MVPHP's federal MLR target for this filing is 87.4%. *See* SERFF Filing at 14.

modification would reduce the medical trend from 4.3% to 4.0%, and the average annual rate increases to 13.2%, 13.8%, 14.1%, and 15.3% for the four consecutive quarters of 2019. As modified, L&E opines that the filings do not produce rates that are excessive, inadequate, or unfairly discriminatory. L&E Memo at 10.

17. In its memorandum in support of the filing, MVPHP agrees to accept L&E's recommendation to adjust unit cost, but requests that the Board otherwise approve the filing as submitted. The carrier references information provided in its 2019 Vermont Health Connect Rate Filing, *see* Docket no. 008-18rr, that details actions it has taken to control premium growth, reduce overall costs, and promote quality of care. MVPHC's and MVPHIC's Combined Memorandum in Lieu of Hearing at 3.

18. The HCA contends that the carrier has failed to demonstrate that the proposed rates are affordable and not unfair. The HCA requests that the Board: (1) accept L&E's recommendation to reduce the unit cost trend; (2) limit rate variance "to a reasonable amount"; (3) reduce the increase by 0.5% to incentivize the carrier "to negotiate stringently with providers"; (4) reduce administrative costs by 0.5% to incentivize the carrier to adopt administrative efficiencies; (5) reduce CTR to no higher than 1.5%; and (6) reduce the rate by at least 1.0% for affordability. HCA Memorandum in Lieu of Hearing (HCA Memo) at 7.

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). The Board must consider DFR's analysis and opinion of the proposed rate's impact on an insurer's solvency and reserves, and any public comments received on the filing. 8 V.S.A. §§ 4062(a)(2)(B), (3); 4062(c)(2)(B); GMCB Rule (Rule) 2.000, § 2.201. In the course of its review, the Board takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. *See* 18 V.S.A. § 9375(b)(6). And while the Board's review includes an analysis using commonly defined and accepted actuarial standards—rates cannot be "excessive, inadequate, or unfairly discriminatory," *see* Rule 2.000, § 2301(b)—other review standards are "general and open-ended" and reflect "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16.

The burden falls on the insurer proposing a rate increase to justify the requested rate. Rule 2.000, § 2.104(c).

Conclusions of Law

We agree with the HCA that the rates proposed in this filing—ranging from a 13.8% annual increase in 1Q19 to a 16.2% increase in 4Q19—are substantial. The supporting data show, however, that the significant rate increases are largely driven by recent claims experience that has outpaced trend and produced loss ratios that exceed the carrier's reasonable MLR targets. Findings of Fact (Findings) ¶ 6, 8. We find it particularly striking that claims exceeding $100,000 made up 25.3% of the base experience period. Finding ¶ 6. While the 9.9% pooling

charge will mitigate this issue to some extent, *see* Finding ¶ 7, it will not fully compensate the carrier for the increased claims cost. Absent improved claims experience for the plan membership—which the carrier anticipates in this filing, *see* Finding ¶ 6—the 2019 rates could be inadequate to cover member claims and the carrier's costs of administering the plans. Against that backdrop, we modify the filing as explained below.

We first agree with our actuaries' recommendation that the medical unit cost trend should be reduced to incorporate the results of our recent hospital budget decisions. Finding ¶ 16. This modification lowers the paid medical trend by approximately 0.3%, although we note that the resulting trend is higher than the one we approved in the previous filing for this same book of business. *See* Docket no.007-18rr (medical trend of 2.8%). Accordingly, we expect MVPHP to work to shift the rate of growth downward, and again remind the company that it must rigorously negotiate with providers to achieve reimbursement levels that lower health care costs and advance state health reform goals.

We next note that the prescription drug trend in this filing is high, despite being based on Vermont-specific data and consistent with those we have recently approved.[4] Specific to this filing, the carrier is projecting a continued rise in the utilization of specialty drugs and an increase in unit costs across all drug categories. Finding ¶ 11. Although we do not order a reduction in the trend at this juncture, we expect the carrier to closely monitor drug pricing and utilization and update its formulary as needed to slow the high rate of growth in pharmacy spending.

We also decline to order a reduction in administrative costs at this time, as has been requested by the HCA. HCA Memo at 7. At 8.9%, the expense load is lower than in the previous filing, and consistent with the carrier's administrative spending in 2017. Finding ¶ 12. However, we again remind the carrier that we expect it to increase administrative efficiencies that will help control rising premiums, and reduce the administrative burden on providers. In addition, if the Health Insurer Provider Fee is not reinstated for calendar year 2020, *see* Finding ¶ 13, the carrier must reduce premiums for members with 2Q19, 3Q19, and 4Q19 renewal dates.

The HCA has also requested that the Board limit the rate variance allowed between the large groups covered by this filing. *See* HCA Memo at 5-6. In accordance with current law, large groups are experience-rated, rather than community-rated, and each group's claims experience (as well as factors such as enrollee plan selection) will unavoidably produce variations in rates. Although the insurer's Experience Rating Formula allows for some adjustment to rates based on "underwriter's judgment," such adjustments are supplemental to claims experience, and tied to specific, relevant rating considerations. *See* SERFF Filing, *MVP Large Group Experience Rating Formula*; MVP Response Letter 3 (considerations include variability in claims experience, changes in group size, participation levels, sponsor contribution levels, number of plan offerings, and stability of covered population). We therefore decline to order this adjustment.

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[4] Each of the three most recent rate filings reviewed by the Board include drug trends consistent with this filing: Docket nos. 007-18rr (MVPHP Large Group Filing with 14.7% paid drug trend); 008-18rr (MVPHP Individual and Small Group Filing with 13.3% paid drug trend); and 009-18rr (BCBSVT Individual and Small Group Filing with 13.3% allowed drug trend).

Next, consistent with modifications we have ordered in other rate filings, we order that the carrier reduce its proposed CTR from 2.0% to 1.5%. *See, e.g.* Docket no. 008-18rr (CTR reduced from 2.0% to 1.5% in Vermont Health Connect filing); Docket no. 007-18rr (CTR reduced from 2.0% to 1.0% in Large Group filing). As discussed in DFR's Solvency Analysis, MVPHP's operations in Vermont represent only a small percentage of its overall business. Finding ¶ 15. We therefore conclude that a minimal reduction of 0.5% in CTR will pose no threat to the insurer's solvency.

Finally, to lessen the impact of this sizeable rate increase on Vermonters, we order the carrier to implement an additional rate reduction of 1.0%. The additional 1.0% reduction makes rates more affordable for Vermonters—the Board is expressly charged with considering affordability in its decision-making process—and should incentivize the carrier to streamline its operations and institute innovations that improve care delivery, health outcomes, and reduce health care costs.

Order

For the reasons discussed above, we order that MVPHP: (1) reduce the medical unit cost trend by 0.3%; (2) reduce CTR from 2.0% to 1.5%; and (3) reduce the rates by an additional 1.0% to make them more affordable. With these modifications, the average annual rate increase is reduced to approximately 11.5%, with increases of approximately 11.5%, 12.1%, 12.4%, and 13.5% for members renewing in 1Q19, 2Q19, 3Q19, and 4Q19, respectively. In addition, we order that the insurer reduce the rates of members renewing in 2Q19, 3Q19, and 4Q19 by the amount attributable to the Health Insurer Provider Fee, if the fee is not reinstated for 2020.

As modified, we approve the filing.

SO ORDERED.

Dated: November 2, 2018 at Montpelier, Vermont

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

Filed: November 2, 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:thomas.crompton@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, if any, must be filed with the Clerk of the Board within ten days of the date of this decision and order.