STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2020 Individual and Small Group Market Rate Filing	)	GMCB-005-19rr
	)	SERFF No. MVPH-131934219

DECISION AND ORDER

Introduction

On May 10, 2019, MVP Health Plan, Inc. (MVP), one of the two carriers offering qualified health plans in Vermont, proposed an average annual rate increase of 9.4% over 2019 individual and small group rates, with plan-level increases ranging from 5.0% to 23.7%. Following a review by Lewis & Ellis (L&E), the Green Mountain Care Board's (GMCB or Board) contract actuaries, MVP increased its proposed rate from 9.4% to 10.9%. Based on our review of the record, the testimony and evidence presented at hearing on July 22, 2019, and guided by our statutory directives and commitment to approve the most affordable rates possible without threatening the carrier's financial stability—thus enabling it to continue to offer health insurance in Vermont's individual and small group market—we modify the rates downward from 10.9% as explained below, and then approve the filing for an annual average rate increase of 10.1%.

Background

1. The Patient Protection and Affordable Care Act (ACA), signed into law on March 23, 2010, fundamentally changed the federal government's role in regulating health insurance and required the establishment of state health insurance exchanges where individuals, families, and small businesses could shop for qualified health insurance coverage. In 2011, the Vermont Legislature enacted Act 48, which, among other reforms, created Vermont Health Connect, the state's health benefit exchange (VHC or "the Exchange"). VHC allows individuals, families, and small employers (up to 100 employees) to compare qualified health plans (QHPs) with rates based on a single risk pool, or "merged market." *See* 33 V.S.A. §§ 1803, 1811.

2. Health insurance plans are offered in Vermont's merged individual and small group market in bronze, silver, gold, and platinum metal levels; catastrophic coverage is also available to qualifying individuals.[1] *See* 42 U.S.C. § 18022(d)(1). Each of the four metal levels corresponds to an "actuarial value" (AV)—the expected percentage of claims for essential health benefits that a health insurer will cover on average. The bronze plans have the lowest AV and least generous coverage, while the platinum plans, with the highest AV, have the most generous coverage.

[1] Catastrophic coverage, which is characterized by low premiums and high deductibles, is available primarily to persons under thirty years of age. *See* 42 U.S.C. § 18022(e).

3. The ACA and state law incorporate several mechanisms to make health insurance plans offered on the exchange more affordable for individuals without employer-sponsored insurance. Taxpayers may be eligible for premium assistance (based on a percentage of their household incomes and calculated relative to the second lowest cost silver plan) through federal advanced premium tax credits (APTCs)[2] that can be applied to the cost of any metal level plan. *See* 26 U.S.C. § 36B.

4. The ACA also requires insurers to reduce out-of-pocket costs for enrollees earning from 100% to 250% of the federal poverty level (FPL) through cost sharing reductions (CSRs). 42 U.S.C. § 18071. The federal government used to offset the cost of CSRs by making payments directly to insurers. In October 2017, however, the federal government announced that it would stop making CSR payments to insurers, notwithstanding the insurers' continued obligation to offer CSRs to enrollees. Letter from Eric Hargan, Acting Secretary, U.S. Dep't of Health & Human Services, to Seema Verma, Administrator, Centers for Medicare & Medicaid Services (Oct. 12, 2017).[3] To date, the federal government has not resumed making CSR payments to insurers.

5. In addition to federal premium assistance, Vermonters at or below 300% of the FPL who purchase coverage through VHC are eligible for Vermont premium assistance that reduces their premium contribution by 1.5% below the amount available under the federal law, *see* 33 V.S.A. § 1812(a), and Vermont cost-sharing assistance that further reduces their deductibles and copayments. 33 V.S.A. § 1812(b).

6. As of January 2019, approximately two out of every three Vermonters in the individual market received APTCs. Many of these Vermonters also received additional state or federal assistance such as CSRs to reduce their premiums and out-of-pocket costs. Dep't of Vermont Health Access (DVHA), Health Coverage Map (June 7, 2019).[4]

7. Central to its reform provisions, the ACA includes an "individual mandate" requiring that individuals and families have qualifying health insurance coverage[5] or pay a penalty on their personal income tax returns. *See* 26 U.S.C. § 5000A. The Tax Cuts and Jobs Act (TCJA), enacted by Congress in December 2017, eliminated the imposition of a penalty beginning in plan year 2019 for failure to purchase qualifying coverage.

8. To help counteract the elimination of the penalty associated with the federal individual mandate, the Vermont Legislature in its 2018 session enacted Act 182. The Act requires Vermonters to maintain minimum essential health coverage beginning in 2020; established a working group to make recommendations and issue a report regarding enforcement of the mandate,

[2] Taxpayers can choose to have the estimated credit computed and paid to the insurance company to lower monthly premiums or can claim the benefit when filing their tax return for the year. APTCs must be reconciled with actual income when the taxpayer files his or her annual tax return. *See* IRS Questions and Answers on the Premium Tax Credit, *available at* https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.

[3] https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf

[4] https://info.healthconnect.vermont.gov/sites/hcexchange/files/Health_Coverage_Map-2019Mar%20v2.pdf.

[5] Qualifying coverage includes insurance provided by or through an employer, insurance purchased through a health benefit exchange, or government-sponsored coverage that meets federally mandated minimum levels of coverage.

with the enforcement mechanism to be enacted by the 2019 Legislature; and required that DVHA and stakeholders engage in outreach and education to encourage Vermonters to retain insurance for the 2019 and 2020 plan years. Act 182 (2018).[6] The working group formed under Act 182 ultimately agreed that "there should be a continued focus and additional emphasis on outreach about health care coverage as a key mechanism to maintain and increase coverage and that improved monitoring and timeliness of data on the uninsured is a good idea" but the group did not reach consensus on whether to recommend a financial penalty. *See* Individual Mandate Working Group Report (Nov. 1, 2018).[7] In its 2019 session, the Vermont Legislature enacted Act 63. This Act requires taxpayers to report whether they have had minimum essential health insurance coverage during the tax year on their tax return and puts a process in place for targeted outreach to those without minimum essential coverage. *See* Act 63 (2019), Sec. 1.[8]

9. Despite the concern about the negative impact the elimination of the federal penalty for the individual mandate could have on enrollment through VHC, the absence of a penalty did not seem to impact enrollment for the 2019 plan year. In February 2019, DVHA reported that while there were significant changes in federal and state policy in 2018, "enrollment in Vermont's individual health plans remained stable from 2018 to 2019. The number of new members, subsidized members, and unsubsidized members all exceeded the prior [2018 plan] year." Vermont's 2019 Individual Enrollment in Five Graphs (Feb. 2019), 2.[9]

10. To help stabilize premiums across the market, the ACA includes a risk adjustment program. Under this program, insurers with an enrolled population with lower than average actuarial risk provide payments to insurers whose population has higher than average actuarial risk. The risk adjustment program is intended to reduce incentives for insurers to avoid high-risk enrollees by structuring plan offerings to make them most attractive to a healthy, low-risk population, while unattractive to a less healthy population more in need of health care services.

11. By final rule in 2019, HHS made several changes related to the risk adjustment program that are intended to ensure the integrity of the results of risk adjustment, and others intended to alleviate issuer burden associated with complying with risk adjustment data validation requirements. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 17454, 17457 (Apr. 25, 2019). The changes to the HHS risk adjustment program relate to the determination of the final coefficients for the 2020 benefit year, and the data sources used to calculate those coefficients. *Id.* at 17459.

12. To help fund federal and state marketplaces, the ACA also includes a Health Insurance Providers Fee based on a covered entity's share of net premium in the prior year. *See* 26 C.F.R. Part 57. Congress imposed a moratorium on collection of the fee for plan year 2017. The fee was resumed for 2018 and was again suspended for the 2019 calendar year. *See* Internal Revenue Service, Affordable Care Act Provision 9010 - Health Insurance Providers Fee (June 15, 2018)

[6] https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT182/ACT182%20As%20Enacted.pdf
[7] https://legislature.vermont.gov/assets/Legislative-Reports/Individual-Mandate-Working-Group-Report.pdf
[8] https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT063/ACT063%20As%20Enacted.pdf
[9] https://info.healthconnect.vermont.gov/sites/hcexchange/files/2019%20Individual%20Enrollment%20Recap.pdf

(IRS guidance explains fee calculation and moratorium).[10] Absent a new moratorium, which is unlikely, the fee will resume in 2020.

13. The U.S. Department of Labor (DOL) adopted a final rule in June 2018 that expanded the ability of small employers and sole proprietors to band together to purchase large group coverage under an Association Health Plan (AHP). Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912, 28912-28964 (June 21, 2018).[11] The next month, twelve state Attorneys General brought an action in the U.S. District Court for the District of Columbia to vacate and set aside DOL's final rule. Complaint for Declaratory and Injunctive Relief, Case 1:18-cv-01747.[12]

14. On March 28, 2019, the U.S. District Court for the District of Columbia invalidated major portions of DOL's final rule. *New York v. United States Dep't of Labor*, 363 F. Supp. 3d 109, 141 (D.D.C. 2019). DOL appealed the district court's ruling on April 26, 2019 but did not request a stay. On June 13, 2019, the Vermont Department of Financial Regulation (DFR) issued guidance addressing the status of AHPs in Vermont in light of the federal court's decision. The guidance clarifies that AHPs formed under DOL's final rule will not be permitted to operate in Vermont beyond 2019, and members of these AHPs will need to seek alternative coverage for 2020. DFR Insurance Bulletin No. 205, *Vermont Association Health Plans* (June 13, 2019).[13]

Procedural History

15. On May 10, 2019, MVP filed its 2020 Individual and Small Group Market Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The filing outlines the development of proposed rates for coverage commencing January 1, 2020 and proposes an average annual rate increase of 9.4% with plan-level increases ranging from 5.0% to 23.7%. Exhibit (Ex.) 1 at 2.[14]

16. On May 17, 2019, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care services and health insurance, entered a Notice of Appearance as an interested party to the proceeding. *See* 8 V.S.A. § 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule (Rule) 2.000 §§ 2.105, 2.202, 2.307.

17. From May 10 through July 25, 2019, the Board requested that MVP respond to a series of interrogatories, including questions provided to the Board by the HCA and submitted to the company on the HCA's behalf. MVP provided responses to the Board's interrogatories. *See* Ex. 3-8.

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[10] https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

[11] https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans

[12] https://ag.ny.gov/sites/default/files/complaint_as-filed.pdf

[13] https://dfr.vermont.gov/reg-bul-ord/vermont-association-health-plans

[14] The exhibits referred to in this decision were stipulated to by the parties, and the page numbers refer to the numbers as shown in the admitted exhibits. All documents, hearing transcript, and public comments referenced in this Decision and Order are available at https://ratereview.vermont.gov/MVP-health-connect-2020.

18. On May 23, 2019, MVP submitted an amended filing (Exhibit 2) to address an error in its initial filing (Exhibit 1).

19. On July 10, 2019, DFR issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency. Ex. 10.

20. L&E conducted a review of the filing and on July 9, 2019, issued an actuarial memorandum summarizing its analysis and recommendations (based on MVP's May 23rd amended filing and responses to interrogatories to date). On July 16, 2019, L&E issued an amended actuarial memorandum to correct two errors in the July 9, 2019 memorandum; the corrections did not affect L&E's recommendations as to MVP's proposed rates. Ex. 9.

21. The Board held an administrative hearing on the proposed rates on July 22, 2019, at the Vermont State House. GMCB General Counsel Michael Barber served as hearing officer by designation of Board Chair Kevin Mullin. Gary F. Karnedy, Esq. of Primmer Piper Eggleston & Cramer, P.C. represented MVP and presented testimony from MVP's Director of Actuarial Services, Matthew Lombardo. Jay Angoff, Esq. of Mehri & Skalet in Washington D.C. represented the HCA, assisted by local counsel Kaili Kuiper and Eric Schultheis, and Chief Health Care Advocate Michael Fisher testified on behalf of the HCA. Jesse Lussier testified for DFR regarding its solvency analysis. GMCB Associate General Counsel Amerin Aborjaily led the direct testimony of Jackie Lee of L&E, the Board's consulting actuary.

22. During its testimony at the July 22nd hearing, MVP requested an 11.0% average annual rate increase (up from MVP's initial proposed rate of 9.4%), which included a 0.5% rate increase to account for the recently filed Vermont hospital 2020 budget submissions. Hearing Transcript (Tr.) at 19, 33-38.

23. Following the hearing, MVP responded to an L&E interrogatory and provided quantitative support for MVP's proposed 0.5% increase for recently filed Vermont hospital budget submissions. *See* L&E Objection Letter 5 (Jul. 24, 2019); MVP Response to Objection Letter 5 – Confidential (Jul. 25, 2019).

24. During the course of the hearing, the Board requested additional information from MVP concerning the company's quality improvement and care management programs, telemedicine visits, the status of *Common Ground Healthcare Cooperative vs. US*, the company's online cost comparison website, trends in unwanted variations in treatment, the status of its contract with the Green Mountain Surgery Center, additional information regarding MVP's fixed and variable costs, and the colonscopy screening requirement. GMCB Request for Supplemental Information (July 24, 2019) at 1-2.

25. A special public comment period began on May 13, 2019 and closed on July 25, 2019. The Board received approximately 600 written comments, an unprecedented number. The Board also accepted public comment from Vermonters who chose to speak in person at a public comment session held on July 23, 2019 from 4:30 p.m. to 6:30 p.m. Commenters overwhelmingly requested that the Board deny any rate increases, stated that health insurance and health care in general is unaffordable—many offering personal accounts of their own or their families' difficulties in

accessing or paying for care — and numerous commenters urged the Board to implement a single payer system.

26. On July 25, 2019, DFR notified the Board that MVP's 2020 QHP forms had been approved.

27. On July 29, 2019, MVP submitted written responses to the Board's Request for Supplemental Information and indicated that its contract with Green Mountain Surger Center would have a 0.1% reduction in the rate (for a total requested rate of 10.9%).

28. On July 29, 2019, HCA and MVP filed post-hearing memoranda with the Board.

29. On July 30, 2019, L&E issued an addendum to its actuarial memorandum (L&E Addendum).

Findings of Fact

30. MVP is a non-profit health insurer domiciled in New York State and licensed as a health maintenance organization (HMO) in New York and Vermont. The company is a subsidiary of MVP Health Care, Inc., a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries, and which, according to its financial statements, has more than 370,000 members across New York and Vermont. MVP offers HMO products to individuals in Vermont's large group, individual, and small group health insurance markets.

31. MVP developed the rates in this filing for QHPs offered through VHC and for reflective silver plans offered off the exchange, with coverage beginning January 1, 2020 and ending December 31, 2020.

32. MVP has garnered an increasing market share in Vermont as a result of its competitive pricing. Based on its February 2019 membership, MVP projects that its 2020 filing will cover 11,696 policyholders, 20,156 subscribers, and 30,887 members. Ex. 2 at 22. By comparison, MVP had 6,614 members as of March 2016. *See* GMCB Docket No. 007-16rr (MVP 2017 VHC rate filing).

33. To develop its 2020 rates, MVP used as its base experience period claims incurred between January 1 and December 31, 2018 and paid through February 28, 2019. MVP restated its incurred medical claim estimates to complete the claims through March 31, 2019. Ex. 2 at 23.

34. In 2018, MVP requested a market-wide adjustment for the 2019 MVP rate filing to address the impact of the elimination of the federal individual mandate penalty on enrollment. *See* Tr. at 87-88. However, based on data provided by the Department of Vermont Health Access (DVHA) which indicated that enrollment in January 2019 was unaffected by the removal of the federal individual mandate penalty, MVP removed the market-wide adjustment in its proposed premium rates for 2020. Ex. 2 at 26; Ex. 9 at 5; Tr. at 87-88.

35. MVP projected the experience period claims forward to the rating period using an average annual allowed medical trend factor of 4.2%. As initially filed, the medical trend incorporated a 0.0% utilization trend and a 4.2% unit cost trend. Ex. 2 at 28. In response to an interrogatory requesting that the company provide support for the medical unit cost trend assumptions for Vermont providers that are governed by the GMCB and all other providers, MVP provided the information weighted by facility and physician trends on a confidential basis. *See* Ex. 3, 3a.

36. As initially filed, MVP's unit cost trend of 4.2% incorporated known and expected contractual increases with providers in its network. In response to an interrogatory from L&E, MVP determined that it had made an error in calculating its allowed unit cost trend and amended its filing to reflect an allowed unit cost trend of 3.7% rather than 4.2%.[15] Ex. 9 at 5-6*;* Tr. at 32.

37. As amended, MVP's unit cost trend resulted in a 2.5% unit cost trend increase for Vermont facilities and providers impacted by the Board's hospital budget review, and a 5.5% increase for other facilities and providers. Ex. 9 at 5. Vermont hospitals submitted their FY2020 budgets in July 2019, after MVP submitted its 2020 Individual and Small Group Rate Filing. Hospitals will present their budgets to the Board from mid- to late-August 2019. GMCB FY 2020 Hospital Budget Hearing Schedule.[16] The Board will establish each hospital's budget by September 15, 2019, pursuant to 18 V.S.A. § 9456. Because at the time it developed its rates MVP had not finalized its negotiations with Vermont hospitals and proposed hospital budgets had not been submitted to the Board, MVP assumed in its initial filing that 2020 hospital budget increases would match 2019 increases. Ex. 9 at 5-6*;* Tr. at 32.

38. MVP included within its rates non-claim expense plan level adjustments that do not vary by plan, including a 1.6% increase for federal and state taxes and fees,[17] a 1.5% increase for contribution to reserves (CTR), and an increase from $39.80 to $42.00 in general administrative expenses.[18] MVP attributes $2.52 of the $42.00 to quality improvement and cost containment programs. Ex. 2 at 31; Ex. 9 at 13-14.

39. MVP adjusted rates at the plan level by 0.4% of premium for an increase in bad debt, based on historical data.[19] Ex. 2 at 32; Tr. at 28-29.

40. MVP has targeted a traditional medical loss ratio (MLR) of 88.6% and a federal MLR of 90.6%. Ex. 2 at 33.

41. In its filing, MVP initially assumed a 1.0% increase to market-wide average morbidity due to Association Health Plans from the experience period to the rating period. Ex. 2 at 27.

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[15] As originally filed, MVP calculated its unit cost trend using *proposed* 2019 hospital budgets rather than approved 2019 hospital budgets.

[16] https://gmcboard.vermont.gov/sites/gmcb/files/Hospital%20Budget%20Calendar-revised%20comment%20periods.pdf

[17] The reinstatement of the ACA Health Insurer Tax for the 2020 plan year accounts for 1.0% of the 1.6% increase.

[18] Although the $42.00 PMPM is an increase from the 2019 Exchange filing's assumption of $39.80, the 2020 premium is also increasing from the 2019 Exchange filing and therefore the administrative expenses, as a percentage of premium, are decreasing by 1.0%. Ex. 9 at 13.

[19] Compared to BlueCross BlueShield of Vermont's bad debt trend of 0.1%.

However in recognition of the ruling by DFR prohibiting current 2019 AHPs from operating in 2020, MVP removed the AHP morbidity load on claims for a reduction of 0.8% on the proposed average rate increase. Ex. 2 at 27; Ex. 6 at 1; Ex. 9 at 11, 15; Tr. at 40, 82-82.

42. MVP proposed a 1.5% CTR to protect itself against unanticipated liabilities and to help meet New York statutory reserve requirements. Ex. 2 at 32; Tr. at 57-58. New York regulators require that the company reserve a minimum of 12.5% of overall premium, and MVP has targeted a range of between 16% and 20%. Tr. at 76. At approximately 14.5% - 15.0% of premium, MVP is currently below its target range but above the minimum regulatory requirement. Tr. at 76, 100. DFR issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency. *See* Ex. 10. Noting that in 2018 MVP's Vermont book of business accounted for approximately 4.8% of its total premiums written, DFR opined that the rates as proposed would not have a negative impact on the company's solvency, but that "adequacy of rates and contribution to surplus are necessary for all health insurers in order to maintain strength of capital that keeps pace with claims trends." *Id.* at 1-2.

43. Notwithstanding the significant growth of MVP's Vermont membership, Vermonters' PMPM costs for administrative expenses in this year's filing have increased from $39.80 to $42.00. Ex. 9 at 13. MVP spreads its fixed costs "enterprise-wide" across its Vermont and New York business, and many functions, such as the claims operating system, are located and performed in New York where the company is headquartered and where its membership—though still significantly larger than Vermont's—is still declining. Tr. at 56, 130-40. MVP's actuary testified that as MVP's Vermont membership grows over time, the Vermont fixed costs would go down on a PMPM basis, but that there is still the enterprise-wide fixed costs; he was unable to confirm how the benefit of Vermont's increased membership would be passed to Vermonters. *Id*.

44. Based on its review of the filing, L&E recommended six modifications which would affect the proposed rates. First, L&E recommended that MVP fix its medical unit cost trends for facilities under the GMCB's jurisdiction to reflect the approved 2019 hospital budget, rather than the proposed hospital budgets that were unintentionally reflected in the initial filing, reducing the premiums by approximately 0.9%. Ex. 9 at 15. As noted in L&E's memorandum, MVP acknowledged this error early in the review period and amended its filing on May 23rd to reduce the proposed rate increase by 0.9%. Tr. at 32-33; *see also supra* Findings of Fact (Findings), ¶ 35-36.

45. Second, L&E recommended updating the assumed unit cost trends for 2019 to 2020 if updated information regarding unit cost trends is known at the time the Board issues its decision in this filing. Ex. 9 at 15.

46. Third, L&E agreed with MVP's decision to remove the AHP morbidity load on claims, reducing the projected premiums by approximately 0.8%, due to changes at the federal and state level regarding the operation of AHPs in Vermont. Ex. 9 at 10-11, 15; Tr. at 211; *see also supra* Findings, ¶ 41.

47. Fourth, L&E recommended that the utilization trend be increased to 1.0% per year (compared to 0.0% as filed), which would increase rates by 1.5%. Ex. 9 at 15. In prior years' filings, MVP has assumed an annual utilization trend of 0.0%. *Id.* at 6. Because of the atypical

results produced by MVP's analysis using its own data, this year L&E analyzed utilization trends by using market wide utilization data, i.e. a combination of data from both MVP and BlueCross BlueShield of Vermont (BCBSVT), resulting in recommendations for both carriers. *Id*. L&E made its recommendation based on MVP's oscillating utilization trend in recent years and L&E's review of market-wide data, which L&E believes is more credible data than MVP's closed cohort analysis. *Id.* at 7-8.

48. Fifth, L&E recommended that both carriers in the individual and small group market revise their risk adjustment calculations based on the final 2018 risk adjustment report from CMS, released on June 28, 2019, and that each company use a 2018 estimate of $15,926,267. Ex. 9 at 11-12. In addition, HHS has modified the coefficients used in the risk adjustment model for 2020, which is expected to have a larger impact on lower-risk bronze members (of which MVP has a higher membership) than higher-risk platinum members (of which BCBSVT has a higher membership). *Id*. The result is a marked increase above what MVP expected to pay to BCBSVT for MVP's risk adjustment transfer for 2020. *Id.* Having performed a study on the diagnosis and enrollment data from both carriers, L&E recommends that MVP incorporate into its risk adjustment calculation the most recent estimate of its 2018 risk adjustment payment, which was unavailable to MVP on the date of its initial filing, and also incorporate the changes to the risk model for 2020 in its calculations. *Id*. With the revision, L&E estimates that MVP will make a $64.15 PMPM 2020 risk adjustment transfer payment (rather than MVP's projected $55.61 PMPM payment), resulting in a 1.5% premium increase from the company's initial projection. *Id*.

49. Sixth, L&E recommended modifying premiums due to the required benefit changes to MVP's Plus Gold HSA non-standard plan design, reducing the projected premiums by 0.2%. Ex. 9 at 12-13, 15.

50. At the July 22nd hearing, L&E projected an average annual rate increase of 10.5% based on its above recommendations. Ex. 9 at 15. L&E opined that the rates, as modified, are actuarially sound; they are adequate because they would cover member claims, administrative costs, taxes and fees, and allow for a reasonable CTR; the rates are not excessive because they do not exceed the amount needed to pay for such costs; and they are not unfairly discriminatory because they do not produce impermissible differences in premiums among insureds within similar risk categories. Ex. 9 at 15; Tr. at 204-5, 215.

51. As relayed at both the hearing and in the post-hearing brief, MVP agrees with L&E's recommendations to modify the following rate components: (a) reduce cost trend from 2018 to 2020 resulting in a decrease in rates of 0.9%; (b) increase medical utilization trend to 1.0% per year resulting in an increase in rates of 1.5%; (c) remove the 1.0% AHP morbidity load on claims resulting in a decrease in rates of 0.8%; (d) modify the risk adjustment calculation resulting in an increase in rates of 1.5%; and (e) modify the premiums due to required benefit changes resulting in a decrease in rates of 0.2%. *See* Tr. at 18-19; Ex. 9 at 15; MVP Post-Hearing Proposed Findings of Fact and Conclusions of Law (MVP Post-Hearing Memo), 1-4.

52. MVP advised the Board at the hearing that it had recalculated its unit cost trend, based on information in the recent Vermont hospital budget filings, which MVP asserted would require an increase of 0.5% to the rate. Tr. at 36. At hearing, L&E declined to provide an opinion about MVP's analysis of the impact of the hospital budgets on rates because L&E had yet to see MVP's

recalculation. Tr. at 208-9. On July 30, 2019, L&E filed an addendum to its Actuarial Memorandum addressing MVP's proposed 0.5% increase. Based on an examination of the historical variance between submitted and approved hospital budgets, L&E recommended a 0.3% increase to MVP's proposed rate, rather than MVP's requested 0.5%. L&E Addendum (July 30, 2019), 1-2.

53. MVP also testified at hearing that it had a number of programs and initiatives in place to lower costs, promote quality care and access, and establish the affordability of rates by managing care and medication, managing administrative costs and contracts, and managing the plan and membership, though MVP did not quantify a decrease in rates due to these initiatives. Tr. at 58-76, 148; *see also* Ex. 5 at 2-6. For example, MVP has implemented a telemedicine benefit for its members that allows access to a health care provider via a computer or smartphone. According to the company, telemedicine visits are a fraction of the cost of an emergency room (ER) visit ($45 for a telemedicine visit compared to possible thousands of dollars at the ER). Ex. 5 at 4-5; Tr. at 62, 65-66.

54. On July 29, 2019, in response to post-hearing questions from the Board, MVP advised that it had recently signed a contract with the Green Mountain Surgery Center and estimated that the contract will reduce the proposed rate by 0.1%. MVP Response to GMCB Request for Supplemental Information, 2.

55. MVP is currently engaged in negotiations with OneCare Vermont to enter into a contract for the 2020 plan year, and hopes that data sharing and collaboration with OneCare will have a favorable impact on claim trends and, as a result, future rate filings. Ex. 5 at 8; Tr. at 68-69.

Standard of Review

The Board reviews rate filings to 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 the laws of this State." 8 V.S.A. § 4062(a)(3). In addition, proposed rates cannot be excessive, inadequate, or unfairly discriminatory. Rule 2.000, § 2.301(b). The Board is required to consider changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); Rule 2.000, § 2.401. The Board must also consider DFR's analysis and opinion of the impact of the proposed rate on the insurer's solvency and reserves, 8 V.S.A. § 4062(a)(2)(B), (a)(3), and any public comments received on the filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201.

The Board's review is plainly not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that the Legislature granted the Board review standards that are "general and open-ended," the result of "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 change to justify the requested rate. Rule 2.000 § 2.104(c).

Conclusions of Law

I.

Before beginning the following discussion, we would like to generally address the affordability of the rate filings this year and the effect these rates will have on Vermonters. During the course of our review process, we received many compelling comments from members of the public, both in writing and in person. Most underscore that for many Vermont individuals, families, and businesses, health care remains unaffordable under any reasonable standard. Affordability and access weigh heavily in our minds as we reach our decision on this filing, knowing that we must somehow reconcile the statutory mandate to determine whether a rate is affordable while also protecting quality and access to care and insurer solvency.

The size of the increase MVP has requested in this filing underscores the importance of the work the State is engaged in with the All-Payer Accountable Care Organization Model. We will continue to use the levers we have to achieve the model's goals of reducing cost growth while improving the quality of care people receive and the overall health of the population. We expect MVP to do the same, for example by using its substantial bargaining power to reduce unnecessary utilization and negotiate lower prices with providers; and implementing and expanding programs, such as the ACO program, that encourage and incentivize more appropriate utilization of services and focus on prevention and wellness.

As one of the two carriers providing health insurance through Vermont's marketplace, we expect MVP to place an emphasis on cost containment and quality improvement strategies moving forward and leverage its current and anticipated initiatives to reduce future rates to the fullest extent possible. *See* Findings, ¶¶ 53, 55. We are deeply concerned that the proposed rates this year will negatively impact the Exchange marketplace and increase the number of uninsured and underinsured Vermonters. While we are bound by statutory requirements that limit the downward pressure we may place on proposed rates, we modify and approve the following rate with these thoughts in mind.

II.

We first address an issue on which MVP and our actuaries are in agreement and which significantly impacts the proposed rates in this year's rate filing. As noted above, MVP has had a substantial increase in its membership over the past few years, which is comprised of a lower-risk population than that of the other martket participant, BCBSVT. Findings, ¶¶ 32, 48. In addition, the modification HHS has made to the coefficients used in the risk adjustment model for 2020 is expected to have a larger impact on lower-risk bronze members (of which MVP has a higher membership) than higher-risk platinum members (of which BCBSVT has a higher membership). Findings, ¶ 48.

The result is a marked increase for MVP's risk adjustment transfer above what MVP expected to pay to BCBSVT for MVP's risk adjustment transfer for 2020. *Id*. Having performed a market-wide study on the diagnosis and enrollment data from both carriers, L&E recommends that MVP incorporate into its risk adjustment calculation the most recent estimate of its 2018 risk

adjustment payment, which was unavailable to MVP on the date of its initial filing, and also incorporate the changes to the risk model for 2020 in its calculations.[20] *Id*. The company agrees with the recommendation, which it has since incorporated into its proposed rates for a proposed risk adjustment increase of 5.9%. Findings, ¶ 51.

While we have heard extensively about the affordability (and unaffordability) of the proposed rates this year, we acknowledge that the risk adjustment calculation should be made using the most recent and accurate information available and reflect a market-wide analysis; we must approve rates that reflect, to the best extent possible, the anticipated liabilities of each carrier.

We therefore adopt L&E's recommendation, which sets the increase to premiums to account for risk adjustment at 5.9%, resulting in an increase of 1.5% to the proposed rate.

III.

Second, we address those issues on which MVP and our actuaries are in agreement, and for which we adopt the recommendation of our actuaries. Upon review of the record—including but not limited to L&E's recommendations, the evidence presented at the July 22nd hearing and the post-hearing briefs—we find the following recommendations reasonable in light of all evidence in the record and approve the following rate modifications: (a) reduce cost trend from 2018 to 2020 resulting in a decrease in rates of 0.9%; (b) increase medical utilization trend to 1.0% per year resulting in an increase in rates of 1.5%; (c) remove the 1.0% AHP morbidity load on claims resulting in a decrease in rates of 0.8%; and (d) modify the premiums due to required benefit changes resulting in a decrease in rates of 0.2%. *See* Findings, ¶¶ 36-37, 41, 46-47, 49, 51.

These four modifications decrease the proposed rate by 0.4%.

IV.

Third, we address MVP's request for a 0.5% increase in rate resulting from its recalculation of unit cost trend that incorporates information from the recently filed Vermont hospital budget submissions. *See* Findings, ¶ 52. We allow MVP to raise premiums by no more than 0.3% to account for new information on FY2020 hospital budgets. These budgets, which we received at the beginning of July 2019, are preliminary and untested. Furthermore, the Board has actively sought to control the growth in hospital spending by consistently ordering reductions to hospitals' initial budget submissions, both in terms of net patient revenues and commercial rate increases. *See* Findings, ¶ 37. Without a better sense of what the Board will do with these budgets, our prior decisions are the best information we have. L&E concluded that, based on the pattern of historical reductions, the budget increases will result in a 0.3% increase to premiums. We therefore allow MVP to adopt this assumption and allow it to raise premiums by no more than 0.3% in connection with this issue.

[20] This study results in a corresponding decrease to BCBSVT's proposed rate based on BCBSVT's receipt of an increased risk adjustment transfer from MVP for 2020.

In addition, in response to post-hearing questions from the Board regarding the impact of its contract with the Green Mountain Surgery Center, MVP decreased its rate proposal by 0.1%. Findings, ¶ 54.

These two modifications result in an approximate 0.2% increase to the proposed rate.

V.

Fourth, we reduce the company's proposed CTR from 1.5% to 1.0%, which we conclude will not materially impact or pose a threat to the company's solvency. Despite capturing a growing share of the Vermont individual and small group market, the company's Vermont membership remains only a small percentage of its overall business. *See* Findings, ¶¶ 32, 42. MVP advised the Board that its New York regulators require that the company maintain a minimum of 12.5% of premium in reserves and MVP currently exceeds that threshold. Findings, ¶ 42.

We find this determination to be in line with the Board's prior decisions; over the past five years the Board has approved, on average, a CTR of 1.1%. *See* GMCB Docket Nos. GMCB-008-18rr; GMCB-007-17rr; GMCB-007-16rr; GMCB-007-15rr; GMCB-017-14rr. Furthermore, in making this decision we have taken into consideration several additional factors that were shared during MVP's testimony. First, we note that the company's Vermont marketshare is expanding and the fixed admininistrative costs spread over a higher enrollment should reduce the PMPM for administrative costs in the Vermont market. However, it appears that the Vermont market is not seeing the benefit of the higher Vermont enrollment given MVP's "enterprise-wide" administrative cost structure and the company's membership losses in its New York business. Findings, ¶ 43. Second, we note that MVP's proposed increase does not demonstrate any decrease in rates due to the quality improvement/care coordination efforts which comprises $2.52 PMPM of the $42.00 PMPM general administrative expenses load.[21] Findings, ¶¶ 38, 53. Third, we note that MVP is undertaking some new initiatives which may have a downward impact on rates, such as the MVP telemedicine program and the possibility of a contract with OneCare for 2020. Findings, ¶¶ 53, 55.

Lastly, as with each year but especially with the rate filings this year, we are mindful of the need to keep rates as affordable as possible. The concept of affordability, unlike our actuarial review standards, is fluid and open-ended, *see In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16, and requires a balancing of statutory considerations—unaffordable rates will hamper Vermonters' ability to access quality care, while affordable rates that imperil an insurer's solvency will likewise threaten Vermonters' access to care. At a time when federal changes to health care policy have disrupted the individual and small group health insurance marketplace, we find that appropriately striking the balance of affordability and solvency has become more difficult, while crucial for Vermonters purchasing health care coverage. Given the proposed rates from carriers as of the hearing date were both above 10% this year, we have determined that affordability requires a reduction to CTR when the carrier is not facing solvency concerns.

The above 0.5% reduction in CTR reduces the proposed rate by approximately 0.6%.

[21] By contrast, we are encouraged by the downward movement in proposed rates by BCBSVT who has identified care coordination programs which improve access to health care while also acting to decrease rates.

Order

For the reasons discussed, we modify and then approve MVP's 2020 individual and small group market rate filing. Specifically, we order that MVP: 1) increase the rate by 1.5% based on updated risk adjustment information; (2) reduce cost trend from 2018 to 2020 to 3.7% resulting in a rate decrease 0.9%; (3) increase medical utilization trend to 1.0% per year resulting in a rate increase of 1.5%; (4) remove the 1.0% AHP morbidity load on claims resulting in a rate decrease of 0.8%; (5) modify the premiums due to required benefit changes resulting in a rate decrease of 0.2%; (6) increase the cost trend for 2019 to 2020 for a rate increase of 0.3%; (7) decrease the rate by 0.1% due to MVP's contract with the Green Mountain Surgery Center; and (8) decrease CTR by 0.5% for a rate decrease of approximately 0.6%.

As modified, we approve an average annual rate increase of approximately 10.1%, with plan level increases ranging from 5.7% to 13.6%. We note that many Vermonters will receive larger federal subsidies to cover the increased costs in 2020, as explained herein, and we encourage Vermonters to use Vermonth Health Connect's Plan Comparison Tool (available at https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action beginning this Fall) when determining their best plan options.

SO ORDERED.

Dated: August 8, 2019 at Montpelier, Vermont

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

Filed: August 8, 2019

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: Christina.McLaughlin@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 or stay, if any, must be filed within ten days of the date of this decision and order.