STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Plan, Inc. 2020 Large Group HMO Rate Filing	)))	GMCB-008-19rr SERFF No.: MVPH-132048265
In re:	MVP Health Insurance Company 2020 Large Group POS Riders	)))	GMCB-007-19rr SERF No.: MVPH-132046387

DECISION AND ORDER

Introduction

Health insurers must submit major medical rate filings to the Green Mountain Care Board, which must approve, modify, or disapprove each filing within 90 calendar days of 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).

This decision pertains to the 2020 large group rate filing submitted by MVP Health Plan, Inc. (GMCB-008-19rr), as well a supplemental rate filing submitted by MVP Health Insurance Company for optional point of service riders (GMCB-007-19rr). Because the riders provide out-of-network coverage to supplement the in-network benefits offered by the plans detailed in the large group filing, the filings were reviewed together.

Procedural History

Between August 13 and 14, 2019, the Board received two rate filings via the System for Electronic Rate and Form Filing (SERFF), one from MVP Health Plan, Inc. (MVPHP) for its 2020 large group HMO products, and one from MVP Health Insurance Company (MVPHIC) for point of service riders offered in connection with the large group products.[1] On August 14, 2019, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid that represents the interests of Vermont health insurance consumers, entered an appearance as a party to the filings. On September 9, 2019, MVP amended the filings to reflect updates to the base medical forms and the inclusion of a new preventive care rider.

On October 10, 2019, the Board posted to its website two analyses prepared by the Vermont Department of Financial Regulation (DFR) regarding the impact on the filings on the carriers' solvency. That same day, the Board posted to its website an actuarial memorandum prepared by Lewis & Ellis (L&E), the Board's contract actuaries. The Board received no public

[1] The SERFF filings, as well as all documents referenced in this Decision and Order, can be found in the rate review section of the Board's website at https://ratereview.vermont.gov/MVP-2020-large-group-hmo (MVPHP) and https://ratereview.vermont.gov/MVP-2020-large-group-POS-riders (MVPHIC).

comment on the filings. Pursuant to GMCB Rule 2.000, § 2.309(a)(1), the parties waived a hearing and filed memoranda in lieu thereof.

Findings of Fact

1. MVPHP is a non-profit health insurer domiciled in New York state and licensed as a health maintenance organization (HMO) in New York and Vermont. MVPHP is a subsidiary of MVP Health Care, Inc. (MVP), a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries and provides health insurance coverage to individuals and employers in the small and large group markets in New York and Vermont.

2. MVPHP's large group filing demonstrates the development of premiums for the carrier's large group HMO products, comprised of both high-deductible health plans (HDHPs) and non-high-deductible health plans (non-HDHPs), and includes proposed rates for all four quarters of 2020. L&E Actuarial Memorandum (L&E Memo), 1. The rates are composed of a manual rate change, an age/gender factor change, and a change in retention. *See* L&E Memo, 2; MVP Memorandum in Lieu of Hearing (MVP Brief), 1.

3. In recent years, the entire product portfolio sold on the license of MVPHIC has been migrated to MVPHP. L&E Memo, 1; MVP Brief, 1.

4. As of April 2019, there were approximately 1,800 members in Vermont enrolled in MVPHP's large group plans. Of these members, 1,430, or approximately 80%, have renewal dates in the first quarter of 2020 (1Q20), 77 have renewal dates in the second quarter of 2020 (2Q20), 151 have renewal dates in the third quarter of 2020 (3Q20), and 140 have renewal dates in fourth quarter of 2020 (4Q20). L&E Memo, 1; MVPHP Actuarial Memorandum (MVP Memo), 1.

5. MVPHP's large group filing is supplemented by POS riders offered on MVPHIC's license. These riders provide out-of-network coverage in addition to the in-network benefits provided by the large group HMO plans. The riders are not stand-alone products and must be purchased in conjunction with MVPHP's large group products. Rates for the POS riders are set as a percentage of premium to the combined medical and pharmacy rates for MVPHP's large group products. L&E Memo, 1; MVP Brief, 1.

6. MVPHP proposes a 16.7% average annual rate increase for members renewing in 1Q20. L&E Memo, 2. The average annual rate increases proposed by MVPHP for members renewing in the remaining quarters of 2020 vary slightly from 16.7% – 16.4% for 2Q20 renewals, 16.5% for 3Q20 renewals, and 16.2% for 4Q20 renewals – due to quarterly trend changes and changes in the health insurer fee. L&E Memo, 2; MVP Memo, 2.

7. The large groups covered by this filing have premiums that are based on a blend of their own claims experience (at approximately 25%) and the rates approved in this filing (at approximately 75%). Therefore, based on their specific claims experience, groups will see premium increases that differ from the rate increases approved in this filing. For example, the currently quoted average premium increase for groups renewing in 1Q20 (representing

approximately 80% of the members covered by these plans) is projected to be 8.4%. L&E Memo, 2. This is largely due to the relatively favorable experience of these groups. For calendar year 2018, the loss ratio for all the large groups combined was 95.7%, while the loss ratio for groups renewing in 1Q20 was 89.0% and the loss ratio for the remaining groups (i.e., non-renewing groups, many of which experienced loss ratios exceeding 100%, and groups renewing in 2Q20 - 4Q20) was 103.9%. L&E Memo, 7.

8. In developing the manual rates, MVPHP used its large group claims data for the period May 2018 through April 2019 and paid through 2019 (with incurred estimates updated through June 2019). The base period experience used by MVPHP has two months of claims run-out and therefore needed to be adjusted for claims "incurred but not reported" (IBNR). L&E concluded that the carrier's IBNR adjustment appears to be actuarially sound and is consistent with MVP's other filings. L&E Memo 2, 4.

9. Claims exceeding $100,000 made up 15.8% of the base period experience. To help mitigate the impact of high cost claims, the carrier replaced claims in excess of $100,000 with a pooling charge equal to 9.9% of claims below the pooling limit – the same pooling charge that was used to develop the 2019 rates. L&E Memo, 2-3; *In re: MVP Health Plan, Inc., 2019 Large Group HMO Rate Filing*, GMCB-010-18rr, Decision and Order, Findings of Fact, ¶ 7. Pooling claims is a typical industry practice and prevents major swings in premium resulting from a small number of cases. L&E Memo, 3. The use of the pooling charge reduced the projected claims by approximately 6% relative to using the base period experience without adjustment. *Id*.

10. Due to its limited large group data in Vermont, MVPHP calculated the pooling charge using its large group business in New York. L&E reviewed the actual large group experience in Vermont and calculated that the percentage of claims above the $100,000 pooling limit during the prior five years ranged from 4.5% to 24.9%, with an average of 14.4%. L&E concluded that the Vermont-only data is not fully credible and MVPHP's use of New York data to set the pooling charge assumption is reasonable and appropriate and results in more stable premiums. L&E Memo, 3.

11. MVPHP projected the adjusted medical and pharmacy (Rx) claims forward to the midpoint of the 1Q20 rating period using an annual paid medical trend assumption of 5.7% and an annual paid Rx trend assumption of 9.5%. To develop the projected claim cost as of 1Q20, MVPHP further adjusted the trended medical and Rx claim cost for items such as Rx rebates and the projected cost of capitation and non-fee-for-service claim expenses (e.g., Patient Centered Medical Home payments). L&E Memo, 3; MVP Memo, 3; MVPHP Response to Objection #1, 3. Reflecting these adjustments, the quarterly manual rate change developed by MVPHP was 10.9% for 1Q20. L&E Memo, 3.

12. MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims, which resulted in rate increases of 1.6% in each quarter of 2020. This means that groups renewing in April will be charged premiums based on manual rates that are approximately 1.6% higher than groups renewing in January. L&E Memo, 3.

13. To develop its paid medical trend assumption of 5.7%, MVPHP analyzed its combined MVPHP and MVPHIC Vermont data for 36 months between 2016 and 2018. It did not consider this data appropriate for utilization trend analysis due to concerns with the large impact that membership growth in other blocks of business (Exchange) was having on the total utilization trend for Vermont. Because removing MVPHP data from the calculation would leave a block that was not credible, MVPHP used the 1.0% utilization trend that L&E calculated for the entire Vermont marketplace during its review of the Exchange filings. L&E concluded that, based on the information available at this time, this 1.0% utilization trend is reasonable and appropriate. L&E Memo, 4.

14. MVPHP's assumed 5.7% annual effective medical trend factor represents the most up-to-date provider contracting information available at the time of filing. L&E Memo, 4. However, after the filing was submitted, the Board made final decisions regarding 2020 Vermont hospital budgets. The budget increases approved by the Board are lower than anticipated at the time of the filing. L&E Memo, 5.

15. To develop its paid pharmacy trend assumption of 9.5%, MVPHP analyzed its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by the carrier's pharmacy benefit manager (PBM). These trend factors reflect the carrier's Vermont business. L&E Memo, 5.

16. MVPHP used 2020 drug rebate forecasts provided by its PBM. These forecasts assume that drug rebates will be equal to $21.57 per member per month (PMPM) for 1Q20 renewals and increase with pharmacy trend for later quarters. L&E Memo, 5; *see also* Filing Amendment, 2020 Vermont Large Group Filing, Ex. 3a-3d.

17. L&E concluded that MVPHP's assumptions regarding Rx trend and Rx rebates appear to be reasonable and appropriate. L&E Memo, 5.

18. The base manual rate projection does not account for changes in demographics. Since the prior filing, the demographics of the block have been observed to deviate from past expectations. The enrolled population was slightly older than the prior experience period, resulting in additional revenue available to cover claims. However, the demographic factors were re-normalized to reflect the updated experience and decreased by 0.5% to maintain the necessary premium level. L&E determined that MVPHP's age/gender normalization methodology appears to be reasonable and appropriate. L&E Memo, 4.

19. MVPHP added retention charges to the blended pure premium to develop the group required premium. The retention charges include 8.2% of premium for general administrative expenses, a reduction from the 8.9% in the prior filing. L&E Memo, 5. The projected 2020 administrative expenses of 8.2% of premium is less than the actual calendar year 2018 expenses of 10.0%. The following table summarizes data taken from the Supplemental Health Care Exhibits:

	Member Months	Premium PMPM	Admin PMPM	Expense Ratio
2013	118,563	$363.04	$39.18	10.8%
2014	97,084	$404.11	$38.31	9.5%
2015	68,766	$432.06	$34.13	7.9%
2016	37,858	$450.19	$36.77	8.2%
2017	25,372	$474.10	$42.09	8.9%
2018	26,765	$484.55	$48.67	10.0%

L&E Memo, 6.

20. MVP reduced the administrative expense load such that the per member per month cost of administrative expenses increase at the same 5.5% rate as MVP's Exchange filing. L&E Memo, 6.

21. L&E concluded that the administrative expense load appears to be reasonable and appropriate. L&E Memo, 6.

22. MVPHP's retention charges also include a broker load equal to 3.1% of premium. Broker fees are increasing compared to 2019 due to the fact that two of the groups not renewing in 2020 did not have broker fees and one of the groups that is renewing did not have a broker in 2019 but added a broker for 2020. The retention charges also include provision for bad debt equal to 0.3% of premiums, an ACA insurer tax of 1.0%, a VT vaccine pilot charge of 0.3%, and a $1.93 PMPM charge based on MVP's projected responsibility for statutory billback. L&E Memo, 5-6.

23. MVPHP's proposed retention charges also include 2.0% for contribution to reserve (CTR). L&E notes that the Board has reduced the proposed contribution to reserve in its past orders and recommends that the Board consider DFR's solvency analysis if changes are made to this assumption. L&E Memo, 6.

24. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR assessed the impact of the proposed filings on the carriers' solvency. DFR noted that New York State, the primary solvency regulator for both MVPHP and MVPHIC, has not learned of any solvency concerns regarding the carriers. DFR noted that MVPHP currently meets Vermont's foreign insurer licensing requirements and that while MVPHIC is currently below Vermont's minimum surplus requirement, it is working with DFR to reach the requirement in the near future. DFR stated that solvency concerns with MVPHIC are lessened because the carrier is moving its business to MVPHP and is not writing any new business. Finally, DFR noted that, in 2018, all of MVP Holding Company's operations in Vermont accounted for approximately 4.8% of its total premiums written and that the carriers' Vermont operations pose little risk to their solvency. DFR opined that the proposed rates will not have a negative effect on the carriers' solvency, absent a finding by L&E that they are inadequate. DFR Solvency Analyses for 2020 Large Group HMO Rate Filing of MVPHP and Large Group Point of Service 2020 Rate Filing of MVPHIC.

25. During the course of L&E's review, MVP recognized that they did not incorporate certain benefit changes into the filed rates, namely increasing the wellness reimbursement to

$200 and adding a new $50 per quarter benefit for meeting certain step thresholds based on a wearable device registered with MVP's vendor. The costs associated with these benefit changes amount to $0.19 PMPM. L&E Memo, 6.

26. In the initial filing, MVPHP built a $1.82 load into the rates to cover certain payments under a risk share arrangement with OneCare Vermont. MVPHP Response to Objection #1, 3. After the initial filing, MVPHP determined that its large group Vermont members will not be included in a 2020 program with OneCare. As a result, MVP stated that it is amenable to removing the load from the rates. *Id.*

27. The target loss ratio is decreasing from 86.9% in 1Q19 to 84.8% for 2020. This change is the result of increasing the CTR from 1.5% (approved in the prior filing) to 2.0%, the reintroduction of the ACA insurer fee beginning in 2020, and an increase in the statutory billback amount. L&E Memo, 6.

28. The federal loss ratio for MVPHP in 2018 is 106.2%, and the rolling three-year average is 96.0%. L&E Memo, 6.

29. L&E reviewed the filing and recommends that the Board adjust the unit cost trends to reflect the FY2020 hospital budgets established by the Board while the filings were pending. L&E also recommends adding in the $0.19 PMPM that was inadvertently excluded from the rates in the initial filings related to changes in benefits. Finally, L&E recommends removing the $1.82 PMPM load that was added for the risk deal with OneCare Vermont. L&E Memo, 8.

30. With L&E's recommended modifications, the manual rate increases for 2020 would be as follows:

Quarter	Manual Rate Change
1Q20/4Q19	10.4%
1Q20/2Q20	1.6%
3Q20/2Q20	1.6%
4Q20/3Q20	1.6%

L&E's recommended reduction to the manual rate would result in an overall change for 1Q20 of 16.2%. L&E Memo, 8.

31. L&E concludes that if its recommended modifications are made, the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. L&E Memo, 8-9.

32. In its memorandum in lieu of hearing, MVPHP states that it is "willing to accept L&E's recommendations," but argues that "[a]ny modifications made by the Board [beyond those recommended by L&E] would not be supported by anything in the record, nor have any actuarial support." MVP Brief, 3.

33. The HCA contends in its memorandum in lieu of hearing that MVP has failed to demonstrate that the proposed rates are affordable; promote access to care; promote quality care; are not unfair, unjust, inequitable or misleading; and are not excessive, inadequate or unfairly

discriminatory. The HCA notes that the rate request far exceeds Vermont's real wage growth and real GDP growth and asks the Board to reduce the proposed rate by at least 2.5%, a 0.5% reduction as recommended by L&E, a reduction of the CTR to between 0% and 1% due to a lack of solvency concerns, and a 1.0% reduction to promote affordability and access to care.

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); GMCB Rule 2.000, § 2.301(b). Although the first several terms—excessive, inadequate, or unfairly discriminatory—are defined actuarial standards,[2] other standards by which the Board reviews rate filings 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 Board additionally takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000, § 2.401.

In arriving at its decision, the Board must 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), (3). The Board must also consider any public comments it receives on a rate filing. 8 V.S.A. § 4062(c)(2)(B); GMCB Rule 2.000, § 2.201. The burden falls on the insurer proposing a rate change to justify the requested rate. GMCB Rule 2.000, § 2.104(c).

Conclusions of Law

First, we adopt our actuaries' recommendations and order the carriers to 1) adjust the unit cost trend to reflect the approved FY2020 hospital budgets; 2) add the $0.19 PMPM that was inadvertently excluded from the rates related to changes in benefits; and 3) remove the $1.82 PMPM load that was added to the rates to account for an expected agreement with OneCare. Findings, ¶ 28. These recommended modifications either correct for omissions in the filing or incorporate more accurate information not available at the time of filing. Moreover, the recommendations were not contested by either party. *See* Findings, ¶¶ 32-33.

Next, consistent with modifications we have required in other filings, we order the carriers to reduce the proposed CTR from 2.0% to 1.0%. *See, e.g., In re: MVP Health Plan, Inc., 2020 Individual and Small Group Market Rate Filing*, GMCB-005-19rr, Decision and Order, 13 (reducing CTR from 1.5% to 1.0%); *In re: MVP Health Plan, Inc., 2019 Large Group HMO Rate Filing*, GMCB-010-18rr, Decision and Order, 6 (reducing CTR from 2.0% to 1.5%); *In re: MVP Health Plan, Inc., Third Quarter 2018 and Fourth Quarter 2018 Large Group HMO Rate*

[2] Under Actuarial Standard of Practice No. 8, rates may be considered adequate if they provide for payment of claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins; rates may be considered excessive if they exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins; and rates may be considered unfairly discriminatory if they result in premium differences among insureds within similar risk categories that: (1) are not permissible under applicable law; or (2) in the absence of applicable law, do not reasonably correspond to differences in expected costs.

Filing, GMCB-007-18rr, 5 (reducing CTR from 2.0% to 1.0%). A reduction of the CTR from 2.0% to 1.0% poses no threat to the solvency of the carriers. *See* Findings, ¶¶ 23-24. At the same time, such a reduction will enhance the affordability of a substantial rate increase, which, as the HCA notes, exceeds relevant economic indicators. *See* Findings, ¶ 33.

With our ordered modifications, the average annual rate increase for 1Q20 will be approximately 15.0%, instead of the 16.7% proposed in the filing, and we expect that, on average, the premium increase experienced by groups renewing in 1Q20 will be approximately 7.0%, instead of the 8.4% initially projected by the carrier. *See* Findings, ¶¶ 6-7. We conclude that these rates, as modified, are not excessive, inadequate, or unfairly discriminatory, and strike the most appropriate balance between maintaining insurer solvency and promoting affordability.

Order

For the reasons discussed above, we order the carriers to 1) adjust the unit cost trend to reflect the approved FY2020 hospital budgets; 2) add the $0.19 PMPM that was inadvertently excluded from the rates related to changes in benefits; 3) remove the $1.82 PMPM load that was added to the rates to account for an expected agreement with OneCare; and 4) reduce the proposed CTR from 2.0% to 1.0%.

SO ORDERED.

Dated: November 13, 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: November 13, 2019

Attest: s/ Jean Stetter, Administrative Services Coordinator
Green Mountain Care Board

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (E-mail 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 with the Clerk of the Board within ten days of the date of this decision and order.