STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP 2016 Vermont Health Connect Rate Filing	)	GMCB-07-15-rr
SERFF No. MVPH-130053210	)	

POST-HEARING MEMORANDUM

I. Introduction

The Office of the Health Care Advocate asks the Green Mountain Care Board to ensure that MVP Health Plan, Inc. justifies its rates by requiring the insurer to make appropriate adjustments to its filing and provide adequate documentation of its rate development.

II. Background

MVP Health Plan, Inc. (MVP) submitted the filing for its 2016 Exchange plans for review by the Green Mountain Care Board (GMCB) on May 15, 2015. MVP requested an average rate increase of 3.0%. The Office of Health Care Advocate (HCA) entered an appearance pursuant to GMCB Rule 2.000 §§2.105(b) and 2.303.

The Department of Financial Regulation (DFR)'s review of MVP's solvency (Solvency Analysis) was filed on July 6, 2015, and the Actuarial Opinion by Lewis and Ellis (L&E), the GMCB's contracted actuaries was submitted on July 14, 2014. The HCA's actuary submitted an Expert Report on the filing on July 20, 2015. The hearing for the filing took place on July 28, 2015.

a. DFR Solvency Analysis

DFR's Solvency Analysis stated that DFR "considers the solvency of insurers to be the most fundamental aspect of consumer protection." Exhibit 8, p. 2. MVPHP's primary regulator is New York rather than Vermont. Id. DFR ensures that foreign companies like MVP "meet certain solvency-based criteria to procure and maintain a license to do business in Vermont." Id. DFR states that MVP's primary regulators in New York have not expressed any concerns about the company's solvency. Id. Moreover, the company's Vermont operations, representing only a small percentage of the total premiums earned, "pose little risk to its solvency or to the solvency of MVP Holding Company." Id. DFR has opined that "the proposed rate will likely have the impact of sustaining MVPHP's current level of solvency." Id. Further, DFR testified at the hearing that lowering MVP's rate increase for this filing to 2.4% would not threaten MVP's solvency. Chieffo Testimony, Transcript p. 56.

b. L&E's Actuarial Opinion

L&E analyzed the filing to in order to assist the GMCB in determining whether to "approve, modify, or disapprove the request." Exhibit 9, p.1. Their recommendation addresses whether the filing produces rates that are "excessive, inadequate, or unfairly discriminatory." Id., p.10. L&E's Actuarial Opinion contained four recommendations and the impact of those recommendations on the overall rate increase:

- Increase the projected index rate to account for changes in demographics: +2%;
- Adjust for the Blueprint payment changes, reducing rates by $1.35 PMPM: -0.4%;
- Reduce the single contract conversion factor from 1.145 to 1.126: -1.7%;
- Correct the 51-100 large group average policy duration factor to reflect the correct adjustment for large group, reducing rates by $0.38 PMPM: -0.1%. Id.

MVP agrees with L&E's recommendations regarding the Blueprint payment and the large group average policy duration factor. Karnedy Opening, Transcript p.6-7. However, after initially calculating that these two recommendations would have lowered MVP's rate request to 2.4%, MVP has since stated that the two factors will decrease its average rate increase to 2.6%. Exhibit 14.[1]

c. Donna Novak's Expert Report

Donna Novak affirmed the two changes L&E and MVP agreed to before her Expert Report was submitted. In addition, she agreed with L&E's recommendation on the demographic changes including increasing the projected index rate and reducing the single contract conversion factor. Although she calculated these factors in a different way than L&E calculated them, they came to the same conclusion as to the impact of these changes.

In addition, Donna Novak found that MVP had overstated its paid to allowed ratio and recommended that this be remedied by requiring MVP to "demonstrate that the rates meet the federal requirements by reproducing the rates following the federal instructions." Exhibit 10, p. 9.

III. Standard of Review

Health insurance organizations operating in Vermont must obtain approval from the GMCB before implementing health insurance rates. 8 V.S.A. §4062(a). The GMCB may approve, modify, or disapprove requests for health insurance rates. 18 V.S.A. §9375(b)(6); 8 V.S.A. §4062(a). "In deciding whether to approve, modify, or disapprove each rate request, the GMCB

[1] While MVP's original chart in Exhibit 12 showed a 0.3% difference between MVP's two agreed upon changes and L&E's four recommended changes, the amended chart in Exhibit 14 shows a 0.1% difference between MVP and L&E. The change from 0.3% to 0.1% arises from MVP determining that the 2% demographic bump was to the INDEX Rate, not the premium, which resulted in a different target loss ratio from the one L&E used in their calculation of the overall impact of their recommendations on MVP's rates. Consequently, if MVP were to incorporate all of L&E's recommendations, the final rate increase would depend on the target loss ratio that MVP uses to implement the recommendations.

shall determine whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory." GMCB Rule 2.000 §2.301(b); GMCB Rule 2.000 §2.401; 8 V.S.A. §4062(a)(3).

In making its decision, the GMCB must consider the requirements of the underlying statutes, changes in health care delivery, changes in payment methods and amount, the Solvency Analysis prepared by DFR in connection with each filing and other issues at the discretion of the GMCB. GMCB Rule 2.000 §2.401; *see also* 18 V.S.A. §9375(b)(6). Further, the GMCB "shall consider any [public] comments received on a rate filing and may use them to identify issues." GMCB Rule 2.000 §2.201(d). The record for rate review includes the entire System for Electronic Rate and Form Filing (SERFF filing) submitted by the insurer; questions posed by the GMCB to its actuaries; questions posed to the insurer by the GMCB, its actuaries, and DFR; DFR's Solvency Analysis; and the Opinion from the GMCB's actuary. GMCB Rule 2.000 §2.403(a).

IV. Analysis

MVP, L&E, and the HCA agree that MVP should incorporate the Blueprint and Large Group Average Policy Duration Factor adjustments. Consequently, this memo will not address those recommendations in any further detail. In addition, the HCA and L&E agree that MVP will produce more accurate cost projections by utilizing first quarter 2015 demographics rather than the 2014 demographics MVP applied to the filing. Finally, the HCA asks the Board to require MVP to demonstrate that MVP's rates are correct and meet the federal requirements by reproducing the rates following federal instructions.

a. Demographic Adjustments: Projected Index Rate and Single Contract Conversion Factor

L&E and the HCA both agree that utilizing demographic data from the first quarter of 2015 to develop rates would predict future costs more accurately than 2014 data. Exhibit 9, p. 10; Exhibit 10, p. 9-11. The 2015 data reflects the most recent available demographic information, captures MVP's population after the last enrollment period, avoids irregularities from Vermont Health Connect's enrollment delays in 2014, and the change is consistent with the Board's decision from last year's MVP Exchange filing. Lee Testimony, Transcript p. 70, 77-78; Decision, GMCB 17-14rr, p.11. However, because the demographic changes increase the rates for policyholders, the overall impact of this change is minor,[2] and MVP has demonstrated strong solvency which will not be threatened if this increase is not implemented, the HCA would not object if the Board declined to adopt the demographic adjustments.

b. Paid to Allowed Documentation

In order to ensure that MVP's rate filing is not excessive, misleading, or contrary to law, MVP must demonstrate that its rates were correctly calculated. MVP attempts to justify the paid to allowed inconsistency Ms. Novak identified in MVP's filing by stating that the issue "is purely based on a federal spreadsheet model and has no bearing on our actual pricing or our actual claim expense." Fish Testimony, Transcript, p. 120. This rationalization is missing the point: The discrepancy in MVP's federal spreadsheet and its lack of compliance with federal rules are a warning that there is a mistake somewhere in the filing. It's not the discrepancy but the mistake that could impact the rates.

Federal rules require any health insurance plan that is subject to a rate increase to submit a Rate Filing Justification (RFJ) for all products in the single risk pool. 45 C.F.R. §154.215. This RFJ must include the Unified Rate Review Template (URRT). Id. The official instructions to the

[2] The total impact of the demographic changes is a rate increase of 0.3%.

URRT state that the URRT "is intended to capture information needed to review rate increases and ensure compliance with the single risk pool, allowable market level index rate adjustments to reflect reinsurance and risk adjustment, and other Federal rating requirements." Exhibit HCA-C, p. 4. These federal instructions specify that insurers must "[p]rovide support for the Paid to Allowed Average Factor in Projection period for the market, shown in Worksheet 1, Section III [and] [d]emonstrate that the ratio is consistent with membership projections by plan included in Worksheet 2." Id., p.53. The rules further state that these ratios must be "relatively consistent" and any difference between them must be "due to differences between the issuer's experience and the experience underlying the AV calculator." Id.

MVP's Paid to Allowed shown in Worksheet 1, Section III is 81% while the membership projections by plan in Worksheet 2 are 70%, indicating that there is a mistake in the filing. Exhibit 1, p. 133, 134; Exhibit HCA-A; Exhibit 10, p. 7. There is more than a 15% difference between the two values. As Donna Novak testified at the July 28, 2015 MVP Exchange hearing, this discrepancy exceeds the variation allowed by the federal rules which says the numbers must be "relatively consistent." Novak Testimony, Transcript p.100. In addition, it far exceeds the norm for ACA rate filings. Within 156 ACA filings Ms. Novak has reviewed, she generally sees a difference of "a few percentage points at the most." Novak Testimony, Transcript p. 86, 98. In her hearing testimony, Kathleen Fish admitted that "it is reasonable to assume that [the values] should be close," and that "it is a larger difference than one would expect." Fish Testimony, Transcript p. 120.

Ms. Novak gave MVP an opportunity to explain the difference by submitting questions to MVP prior to writing her Expert Report. Exhibit 4, p. 1; Exhibit 5, p.1. However, MVP's response stated that the difference is due to induced utilization and a calibration factor. Exhibit 5,

p.1. The federal rules only allow experience to determine this difference, and as Ms. Novak explained in her Expert Report and in her testimony, induced utilization does not qualify as experience for this purpose: "[t]he allowed claims already have the impact of any utilization increases due to benefit richness in them and adding an additional amount would be inappropriately increasing the amount paid on top of an allowed amount that already had the increased utilization included. This would in effect be double counting." Exhibit 10, p. 8; Novak Testimony, Transcript, p. 101. In addition, MVP did not provide any evidence that its experience was significantly out of the norm in the response to the objection letter, in its filing, or in testimony at the hearing. Exhibit 1; Exhibit 5, p. 1; Fish Testimony.

Due to the significant difference between MVP's 81% and 70% AV's included in the filing which is not explained by MVP's experience, it is likely that either the incurred paid or the allowed amounts in MVP's filing are incorrect. Exhibit 10, p. 8. If the paid amounts are incorrect, then MVP's rates are likely inflated. Novak Testimony p. 96; Exhibit 10, p. 8-9. If MVP's allowed amounts are incorrect but paid amounts are correct, then the rates do not need to be adjusted. Exhibit 10, p.8. The HCA is therefore not asking for MVP to implement a specific rate adjustment on this issue, but to provide further support for its rates, following the federal rules.

Because the rates come out correctly if we assume that the paid amount is correct, MVP would like us to trust them that the problem is entirely due to a "flawed" federal URRT. Fish Testimony, Transcript p. 119. However, this significant discrepancy did not arise with BCBSVT, and it has not arisen in the vast majority of filings that Ms. Novak has reviewed which all utilize the URRT. GMCB 08-15rr SERFF Filing; GMCB 08-15rr Donna Novak Expert Report; Novak

Testimony, Transcript p. 86, 98. Further, MVP did not provide any proof that the discrepancy is limited to a flaw in the URRT.

MVP needs to provide further documentation to demonstrate that its rates are justified. MVP has not shown anywhere in the filing how it calculated its paid amounts and its answer to Ms. Novak's objection about this issue did not provide assurance that its calculations are in compliance with federal rules. Novak Testimony, Transcript, p. 111; Exhibit 10, p. 9. As Ms. Novak explains in her report, insurers should prove that any non-standard calculations used to determine their rates are correct and appropriate: "When carriers use a different methodology they still have to provide a demonstration of the rates using the process and factors described in the federal instructions. This is needed so that reviewers can confirm that the Index Rate and Market Adjusted Index Rate are calculated consistent with the ACA requirements and that only permitted adjustments are made to the Market Adjusted Index Rate. We recommend that MVP be required to demonstrate that the rates meet the federal requirements by reproducing the rates following the federal instructions." Exhibit 10, p. 9.

V. Conclusion

As the public comments to this rate filing show, affordability is a major concern for policyholders. After a recent history of offering the more expensive policies on the Exchange, the HCA commends MVP for keeping the rate request in this filing low, including implementing a 0% contribution to reserves. This relatively modest increase tempers the trend of high costs for policyholders and it strengthens competition between the two health insurance companies on the Exchange. However, it is not enough for a rate request to be low, it must also be justified. Because MVP failed to follow the federal rules for rate review filings and its filing includes a glaring discrepancy, MVP should be required to provide documentation to show whether the

discrepancy negatively impacted its rates. Further, if MVP's documentation shows that the mistake did impact its rates, MVP should be required to adjust its rates accordingly.

Dated at Montpelier, Vermont this 3rd day of August, 2015.

s/ *Kaili Kuiper*_____
Kaili Kuiper
Staff Attorney
Office of Health Care Advocate

CERTIFICATE OF SERVICE

I, Kaili Kuiper, hereby certify that I have served the above Memorandum on Michael N. Donofrio, General Counsel to the Green Mountain Care Board, Judith Henkin, Health Policy Director of the Green Mountain Care Board, and Gary Karnedy and Susan Gretkowski, representatives of MVP, by electronic mail, return receipt requested this 3rd day of August, 2015.

s/ *Kaili Kuiper*_____
Kaili Kuiper
Staff Attorney
Office of Health Care Advocate
P.O. Box 606
Montpelier, Vt. 05601
Voice (802) 223-6377 ext. 329