

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2015 Vermont) GMCB-17-14-rr
Health Connect Rate Filing)
)
SERFF No. MVPH-129560321)

DECISION & ORDER

Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) contains provisions aimed at making health insurance rates more transparent for consumers, including the establishment of health benefit “exchanges.” In Act 48 of 2011, the Vermont Legislature created this state’s exchange – Vermont Health Connect (VHC) – a marketplace where individuals, families and small businesses can comparison shop online¹ for qualified health insurance coverage.

Among its other responsibilities, the Green Mountain Care Board is charged with the review of major medical health insurance rates for Vermont consumers. In 2013, the Board reviewed the first health insurance rates offered on the exchange when two carriers – MVP Health Plan, Inc. (MVP) and Blue Cross and Blue Shield of Vermont (BCBSVT) – filed proposed 2014 rates. Again for 2015, each carrier has filed proposed exchange rates for the Board’s review.

In this filing, MVP proposes a 15.4%² average annual rate increase for health plans offered on the exchange beginning in 2015. Based on our review of the record and the testimony and evidence provided at hearing, we modify the rates as explained below, and then approve the filing.

Background

1. Starting January 2014, each Vermont resident must obtain qualifying health insurance coverage. In Vermont, individuals, families, and small employers (fifty or fewer employees) are

¹ In addition to online enrollment, Vermonters may use a specially trained “assistor” who can help provide in-person help. See <http://info.healthconnect.vermont.gov/find> (“Find In-Person Help”).

² In other places in this decision and in the record, *see, e.g.*, Exhibit 8 (Actuarial Memorandum), the proposed average annual increase is shown as 15.3%. The Board’s contract actuary explained at hearing that the minor discrepancy results from the difference between percentage of premium (15.3%) and percentage of overall contracts (15.4%). Transcript (TR) at 109-10.

required to purchase their plans through the exchange. The rates are based on a single risk pool which includes the individual and small group markets.

2. Plans are offered to consumers in five categories, including four “metal” levels – bronze, silver, gold and platinum. The metal levels are based on the cost to the insurer relative to that of the policyholder. For example, a bronze plan will have the least expensive premium, but the insurer will pay a smaller portion of the cost of the consumer’s health care. A platinum plan will require the consumer to pay a higher premium, but a larger percentage of the cost of care will be paid by the insurer. In addition to the metal level plans, catastrophic coverage is available primarily to persons under thirty years of age.³

3. Health insurance plans offered on the exchange must be affordable. Individuals enrolling for coverage who do not have employer-sponsored insurance may be eligible for federal premium assistance depending on their household income. *See* 26 U.S.C. §36B (Refundable credit for coverage under a qualified health plan). Vermont has chosen to further reduce the cost of health insurance by capping the percentage of household income that eligible individuals and families pay for health insurance premiums and by offering subsidies for lower deductibles and co-payments.

4. All plans offered on the exchange must include specific services known as “essential health benefits” (EHBs): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

5. In Vermont, health insurance rate review has historically fallen under the authority of the Department of Financial Regulation (Department). In Act 48, the Vermont Legislature created a role for the newly-formed Green Mountain Care Board, and from 2012 until January 2014, the Board shared the responsibility for rate review with the Department. Under the two-tiered process, the Department received the filing and conducted an actuarial analysis before making a recommendation to the Board that it approve, modify, or disapprove the rate. The 2014 Exchange rates were reviewed under this bifurcated process.

³ Catastrophic coverage is characterized by low premiums and high deductibles, and individuals enrolled in catastrophic plans do not qualify for income-based subsidies.

6. The Legislature expanded the Board's rate review authority when it enacted Act 79 of 2013, and beginning January 1, 2014, the Board became primary reviewer of major medical health insurance rates, with the Department retaining the limited role of advising the Board on the issue of insurer solvency. No. 79, § 5c, *eff.* Jan. 1, 2014. In conjunction with its expanded role, the Board entered into a contract with Lewis & Ellis (L&E), an actuarial firm that supports the Board's decision-making process by providing actuarial analysis of health insurance rate submissions.

7. Last year, this Board for the first time reviewed MVP's exchange rates for the coverage period from January 1, 2014 to December 31, 2014. In our Decision and Order of July 8, 2013, we modified MVP's filing, resulting in an approximate 5.3% reduction in its proposed average annual rate.⁴ *In re: MVP Health Plan, Inc. 2014 Vermont Exchange Rate Filing*, Docket no. GMCB 015-13-rr, *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB_Docket_01513rr_Decision.pdf

Procedural History

8. On June 2, 2014, MVP filed its 2015 Vermont Exchange Products Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The SERFF filing outlined the development of MVP's proposed exchange rates for coverage commencing January 1, 2015. *See* Exhibit 1 (SERFF Filing)⁵ *available at* http://ratereview.vermont.gov/sites/dfr/files/017_14rr_7_21_14.pdf.

9. On June 4, 2014, the Office of Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of consumers of Vermont health care, entered a Notice of Appearance. *See* http://ratereview.vermont.gov/sites/dfr/files/017_14rr_HCA_NOA.pdf.

10. L&E conducted an actuarial review of the filing for the Board, including a series of follow-up questions and requests for additional information from MVP. Taking MVP's responses into consideration, L&E issued an actuarial memorandum summarizing its analysis and recommendations for modification. The memorandum was posted to the Board's rate review website on August 1, 2014. *See* Exhibit 8; *available at* http://ratereview.vermont.gov/sites/dfr/files/017_14rr_Final_Actuarial_Memo.pdf.

⁴ Because cost sharing and benefits will vary among plans, the 5.3% decrease to 2014 proposed rates also varies depending on plan.

⁵ The exhibits referred to in this decision were admitted into evidence either by stipulation or upon motion at hearing.

11. L&E recommends three modifications to the filing prior to approval of the rates: first, that MVP reduce its pharmacy trend from 9.0% to 8.4%; second, that it increase the projected index rate by 2.8% to account for the change in demographics; and third, that it reduce the single contract conversion factor from 1.165 to 1.098. L&E calculates that if all of the modifications were adopted, they would reduce the overall rate increase from 15.3% to 11.6%. L&E opined that after modification, the filing would not produce rates that are excessive, inadequate or unfairly discriminatory. *Id.*

12. On July 28, 2014, the Department issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency. Noting that MVP is one of two Vermont-licensed insurers domiciled in New York that are members of MVP Health Care, Inc. holding company system, the Department opined that the rates as proposed would not materially impact the solvency and surplus of MVP or of the holding company. Exhibit 7.

13. The Board held a public administrative hearing on August 13, 2014 in Room 11 of the Vermont Statehouse. Judith Henkin served as hearing officer by designation of Board chair Al Gobeille. Gary F. Karnedy, Esq. of Primmer Piper Eggleston & Cramer PC represented MVP. MVP Vice President and Chief Actuary Pete Lopatka testified for the carrier.⁶ Kaili Kuiper, Esq. and Lila Richardson, Esq. appeared for the HCA and presented testimony of independent actuary Donna Novak, principal of NovaRest Actuarial Services. The Department's general counsel, David Cassetty, testified regarding the Department's solvency analysis and opinion. In addition, L&E actuary Jackie Lee testified about L&E's actuarial review and recommendations to the Board.

14. The Board accepted public comments on the proposed rates for both MVP and BCBSVT from June 3, 2014 through August 18, 2014. During that period, the Board received 275 comments, 234 of which are based on a template provided to consumers and submitted to the Board by the Vermont Public Interest Research Group (VPIRG). Although some of the VPIRG comments include personal observations and details, each reference both MVP and BCBSVT and state that the proposed rate increases are not affordable. In addition to the VPIRG submission, the Board received 11 comments that specifically address MVP's proposed rate increase, three that address the proposed rate increases in general, and 29 that address only

⁶ MVP actuary Matt Lombardo also testified briefly to provide clarification concerning the company's proposed pharmacy trend. TR at 76.

BCBSVT's proposed rate increase. Virtually all of the comments characterize the impact of the requested rates as unaffordable for Vermonters and encourage the Board to control the cost of health insurance premiums. See Public Comments, available at http://ratereview.vermont.gov/Exchange_Public_Comment.

Findings of Fact

Nature of the Filing

15. MVP is a non-profit health insurer domiciled in New York and licensed as a health maintenance organization (HMO) in New York and Vermont. MVP 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. MVP offers HMO products to individuals and employers in the small and large group markets in Vermont.

16. MVP offers consumers purchasing on the exchange both standard plans, which are not unique to the carrier, and non-standard plans. The standard plans provide benefits approved by the Board and include coverage for all EHBs. The non-standard plans are specific to MVP but must still comply with all requirements for participation in the exchange.

17. There are currently 2,371 policyholders and 4,798 covered lives in MVP's 2014 exchange plans. MVP estimates it will have approximately the same membership in 2015.

MVP's Rate Development

18. MVP developed its 2015 exchange rates utilizing paid claims from its small group EPO, small group PPO, small group HMO, small group HDHP⁷ and individual indemnity books of business from January 1, 2013 through December 31, 2013, with payment through March 31, 2014 (the "experience period"). Exhibit 1 at 59.

19. MVP projected the experience period claims forward to the rating period using a 9.0% pharmacy trend and 6.6% medical trend.⁸

⁷ An EPO (exclusive provider organization) is a managed care plan that only covers services provided by network providers, except in an emergency. A PPO (preferred provider organization) is a health care plan that contracts with medical providers to create a network of participating (preferred) providers. HDHP refers to "high deductible health plan."

⁸ In the most basic terms, trend refers to the change in cost of healthcare and consists of utilization (frequency of use of the product or service) and unit cost.

20. MVP developed its medical trend applying a 0.0% utilization trend assumption and an assumed unit cost that reflects actual and estimated increases from MVP's provider network. Exhibit 1 at 70.

21. Rather than using MVP's historical data to calculate its pharmacy trend, MVP's new pharmacy benefit manager (PBM), CVS Caremark, supplied MVP with a 9.0% estimate of expected changes to pharmacy costs and prescription drug utilization based on national data. Exhibit 1 at 70.

22. MVP proposes a 9.5% administrative load to cover its expenses to market, sell and administer health insurance products. The 9.5% administrative costs charge is equivalent to \$40.60 per-member per-month (PMPM). For 2013, MVP's actual cost to deliver small group and individual products was \$45.58 PMPM. TR at 48-50.

23. In addition to the administrative load, MVP proposes to charge 0.4% for its members to gain expanded access to a national network of providers. *Id.* at 48.

24. MVP proposes a 1.5% contribution to surplus, the same as its 2014 exchange filing request. Exhibit 7.⁹

L&E's Analysis and Recommendations

25. L&E recommends that the Board make three modifications to MVP's filing. First, it recommends that the carrier lower its pharmacy trend from 9.0% to 8.4%. L&E reasons that MVP did not base its trend on its own book of business or Vermont-specific data, and that 8.4% – the same pharmacy trend “used by Vermont's largest carrier based on state-specific experience,” – is a more reliable indicator of actual trend than the estimate based on national data provided by its PBM. Exhibit 8 at 5, n.7.

26. Second, L&E maintains that MVP did not properly adjust for demographics in its rate development. L&E recommends that MVP apply a demographic adjustment factor of 1.028. *Id.* at 5.

27. Last, L&E advises that MVP must also adjust the single contract conversion factor – an adjustment that reflects the composition of enrollment tiers and average contract size

⁹ For 2014, we reduced the requested 1.5% contribution to surplus to 0.5%. *See In re: MVP Health Plan, Inc. 2014 Vermont Exchange Rate Filing* at 11-12, available at http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB_Docket_01513rr_Decision.pdf.

(members per contract) – using its actual 2014 enrollment instead of 2013 enrollment. This modification would decrease the factor from 16.5% to 9.8%. *Id.* at 7.

28. If the Board accepted all of L&E’s recommendations, MVP’s rate increase would be reduced from 15.3% to 11.6%.

The HCA’s Actuarial Report, Supplemental Report and Testimony

29. The HCA’s expert witness, Donna Novak, provided an actuarial report that outlined her analysis of the filing, a supplemental analysis, and also testified at hearing. Novak has extensive experience as an actuary, worked as an advisor to the U.S. Department of Health and Human Services (HHS) concerning ACA implementation, and has provided analysis of ACA and non-ACA rate filings for state regulators and on behalf of state health care advocates. Exhibit 9 at 18-21.

30. In her August 5, 2014 report, Novak made three recommendations for changes to the filing. First, she asserted that MVP made an error in its federal Uniform Rate Review Template (URRT), causing an error in calculation of its manual rate; second, she agreed with L&E that MVP’s pharmacy trend should not be based solely on national data; and third, she recommended that MVP reduce its administrative expenses by 1.0%. In addition to her recommendations, she opined that due to its strong financial health, MVP could reduce its contribution to surplus from 1.5% to 1.0%. Exhibit 9.

31. Specifically addressing L&E’s recommendations, Novak advised that other than the issue of pharmacy trend, she could not comment because L&E had not “provide[d] quantitative support for its calculation[s] of the proposed change[s].” Exhibit 9 at 14.

32. On August 11, 2014, two days prior to the hearing, the HCA submitted a letter from Ms. Novak supplementing her report. Novak explained that she had not had “sufficient time to research two of L&E’s recommendations” prior to completing her report, and having since spent more time “research[ing] the methodology and assumptions,” she now agrees with L&E that there should be a change based on demographics and a change in the contract conversion factor. HCA Exhibit A.

33. At hearing, Novak elaborated on each of her recommendations. She explained that an error in the URRT resulted in an overstatement of the rate of approximately 0.5%. TR at 148-52.

34. As to her agreement with L&E that the pharmacy trend should not be based solely on national data, she acknowledged that there is “a range of methodologies that produces the most

accurate [pharmacy] trend,” and that historical trend data may not be indicative of the reasonableness of future trend. Novak explained that she recalculated the trend using a “blend” of historical and proposed trend. TR at 145-46; 126.

35. Novak then advised the Board that because MVP’s administrative load will increase by the overall approved rate increase, absent any downward modifications, the carrier’s 2015 administrative costs would rise approximately 19.0% over 2014 costs. TR at 147; Exhibit 9 at 11.

MVP’s Evidence and Testimony at Hearing

36. MVP disputes all of the issues raised by L&E and the HCA, and underscores that the two sets of actuaries – L&E and NovaRest – did not agree to the majority of the proposed modifications. *See, e.g.*, Exhibits 11, 12; MVP’s Post-Hearing Memorandum (MVP Memo) at 3.

37. In contrast to L&E and the HCA’s assertion that the pharmacy trend should not be based on national data provided by MVP’s vendor, MVP maintains that its PBM has provided an accurate “expert view” of MVP’s pharmacy trend. *Id.* at 4; TR at 38-41.

38. MVP also disagrees with L&E’s proposed modification based on demographics, explaining that it appropriately made “a two percent reduction [from its 2013 experience] to account for morbidity improvement.” TR at 41. MVP actuary Lopatka testified at hearing that age and morbidity are connected: “[A]ge is a big indicator of usage of health care services . . . [a]nd so the older you are, call it sicker, the morbidity level, the more usage of health care.” TR at 190-91.

39. Although MVP agrees with the HCA’s contention that the URRT contains a mathematical error, it does not agree that the error has any impact on the rate because the specific calculation was “assigned zero percent credibility.” TR at 45-47; 67-70. L&E agrees that the error on the URRT is inconsequential to the final rate, confirming this opinion in response to a written interrogatory from the HCA and again at hearing. Exhibit 13; TR at 128.

40. In response to the HCA’s recommendation that MVP reduce its administrative load, MVP actuary Lopatka testified that MVP’s proposed 2015 PMPM administrative costs are approximately \$5 lower than its 2013 actual costs. TR at 49. Lopatka explained that this shortfall results from company’s “unique issue with critical mass” and that administrative costs are not the primary driver of the high cost of health care and rising premiums; rather, “[t]he primary major issue is the cost of hospital services, physician services and prescription drugs.”

TR at 84. Lopatka further explained: “[T]he last four years, we have lost money. We don’t cover our costs. It’s not all due to admin.” TR at 85.

41. MVP is actively working to reduce its administrative costs, and for 2014 is focusing on “operational efficiencies.” In 2014, the company laid off 100 full-time employees. *Id.* at 49-50.

Standard of Review

1. The Board reviews rate filings to ensure that rates are not “excessive, inadequate or unfairly discriminatory,” that they are affordable, promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. §§ 5104(a)(2); 4062(a)(2); GMCB Rule 2.000, *Rate Review*, §§ 2.301(b), 2.401. In addition, the Board 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).

2. As part of its review, the Board will consider the Department’s analysis and opinion on the impact of the proposed rate on the insurer’s solvency and reserves. 8 V.S.A. § 4062(a)(2), (3). The Board shall also consider any public comments received on a rate filing. Rule 2.000, §2.201.

3. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id.* § 2.104(c)

Conclusions of Law

I. **MVP’s Proposed Pharmacy Trend, Supplied by its Pharmacy Benefit Manager, is Not a Reliable Indicator of the Pharmacy Trend for its Vermont Book of Business.**

To arrive at its prescription drug trend, MVP used annual pharmacy trend factors split by generic, brand and specialty drugs based on national data provided by its new pharmacy benefit manager, CVS Caremark. TR at 112-14. According to MVP, it appropriately relied on its vendor’s “expertise of what the pharmacy market will look like in 2015 and 2014.” TR at 38.

At hearing, L&E actuary Jackie Lee testified concerning MVP’s pharmacy trend calculation, stating:

[It is] a significant limitation to not be utilizing Vermont-specific data. . . . “[T]hat’s where you’re going to be delivering services, that’s where you’re going to be selling your

products; you want to be as reflective as possible where you're going to be doing business. And using state-specific data is the best way to do that.

Id. at 114, 112.

Lee testified that L&E examined three years of historical pharmacy trend data as a “first pass” at determining whether MVP’s proposed trend was reasonable, and concluded that due to factors such as the generic dispensing rate, drugs losing patents, and the change in pharmacy vendors, the historic data was not indicative of the future trend. Absent state-specific data, L&E reasoned that BCBSVT’s 8.4% pharmacy trend – which L&E examined as part of its actuarial review of BCBSVT’s 2015 exchange filing – “was the best source to go with.” TR at 111-15; Exhibit 8 at 5.

The HCA’s actuary, Donna Novak, agrees that MVP should not have solely relied on the national pharmacy trend data provided by its new PBM. TR at 144 (“The least accurate is using national data, national reports put out by consulting firms or PBMs.”) Noting there is “a range of methodologies by which to calculate trend,” Novak utilized a blend of weighted historic trend data and proposed trend, and concluded that using her methodology, the rate increase would be reduced by one-half of a percentage point. Exhibit 9 at 9-11.

We agree that MVP’s vendor-supplied pharmacy trend – which does not take into account state-specific data – should not be used in the carrier’s 2015 exchange rate development. We recognize, however, that there is scant data at this juncture from which MVP can develop a credible prescription drug trend based on the relatively small number of Vermonters enrolled in this new book of business. For that reason, we agree with L&E’s recommendation that the 8.4% pharmacy trend developed by BCBSVT – the only other carrier in the exchange, with more than ten-fold MVP’s membership – most accurately reflects the overall pharmacy trend in the Vermont marketplace.

L&E calculates that this modification reduces the proposed rate increase minimally, by approximately 0.1%.

II. MVP Must Make an Adjustment to its Rate Calculation for the Change in Demographics.

L&E next recommends that MVP make an adjustment to its rate for the change in demographics based on age and gender. In response, MVP argues that it has already made an adjustment for morbidity that is inclusive of age, and that age and morbidity are not “mutually

exclusive” but instead “highly correlated.” TR at 190-91; MVP Memo at 5 (“There is a high correlation between the two because as populations age they become less healthy . . . [age and morbidity] are not separate considerations.”)

MVP’s explanation that age and health status are not mutually exclusive misses the point. To comply with the ACA and with plan filing requirements, a carrier must treat demographics and morbidity as separate projection factors, and must separately adjust for each in the filing. *See, e.g.,* HHS, *Part III Actuarial Memorandum and Certification Instructions* (March 20, 2014) at 8-9 (“Changes to the Morbidity of the Population Insured,” and “Changes in Demographics” listed as separate Projection Factors), *available at* http://www.serff.com/documents/plan_management_data_templates_2015/plan_management_data_template_2015_part3_actuarial_instructions.pdf; Exhibit 8 at 5 (lack of demographic adjustment renders filing non-compliant with HHS definition of “index rate”). Because MVP uses its 2014 enrollment as the basis for its 2015 enrollment, it is reasonable to believe that reflecting the characteristics of the 2014 population would be appropriate, and that an adjustment is required.

Accordingly, the carrier should apply a demographic adjustment of 1.028, as outlined by L&E.

III. MVP Must Recalculate the Single Conversion Factor Using its 2014 Membership, Reducing the Factor From 1.165 to 1.098.

L&E next recommends that MVP adjust its single contract conversion factor, which MVP calculated based on its experience period (2013) claims data. L&E recommends that MVP instead use its April 2014 membership, which it believes is more representative of MVP’s population since it is the basis for the 2015 projection population.

In light of the unavailability of sufficient, reliable claims data, we agree with L&E that the April 2014 membership, albeit a “snapshot” of enrollment, is a more accurate indicator of MVP’s projected 2015 enrollment distribution than is MVP’s 2013 claims data. *See* TR at 121 (Actuary Lee testifies that “[h]ealth claims experience takes a fair amount for time to be collected and then mature. And as of April 2014 it is pretty optimistic that they even had data available through March of 2015 . . . membership is . . . much more concrete.”) Indeed, as we observed earlier in this decision, MVP anticipates that its 2015 enrollment will be relatively the

same as its 2014 enrollment. Thus, in accordance with L&E's recommendation, the single conversion factor should be reduced from 1.165 to 1.098.

IV. The Reporting Error in MVP's Uniform Rate Review Template (URRT) Does Not Affect its Rate Development or Render the Manual Rate Incorrect.

The HCA's expert witness, Donna Novak, maintains that a reporting error in MVP's federal form URRT results in an incorrect calculation of its manual rate. MVP concedes that its URRT was completed improperly and contains an error, but does not agree that the error has any effect on its ultimate rate calculation.

Here, we rely on the credible testimony at hearing and the expert opinion of our actuaries and conclude that there is no error in the manual rate. As an initial matter, L&E thoroughly reviewed the rate request in the two-month period after it was filed, and did not determine that the manual rate was incorrectly calculated. *See* Exhibit 8. After the HCA submitted its report asserting there was a manual rate error, L&E was asked by the HCA to specifically consider and address whether the manual rate was incorrectly calculated, and confirmed that it was not, notwithstanding its agreement that MVP made a reporting error in the URRT. Exhibit 13, ¶ 2. At hearing, after listening to MVP's actuary testify that the error in the URRT had no effect on the rate and was assigned no credibility, TR at 67-69, L&E again confirmed that MVP did not make an error in its manual rate. TR at 128.

Based on the totality of the evidence and testimony, we are satisfied that MVP's reporting error had no impact on its rate calculation. However, in accordance with L&E's analysis and MVP's acknowledgement of the reporting error, we require that the error "be corrected in the final URRT submission." Exhibit 13, ¶ 2.

V. We Decline the HCA's Recommendation to Order MVP to Reduce its Administrative Load at this Time.

The HCA recommends that this Board order MVP to reduce its administrative costs, which it maintains will rise approximately 19% if the Board approves MVP's rate request of 15.4%. Exhibit 9 at 11-12. The HCA contends that MVP has not provided any evidence "that its administrative load is actually increasing at the same rate as other drivers of its premium rates." HCA Post-Hearing Memorandum at 4-5. In contrast, L&E has advised the Board that it

finds MVP's administrative expense changes "reasonable and appropriate." Exhibit 8 at 6; TR 128-29.

MVP actuary Lopatka addressed the issue at hearing, testifying that MVP does not collect adequate premium dollars from its Vermont membership to cover its administrative expenses. Rather, the company's 2013 supplemental health care exhibit, a statutory filing, shows that its PMPM administrative cost was \$45.58, approximately \$5 more than what MVP proposes for the current filing. TR at 49. According to Lopatka, MVP is working towards lowering its costs by making its operations more efficient, has reviewed its contracts with vendors and consultants, and in the process of reorganization has laid off 100 full-time employees. *Id.* at 49-50. Lopatka attributes MVP's current inability to cover its administrative costs the carrier's "unique issue with critical mass," and emphasizes that administrative cost is not the major driver of escalating health care costs: "The primary major issue is the cost of hospital services, physician services and prescription drugs." *Id.* at 84.

Based on the evidence and testimony presented at hearing, we agree with our actuaries that MVP's 9.5% administrative load is appropriate at this time, and decline to modify it downward. While we agree with the HCA that lowering this rate component would make the rate more affordable – reducing *any* rate component would do the same – MVP's hearing testimony demonstrated to this Board that the company is actively seeking ways to trim its administrative expenses so that it may remain competitive in the health insurance marketplace.¹⁰

VI. Based on MVP's Strong Financial Health, the Carrier Should Reduce its Contribution to Surplus from 1.5% to 1.0%.

Last, we consider the HCA's suggestion that MVP's strong financial health allows for a 0.5% reduction of its contribution to surplus. For several reasons, we agree.

First, as discussed in the Department's solvency opinion and analysis, MVP is domiciled in New York State, which has the primary responsibility for assessing its solvency. MVP's Vermont operations are a small part of its overall business; its holding company operations in Vermont account for only 5.3% of its total premium earned. Exhibit 7. The Department has consulted with insurance regulators in New York, and neither state foresees that the current rate

¹⁰ In an effort to limit the amount insurers can spend on administrative costs and profit, the ACA requires that health insurers spend at least 80% of premium dollars on medical care – the Medical Loss Ratio (MLR) rule – or issue rebates to plan enrollees. Though not determinative of our decision here, we note that MVP has complied with the MLR rule, and has not been required to provide rebates to its customers.

filing, as proposed, poses any measurable risk to MVP's solvency. Exhibit 7. Given the relatively small percentage of overall business affected by this filing, we believe that a 0.5% reduction in the contribution to surplus in this particular book of business will have minimal impact on the company's overall solvency.

Next, this view is consistent with MVP testimony that its several entities' solvency must be considered "holistically," TR at 80 (Lopatka testimony), and leaves a reasonable 1.0% surplus contribution intact.¹¹

Finally and most importantly, reducing the contribution to surplus from 1.5% to 1.0% makes the rate more affordable for Vermonters, who are most directly impacted by each increase in the cost of health care premiums. This reduction strikes an appropriate balance between our statutory charge to determine whether rates are affordable, while protecting the solvency of insurers. 8 V.S.A. § 4062(a)(3).

Conclusion

This is the second year that we have reviewed Vermont Health Connect insurance rates, and again we face the challenge of balancing the goal of affordability for Vermonters with the responsibility of ensuring that issuers in this marketplace can continue to offer quality, necessary health insurance coverage to our citizens. We have reached our decision after consideration of all the evidence and testimony, the opinions of concerned Vermonters, and careful deliberation.

Based on our discussion above, we modify the proposed 15.4% average annual increase downward as outlined in this decision, to 10.9%.

Order

Based on the reasons discussed above, the Board orders that MVP modify its 2015 Vermont Health Connect Rate Filing, and then approves the filing. Specifically, MVP shall (1) reduce its pharmacy trend from 9.0% to 8.4%; (2) apply a demographic adjustment factor of 1.028; (3) reduce the single contract conversion factor from 16.5% to 9.8%, and (4) reduce the contribution to surplus from 1.5% to 1.0%.

¹¹ We note that this result is consistent with our decision in Docket no. GMCB 018-14-rr, also issued today, regarding BCBSVT's exchange filing, in which we approved a 1.0% contribution to surplus.

So ordered.

Dated: September 2, 2014 at Montpelier, Vermont

s/ Alfred Gobeille)
)
s/ Karen Hein)
)
s/ Cornelius Hogan)
)
s/ Allan Ramsay)
)
s/ Betty Rambur)

GREEN MOUNTAIN
CARE BOARD
OF VERMONT

Filed: September 2, 2014

Attest: s/ Janet Richard

Green Mountain Care Board, Administrative Services Coordinator

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: Janet.Richard@state.vt.us). 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.