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July 29, 2019

VIA U.S. MAIL & E-MAIL

Michael Barber, Esq.
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: MVP Health Care 2020 Vermont Health Connect
Rate Filing – Docket No. GMCB-005-19rr

Dear Hearing Officer Barber:

On behalf of MVP Health Plan, Inc., enclosed please find *MVP Health Plan Inc.'s Post-Hearing Proposed Findings of Fact and Conclusions of Law* and *Certificate of Service.*

Respectfully submitted,

Ryan M. Long, Esq.

cc: ***(VIA E-MAIL ONLY)***
Kaili Kuiper, Esq.
Jay Angoff, Esq.
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Christina McLaughlin
Amerin Aborjaily
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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Care, Inc. 2020 Vermont Health Connect Filing SERFF No. MVPH-131934219	)))))	DOCKET NO. GMCB-005-19rr

MVP POST-HEARING PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

MVP Health Plan, Inc., ("MVP") by and through Primmer Piper Eggleston & Cramer PC, submits this Post-Hearing Memorandum to the Green Mountain Care Board (the "Board"), pursuant to Board Rule 2.307(g), in support of its 2020 Vermont Exchange Rate Filing (the "Rate Filing"), requesting a rate increase by an average of 11%. MVP reserves its right to supplement this Post-Hearing Memorandum on August 1, 2019 for any new information presented.

Findings Of Fact

1. **L&E Agrees With MVP In 2020.** MVP seeks a 2020 rate increase as amended of 11%. *See Matt Lombardo Testimony ("Lombardo"), pp. 19-20.* MVP originally proposed a 9.4% increase. *MVP's May 10, 2019 Rate Filing, at Exhibit 1, p. 2*; *Lombardo, p. 18.* The Board's actuary Lewis & Ellis ("L&E") conducted an exhaustive 60-day review of the Rate Filing and filed L&E's July 9, 2019 Actuarial Report recommending a rate increase of 10.5%. *See L&E's Actuarial Report As Amended (the "Actuarial Report") at Exhibit 9, p. 15*; *Jacqueline Lee Testimony ("Lee"), p. 206.* L&E amended the July 9, 2019 Actuarial Report on July 16, 2019 due to a typographical error that did not affect L&E's recommendations. *Lee, p. 226.* The purpose of L&E's Actuarial Report is to "**assist the Board** in determining whether the requested 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 law, and is not excessive, inadequate, or unfairly discriminatory." *Ex. 9, p. 2 (emphasis added)*; *Lee, p. 232.* MVP agreed with all seven of L&E's proposed modifications. *Ex. 9, p. 15*; *Lombardo, p. 48*; *Lee, p. 223.*[1] Therefore, all five actuaries who have reviewed this Rate Filing have reached consensus that 10.5% is an appropriate and adequate rate increase before considering adjustment for proposed hospital budgets—information that was not available to the parties until after L&E filed its Actuarial Report. *Lombardo, p. 48; Lee, pp. 223-24. Ex. 9, p. 17.* On July 19, 2019, the Department of Financial Regulation ("DFR") requested and later approved additional modifications to MVP's Gold 2 Non-Standard Plan, which has no additional impact on the contract weighted rate increase of 0.2% presented at the hearing. *See, July 25, 2019 MVP Letter to Hearing Officer Barber Regarding Gold 2 Non-Standard Plan.*

2. **All The Experts Agree That The 10.5% Rate Should Be Increased To Reflect The 2020 Hospital Budget.** MVP increased its proposed rate to 11% based on MVP's analysis of proposed hospital budget information released on July 16, 2019. *See MVP's Response to L&E Objection Letter #5*; *Lombardo, pp.* 33 and 36. As of this date, L&E has not yet filed an analysis of the proposed hospital budgets. An increase to the proposed rate to reflect the proposed 2020 hospital budgets is appropriate: "(T)he hospital budget and insurance rate processes should not be siloed, and the information before us at this time, prior to approving insurance rate increases, should be used to maximize consistency." *2018 Vermont Health Connect Rate Filing, SERFF No. MVPH – 131034103, pp. 8-9.*

An increase of 0.5% is actuarially sound because it reflects the current proposed hospital

[1] (Rec. #1) (-0.9%): *Ex. 9, p. 15; Lombardo, pp. 32-33.* (Rec. #2): *Ex. 9, p. 15; Lombardo, p. 33.* (Rec. #3) (+1.5%): *Ex. 9, p. 15; Lombardo, pp. 38 and 40.* (Rec. #4) (-0.8%): *Ex. 9, p. 15; Lombardo, pp. 40.* (Rec. #5) (+/- 0.0%): *Ex. 9, p. 15; Lombardo, pp. 41-42.* (Rec. #6) (+1.5%): *Ex. 9, p. 15; Lombardo, pp. 45-46.* (Rec. #7) (- 0.2%): *Ex. 9, p. 15; Lombardo, pp. 46-48.*

budgets, which is the best data currently available. *Lombardo, p. 37; See Lee, pp. 208-9.* Ms. Lee testified at the hearing that L&E would likely recommend a 0.2-0.3% increase based on a historical analysis of the Board's hospital budget decisions. *Lee, p. 222.* Basing a proposed rate on what the Board *might* decide based on what the Board decided in previous years is speculative and MVP's method is superior because it reflects the most up-to-date information. *Lombardo, pp. 37-38;* Furthermore, the Board, as it did already in 2019, has the discretion to change approved hospital budgets mid-year. *Ex. 3a, pp. 1-2*; *Lombardo, p. 34.* Basing this year's rate increase on review of previous Board decisions on hospital budgets creates yet another layer of assumption and risk. *Lombardo, p. 37.*

3. **L&E's 1.5% Increases For Medical Utilization Trend And Changes To Risk Adjustment Reflect Superior Market-Wide Data.** L&E analyzed market-wide data from both carriers and determined that a 1% increase to medical utilization trend was appropriate, resulting in 1.5% increase to MVP's rates. *Ex. 9, pp. 6-8 and 15*; *Lombardo, pp. 38-39*; *Lee, pp. 209-11 and 230.* MVP does not have access to the same market-wide data as L&E. *Lombardo, pp. 38-39*; *See Lee, pp. 209-10.* Although MVP had initially assumed a 0% increase, in all scenarios modeled by L&E, the medical utilization trend was positive and supported an increase in the rate. *See Lee, p. 210*; *MVP's Responses to the Board's Non-Actuarial Interrogatories at Exhibit 5, pp. 6-8 and 15.* "L&E has the ability to analyze data from both sets of carriers, so they have a whole snapshot of the QHP market, so their data and analysis is more robust and more comprehensive than what MVP has at its fingertips for utilization trend purposes." *Lombardo, pp. 38-39.*

As with Medical Utilization Trend, L&E analyzed data and information from both MVP and Blue Cross Blue Shield of Vermont and recommended an overall increase to MVP's rate of

1.5%. *Ex. 9, p. 11-12 and 15*; *Lombardo, p. 42*; *Lee, p. 213.* Properly calculating risk adjustment is challenging because, "from a carrier perspective it requires them to have knowledge of the other carriers in the market that is confidential . . .." *Lee, p. 212.* L&E was in a better position to review confidential information from both carriers and form a more complete analysis, therefore MVP agreed with L&E's recommendation. *Lee, p. 212-13; Lombardo, pp. 38-39.* Based on L&E's analysis, MVP's risk adjustment payment will be higher for 2020 and this increase in cost should be supported by an increase in MVP's rate.

4. **MVP's Proposed Contribution To Reserves ("CTR") Is Adequate, And Lower Than 80% Of Rate Filings Across The Country.** The DFR and L&E both agree with MVP's proposed CTR. *See Testimony of Jesse Lussier ("Lussier") pp. 190-92*; Ex. *9, p. 14*; *Lee, pp. 226-27.* As a "reasonableness check," L&E looked at rate filings nationwide and of the 777 Single Risk Pool ("QHP") filings, MVP's proposed CTR is lower than 82% of all filings for 2019. MVP's CTR is lower than 79% of all QHP filings in 2018. *Ex. 9, p. 14.* A CTR reduced below 1.5% would therefore be an outlier based on L&E's "reasonableness check." *Lussier, pp. 190-91.* Ms. Lee agreed that being an outlier is not actuarially sound. *See Lee, p. 229.*

Each rate filing should be self-supporting and MVP proposed a CTR of 1.5%—a figure the Board approved last year, and on which L&E, DFR, and MVP all agree this year. *MVP's Amended Rate Filing at Exhibit 2, p. 32*; *Lombardo, pp. 53-54*; *Lee, pp. 226-27*; *Department of Financial Regulation Solvency Opinion, Exhibit 10, p. 14*; *See Lussier, pp. 190-92.* Reducing MVP's already low proposed CTR without actuarial justification is not sustainable and reductions without justification jeopardize the adequacy of the proposed rates. *Lombardo, p.* 80.

5. **MVP Is Lowering Costs, Promoting Quality Care, Access, And Affordability In This Rate Filing, And The Board Should Not Reduce The Proposed Rate Increase On Any Of These Bases.** The Rate Filing, testimony of the witnesses, and exhibits all provide evidence that MVP has taken significant steps to contain costs and address affordability, access, and quality of care: (1) MVP promotes an affordable rate with a quality product; (2) MVP maintains its premium rate advantage against Blue Cross Blue Shield; (3) MVP supports Vermont providers in achieving quality for its members through the Marketplace Primary Care Improvement Program; (4) MVP's quality improvement initiative reduces costs, inpatient readmissions, medical errors, and includes health and wellness initiatives; (5) MVP promotes primary care; (6) MVP aligns fees to increase access to primary care physicians in the community, to make sure that, "the physician down the road is compensated comparably to the physicians that are employed by hospitals." *Lombardo, p. 60.* This initiative hopes to incentivize physicians to stay community-based and increase local quality of care; (7) MVP employs a comprehensive staff of clinicians including registered nurses, respiratory therapists, social workers, health coaches, and patient engagement specialists to administer a variety of care management programs targeted at helping our members receive the right service at the right time and at the right place, all of which results in lowering overall health care costs; (8) MVP has a nurse available 24/7 to answer non-emergency questions our members may have, especially at times when their doctor is not available; (9) MVP provides access to health care case managers to help members navigate the health care system; (10) MVP administers over 10 care management programs directly with members; (11) MVP's transplant care management program provides direct 1:1 assistance for members as they navigate pre- and post-transplant care; (12)

MVP's catastrophic care management program helps members with complex health issues such as those with a new cancer diagnosis; (13) MVP administers an unplanned care management program, which helps members who frequently use emergency care by coordinating care with their providers and educating them about alternatives; (14) MVP's care management team successfully engaged 30% of Vermont members who were specifically outreached for care management; (15) MVP engages in a competitive bidding process to obtain the best terms possible when contracting out for a vendor or a service; (16) MVP negotiates rates that reflect appropriate reimbursement levels across all provider types in MVP's network; (17) MVP keeps indirect costs down through contract negotiations with doctors, hospitals, and pharmacies; (18) MVP contracts with a Pharmacy Benefit Manager, to get the best prices on prescription pharmaceuticals; (19) MVP continuously analyzes MVP's formulary to make sure the most cost-efficient medications are on it; (20) MVP incentivizes members to use lower costs generic drugs where possible; (21) MVP undertakes an annual initiative focused on managing administrative costs; (22) MVP has worked to increase member engagement and cost transparency via its website, with users logging 3.5 million sessions from August 1, 2018 to the end of June 2019; (23) MVP supports the use of telemedicine and provides members the option to forward records of any telemedicine services to their primary care provider; (24) MVP provides welcome packets to help members understand benefits, increase utilization and help make members healthier; (25) MVP promotes an on-line tool which informs members of the cost of a given procedure, whether the member has satisfied their deductible and how much they will pay out of pocket; (27) MVP has online tools to help members with health and wellness activities, such as quitting smoking and eating healthier; (28) MVP offers a personal health assessment tool to measure progress toward health goals, and a LivingWell newsletter series; (29) MVP has a "Find a Doctor" tool

which members can use to search for providers, facilities and hospitals; (30) MVP has created special enrollment period guidelines and a user-friendly website to help Vermonters who did not start coverage during the open enrollment period; (31) MVP constantly reviews and regularly updates its information technology infrastructure to increase efficiency and reduce cost; (32) MVP includes credentialing and accreditations in administrative costs; (33) MVP maintains a nationwide network of providers, reducing costs paid for out-of-area fees for Vermonters on the road; (34) MVP participates in silver reflective plan efforts to help mitigate loss of the subsidy eliminated by the federal government; (35) MVP offers both standard and non-standard plans so members can compare plans; (36) MVP has a dedicated unit that investigates fraud and recovers monies improperly paid; (37) MVP coordinates meetings with Vermont Health Connect and Blue Cross Blue Shield of Vermont on critical issues; (38) MVP is developing robust evidence-based guidelines such as MVP's Medical Policies and Utilization Management Program designed to decrease unwarranted variations in care and support appropriate utilization; (39) MVP guides members who may be eligible for premium assistance through federal Advanced Premium Tax Credits; (40) MVP reduces out-of-pocket costs for enrollees earning 100% - 250% of the federal poverty level through cost-sharing reductions; (41) Vermont cost-sharing assistance can further reduce deductibles and copayments; (42) MVP helps members take advantage of federal and state cost-sharing incentives or subsidies; (43) MVP's New York business is National Committee for Quality Assurance (NCQA) accredited, and MVP is currently seeking certification of the Vermont book of business; (44) MVP continues negotiations with OneCare; (45) for high risk, high cost procedures such as transplants, MVP only uses the highest quality networks and providers to reduce downstream impacts; and, (46) MVP's pharmacy comparison tool helps members understand costs, and for prescriptions, show

the cost of drugs at various pharmacies in a given area. *Ex. 5 pp. 2-6*; *Lombardo, pp. 58-76.*

Furthermore, MVP's administrative costs have fallen substantially since 2013. *Ex. 9, p. 13*; *Lee, p. 225.* "In light of the steps taken by MVP to reduce administrative costs over the recent years, the assumed administrative 2020 costs are reasonable and appropriate." *Ex. 9, p.13*; Lee, *p. 226.*

Any Board reduction of the rate increase based on affordability or other non-actuarial grounds should be made within the frame of what is actuarially sound and statutorily adequate. *Lombardo, p.* 80. When it comes to statutory criteria, "[t]hey are all interrelated." *Lee, p. 230.*

Conclusions of Law

1. Health insurance rates in Vermont must be approved before they are implemented. *See* 8 V.S.A. § 4062(a) and § 5104(a). The Board is empowered to approve, modify, or disapprove requests for health insurance rates. *See* 18 V.S.A. § 9375(b)(6); 8 V.S.A. § 4062(a). MVP bears the burden of demonstrating that its rates satisfy the statutory criteria. *See Board Rule 2.104(c).* The Board must consider changes in health care delivery as well as changes in payment methods and amounts, DFR's solvency analysis, and other issues at the discretion of the Board. *Board Rule 2.401.* The Board shall modify or disapprove a rate request only if it is unjust, unfair, inequitable, misleading, or contrary to law, or if the rates are excessive, inadequate or unfairly discriminatory, fail to protect the insurer's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access. 8 V.S.A. §§ 5104(a) and 4062(a)(2)-(3); *Board Rule 2.0.* Each piece of evidence in the record could apply to one, multiple, or all of these statutory criteria. All of the statutory criteria are interrelated.

2. Pursuant to Actuarial Standards of Practice No. 8 (*rev'd* 2014) ("ASOP 8"), MVP's proposed rate increase as modified is adequate and not excessive because it provides for

and does not exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees and have reasonable contingency and profit margins. *Lombardo, p. 78-79*; *Lee, p. 231*; *ASOP 8, p. 8.* MVP's proposed rate increase is not unfairly discriminatory because it does not result in premium differences among the insured within similar risk categories that are not permissible under applicable law, or do not reasonably correspond to differences in expected costs. *Ex. 9, p. 15; Lombardo, p. 79*; *Lee, pp. 204-205.* The proposed premiums are reasonable relative to the benefits that are included in the Rate Filing, and will maintain minimum solvency requirements in 2020. *Lombardo, p. 78*; *Ex. 10*; *Lussier, pp. 188-89.* Based on the rate filing and all the other evidence submitted at the hearing, including testimony, the rates are not unjust, inequitable, misleading, or contrary to Vermont law because they are actuarially sound and fairly charge premium for services covered, and are reasonable based on the data that MVP and L&E analyzed. *Lombardo, pp. 77-80*; *see Lee, p. 216*; *see Ex. 9, p. 2.*

3. The Board must consider affordability, promotion of quality care and access to care in a "fair, predictable, transparent, [and] sustainable" manner. *In re MVP Health Ins. Co.*, 203 Vt. 274, 284 (2016). The Board should give significant weight to the opinion of the three L&E actuaries. *See Board Rule* 2.403. L&E established that MVP's proposed rate increase as amended is actuarially sound. No other actuarial evidence on the record supports a reduction in MVP's proposed rate. If the Board chooses to disregard all three Board actuaries, its modification must be based on evidence and still satisfy all statutory criteria and result in a balanced rate. *In re MVP Health Ins. Co.*, 203 Vt. 274, 286 (2016). A reduction on non-actuarial grounds could result in a rate that does not meet the statutory criteria of adequacy, and is not sustainable.

4. The Board must consider the analysis and opinion of the DFR in making its

solvency determination. 8 V.S.A. § 4062(a)(3). This year the DFR, L&E, and MVP all concur that the MVP's proposed 11% rate increase is adequate to protect its solvency. *Ex. 10, p. 2*; *Lussier, pp. 187 and 189*; *Ex. 9, p. 15*; *see Lee, p. 224*. Reduction to MVP's 1.5% contributions to reserves is not supported by DFR in this closed record and the Board may not consider a reduction from 1.5% in the absence of DFR's analysis or opinion on that reduction.

5. Although the Health Care Advocate's evidence focuses on affordability, all of the statutory criteria are interrelated and a change based on one criterion requires a consideration of that change's impact on all others. The Board should not, without sound actuarial justification, upset the balance of the proposed rate increase that all five actuaries carefully and exhaustively examined and recommended on the record, and cause the interrelated stack of statutory stones to come tumbling down.

6. Based on all of the evidence, which was substantial, the Board should find that MVP has met its burden of proving that the rate filing, as amended to an average of 11%, meets all of the statutory criteria. 8 V.S.A. §§ 4062(a); 5104(a); and, 18 V.S.A. § 9375(b); *Exs. 1-11*; *Lombardo, pp. 14-106*; *Lee, pp. 198-259*; *Lussier, pp. 186-194*.

Dated at Burlington, Vermont, this 29th day of July, 2019.

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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

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CERTIFICATE OF SERVICE

I, Ryan M. Long, Esq., hereby certify that I have served ***MVP Health Plan, Inc.'s Post-Hearing Proposed Findings of Fact and Conclusions of Law*** via e-mail and U.S. mail upon the following:

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Dated at Burlington, Vermont, this 29th day of July, 2019.

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