VERMONT

Green Mountain Care Board
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DELIVERED ELECTRONICALLY

July 23, 2020

Office of the Health Care Advocate
Kaili Kuiper, Esq.
Eric Schultheis, Esq.
Vermont Legal Aid
56 College Street
Montpelier, VT 05602

RE: MVPHP's Individual & Small Group Rate Filing (Docket No. GMCB-006-20rr; SERFF Tracking #: MVPH-132371260)

Dear Ms. Kuiper and Mr. Schultheis,

I am writing to follow up on a question posed by the Board during this week's hearing on the above-referenced filing. Pursuant to its authority under 8 V.S.A § 4062 and 18 V.S.A. § 9375(b)(6), the Board requests that the Office of the Health Care Advocate (HCA) provide the following information to assist the Board with its review:

1. Please provide explain whether the HCA's request to reduce the carrier's proposed rate increase to 0.0% 1) is consistent with certification requirements for Vermont Health Connect, and 2) would result in rates that are adequate and protect insurer solvency. *See* 8 V.S.A. § 4062(a)(3); GMCB Rule (Rule) 2.000, § 2.301(b).

Please submit the above information no later than July 30, 2020.

Sincerely,

/s/ Michael Barber

Michael Barber, General Counsel
Green Mountain Care Board

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.	)	
VT Health Connect 2021 Filing	)	GMCB-006-20rr
	)	

HCA RESPONSE TO GREEN MOUNTAIN CARE BOARD HEARING QUESTION

I. QUESTION

Please explain whether the HCA's request to reduce the carrier's proposed rate increase to 0.0% 1) is consistent with certification requirements for Vermont Health Connect, and 2) would result in rates that are adequate and protect insurer solvency. See 8 V.S.A. § 4062(a)(3); GMCB Rule (Rule) 2.000, § 2.301(b).

II. RESPONSE

a. *Ordering no rate increase is consistent with the certification requirements for Qualified Health Plan (QHP) issuers to sell on Vermont Health Connect (VHC).*[1]

To address the VHC insurer certification question, we are going to focus on two topics: solvency and actuarial value. We are happy to provide additional briefing on other aspects of the certification requirements if the Green Mountain Care Board (Board) has specific concerns that do not fall within these two areas.

i. *Solvency Requirements*

45 C.F.R. §156.200(b) lists the seven requirements for an issuer to sell QHPs on VHC. None of these seven requirements are related to premium charged. An insurer's solvency could implicate 45 C.F.R. §156.200(b)(4), which requires an insurer to be licensed and in good standing to offer health insurance coverage within the state. However, MVP's primary regulator,

[1] We do not believe the 0% rate increase request poses any threat to VHC's continued satisfaction of the requirements for state-based exchanges established by the U.S. Department of Health and Human Services. However, if the Board has a specific question on this topic, we are happy to submit a supplemental brief.

New York, has not communicated any solvency concerns about MVP to the Department of Financial Regulation (DFR). Further, MVP's VHC book of business does not implicate solvency due to the small percent of premium that Vermont business accounts for. Given the solvency position of the insurer and the fact that the Board's decision on this filing applies to only one product line means that there is absolutely no evidence that a 0% increase would cause the state to no longer allow MVP to sell insurance here. Therefore, our proposed 0% increase does not violate the certification requirements related to solvency.

ii. Actuarial Value Requirements

A 0% rate increase would not violate federal actuarial value (AV) requirements. Qualified Health Plans are required to meet federal AV standards.[2] Actuarial value calculation is designed "to establish a comparison tool and was not developed for pricing purposes."[3] AV is set based on a standard population that is calculated from national, not Vermont-specific or carrier-specific data. Therefore, a plan's actuarial value does not change based on final plan pricing.

The AV methodology ensures that there is sufficient differentiation in the benefit richness of the different metal plan levels (bronze, silver, gold, and platinum) and sufficient similarity in the benefit richness of plans within the same metal level to give consumers a reasonable variety of choices and to make comparison shopping easier. Federal AV requirements impact relative pricing among the different plans held by a single insurer, so platinum plans will be more expensive than bronze plans. An across-the-board increase or decrease does not impact this.

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[2] Department of Vermont Health Access, Health Benefits Eligibility and Enrollment Rule 2.04.
[3] Draft 2021 Actuarial Value Calculator Methodology, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2021-AV-Calculator-Methodology.pdf.

b. A 0% rate increase is consistent with the Board's broad authority to set rates by balancing all of the factors listed in 8 V.S.A. §4062 given the circumstances, including responding to the current Covid-19 crisis.

The federal government defers to the state's analyses of whether a rate increase is reasonable when a state has an effective rate review program, and the state provides the Center for Medicare and Medicaid Services (CMS) with a brief explanation of how it came to its final determination.[4] CMS has found that Vermont has an effective rate review program. [5] A state's rate review process and its explanation to CMS of how it came to its final determination must include an examination of the insurer's data and the reasonableness of the assumptions the insurer used to develop its proposed rate increase.[6]

While the federal government has its own definition of reasonableness that it applies when reviewing a rate for states that do not have an effective rate review program,[7] states like Vermont that have an effective rate review program do not follow the federal standard but instead set their own statutory criteria to determine whether a rate increase is reasonable.[8] Vermont's rate review statute requires the Board to 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.[9] The Board is not asked to privilege any of the statutory factors above any others. For example, the Board is not asked to ensure that the business protection standards

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[4] 45 C.F.R. §154.210(b).
[5] Center for Medicare and Medicaid Services, The Center for Consumer Information and Insurance Oversight, State Effective Rate Review Programs, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.
[6] 45 C.F.R. §154.301(a)(3).
[7] 45 C.F.R. §154.205(a). ("When CMS reviews a rate increase subject to review under §154.201(a), CMS will determine that the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, unjustified rate increase, or an unfairly discriminatory rate increase.").
[8] 45 C.F.R. §154.301(a)(5).
[9] 8 V.S.A. §4062; 18 V.S.A. §9375.

of rate adequacy and solvency must be met before the Board can consider the consumer protection standards of affordability and access to care. We note that if the Board was to believe that it could not make affordability cuts unless approved by the actuaries, it would have to believe that the statutory term "affordability" is superfluous to the actuarial terms of "not excessive or inadequate." Instead, it is up to the Board to determine whether each of the factors have been met in the proposed rate increase and then decide how to balance the many factors when setting the final rates.

The insurers spend significant time arguing that they need their requested rate increases for solvency. As stated above, we do not believe there is any evidence that a one-time 0% rate increase on one product line would threaten the insurers' solvency. Still, it is worth noting that the Board is not responsible for guaranteeing that insurers meet their solvency goals. The Board is responsible for setting insurance rates for fully-insured commercial plans, balancing the statutory factors. DFR and MVP's primary regulator, New York, has the responsibility to monitor insurer solvency and take action if it appears the insurer is at risk of not being able to pay its claims.

The Board is not required to privilege solvency above any of its other statutory factors, nor is it responsible for ensuring an insurer will meet its solvency target range.[10] For example, the insurer can implement administrative cost cutting measures, change its investment strategy, or increase its charges for the portions of its business that fall outside of the Board's review.

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[10] We note that it would be patently unreasonable for the Board to be expected to make sure an insurer meets its solvency range when solvency is impacted by issues outside of the Board's control such as investment strategies and whether lines of business that the Board does not oversee make or lose money. If an insurer falls below its target range, it will make a plan with DFR to get back into the range. This can be done through various means that are not limited to raising the premium rates that the Board oversees. It

As discussed in our Post-Hearing Memorandum, due in part to the extreme uncertainty in next year's claims predictions brought on by the Covid-19 pandemic, many of the insurers' arguments for rate increases are unreasonable. In addition, as demonstrated in our Post-Hearing Memorandum, health insurance premiums were not affordable before the current rate increases were proposed and before the Covid-19 economic crisis. As a result, looking at affordability and access to care in isolation, a *decrease* in premiums is needed. Given these considerations, the Board would be well within its powers to apply its discretion, balancing all of the statutory factors, and give Vermonters a much-needed temporary relief during a time of acute economic crisis by approving no increase for the 2021 plan year for individual and small group plans.

Dated at Montpelier, Vermont this 30th Day of July, 2020.

s/ Jay Angoff
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CERTIFICATE OF SERVICE

I, Eric Schultheis, hereby certify that I have served the above HCA Response to Green Mountain Care Board Hearing Question on Michael Barber, Green Mountain Care Board General Counsel; Amerin Aborjaily, Green Mountain Care Board Staff Attorney; and Gary Karnedy, Ryan Long, and Michelle Bennett, representatives for MVP Health Plan, Inc., by electronic mail, return receipt requested, this 30th day of July, 2020.

s/ Eric Schultheis
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