

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.)	GMCB-006-20rr
2021 Individual and Small Group Market)	
Rate Filing)	
)	SERFF No. MVPH-132371260
)	

DECISION AND ORDER

Introduction

On May 8, 2020, MVP Health Plan, Inc. (MVP), one of the two companies offering qualified health plans in Vermont, proposed an average annual rate increase of 7.3% over 2020 individual and small group rates, with plan-level increases ranging from 0.5% to 9.5%. Following a review by Lewis & Ellis (L&E), the Green Mountain Care Board’s (GMCB or Board) contract actuaries, MVP reduced its proposed rate from 7.3% to 6.1%. Following the submission of Vermont community hospitals’ fiscal year (FY) 2021 budget proposals to the Board on July 31, 2020, MVP raised its proposed average increase from 6.1% to 6.4%.

Based on our review of the record, the testimony and evidence presented at hearing on July 21, 2020, and guided by our statutory directives and commitment to approve the most affordable rates possible without threatening the company’s financial stability—thus enabling it to continue to offer health insurance in Vermont’s individual and small group market—we modify the rates downward from 6.4% as explained below, and then approve the filing for an annual average rate increase of approximately 2.7%.

Procedural History

1. On May 8, 2020, MVP filed its 2021 Individual and Small Group Market Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The filing outlined the development of proposed rates for coverage commencing January 1, 2021 and proposed an average annual rate increase of 7.3% with plan-level increases ranging from 0.5% to 9.5%. Exhibit (Ex.) 1 at 2.

2. On May 12, 2020, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care services and health insurance, entered a Notice of Appearance as an interested party to the proceeding. *See* 8 V.S.A. § 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule (Rule) 2.000 §§ 2.105, 2.202, 2.307.

3. On May 31, 2020, the Board issued fiscal year (FY) 2021 budget guidance for Vermont's 14 community hospitals. Typically, hospitals must submit their budget proposals to the Board by July 1. *See, e.g.*, FY 2020 Hospital Budget Guidance and Reporting Requirements (eff. March 31, 2019). However, to enable the hospitals to focus on responding to the COVID-19 pandemic, the Board gave them until July 31, 2020 to submit their FY2021 budget proposals. FY 2021 Abbreviated Hospital Budget Guidance and Reporting Requirements (eff. May 31, 2020), 4.

4. Following a request from MVP, the Board extended the timeline for reviewing MVP's filing to allow the parties and L&E to submit supplemental analyses regarding the impact of FY21 hospital budgets on MVP's proposed rates. *See* Second Amended Scheduling Order (June 1, 2020).

5. From May 18 through June 29, 2020, the Board requested that MVP respond to a series of interrogatories, including questions provided to the Board by the HCA and submitted to the company on the HCA's behalf. MVP provided responses to the Board's interrogatories. *See* Ex. 2-7.

6. On July 7, 2020, the Vermont Department of Financial Regulation (DFR) issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency. Ex. 11.

7. L&E conducted its review of the filing and on July 7, 2020, issued an actuarial memorandum summarizing its analysis and recommendations. Ex. 10.

8. The Board held a virtual administrative hearing on the proposed rates on July 21, 2020, through the Microsoft Teams platform. GMCB General Counsel Michael Barber served as hearing officer by designation of Board Chair Kevin Mullin. Gary F. Karnedy, Esq. of Primmer Piper Eggleston & Cramer, P.C. represented MVP and presented testimony from MVP's Director of Actuarial Services, Matthew Lombardo. Jay Angoff, Esq. of Mehri & Skalet in Washington D.C. represented the HCA, assisted by HCA staff attorneys Kaili Kuiper and Eric Schultheis, and Chief Health Care Advocate Michael Fisher testified on behalf of the HCA. Jesse Lussier testified for DFR regarding its solvency analysis. GMCB Associate General Counsel Amerin Aborjailly led the direct testimony of Jackie Lee of L&E, the Board's consulting actuary.

9. During testimony at the July 21st hearing, MVP requested a 6.1% average annual rate increase (down from MVP's initial proposed rate of 7.3%). Hearing Transcript (Tr.) at 24-26.

10. During the course of the hearing, the Board requested additional information which MVP and the HCA agreed to provide following the hearing. The Board sent MVP a letter requesting written responses to questions that Board members had posed at the hearing. *See* GMCB Request for MVP Supplemental Information (July 23, 2020) at 1-2. The Board also sent a request for information to the HCA. *See* GMCB Request for HCA Supplemental Information (July 23, 2020).

11. The Board opened a special public comment period on May 11, 2020, so that members of the public could comment on the two 2021 individual and small group rate filings—this filing from MVP and a filing from Blue Cross Blue Shield of Vermont. By the time the special comment period closed on July 23, 2020, the Board had received more than 950 written comments.

The Board also accepted public comment from Vermonters who chose to speak “in person” (via Microsoft Teams) at a public comment session held from 4:30 p.m. to 6:30 p.m. on July 21, 2020. Commenters overwhelmingly voiced the opinion that this is not a time to be raising insurance rates and that the Board should deny the carriers’ requested increases. Many commenters described the financial hardships they are facing because of the COVID-19 pandemic and the difficulties they have paying for increasing premiums and deductibles. Commenters also expressed frustration that insurance companies are seeking to raise insurance rates when the insurers have financially benefited from the pandemic. Finally, several commenters expressed anger and frustration at the current health insurance system and urged the Board to implement a single payer system.

12. On July 28, 2020, HCA and MVP filed post-hearing briefs. *See* HCA Brief (July 28, 2020); MVP Brief (July 28, 2020).

13. MVP and the HCA submitted written responses to the Board’s July 23, 2020 Requests for Supplemental Information. *See* MVP Response to GMCB Request for Supplemental Information (MVP Response) (July 31, 2020) and HCA Response to GMCB Request for Supplemental Information (HCA Response) (July 30, 2020).

14. On August 5, 2020, MVP submitted its “Supplemental Analysis on Proposed Hospital Budgets” (MVP Supplemental Brief) providing quantitative support for MVP’s proposed 0.3% overall rate increase resulting from the recently filed Vermont hospital budget submissions. *See* MVP Supplemental Brief (Aug. 5, 2020). On August 5, 2020, the HCA submitted its “Supplemental Analysis on Proposed Hospital Budgets” (HCA Supplemental Brief) urging the Board not to apply any increases in hospitals’ FY 2021 commercial rates to the premiums for individual and small group plans.

15. On August 7, 2020, DFR notified Board staff that MVP’s 2021 QHP forms had been approved. Email from Anna Van Fleet, Asst. Dir. of Rates and Forms, Life and Health, DFR to Amerin Aborjaily, Associate General Counsel, GMCB (Aug. 7, 2020). Approval was later formally confirmed in a letter from DFR to Commissioner Cory Gustafson at the Department of Vermont Health Access. Letter from Kevin Gaffney, Deputy Commissioner of Insurance, Dep’t of Financial Regulation, to Cory Gustafson, Commissioner of Dep’t of Vermont Health Access (Aug. 10, 2020).

16. On August 7, 2020, L&E issued an addendum to its actuarial memorandum (L&E Report Addendum) to opine on the MVP Supplemental Brief filed on August 5, 2020.

Findings of Fact

17. MVP is a non-profit health insurer domiciled in New York State and licensed as a health maintenance organization (HMO) in New York and Vermont. The company 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 in Vermont’s large group, individual, and small group health insurance markets. Ex. 1, 1-2.

18. MVP developed the rates in this filing for QHPs offered through Vermont Health Connect (VHC)—Vermont’s health insurance exchange—and for reflective silver plans offered off the exchange, with coverage beginning January 1, 2021 and ending December 31, 2021. Ex. 1 at 2.

19. MVP has steadily increased its Vermont membership since first offering QHPs in 2016. Based on its February 2020 membership, MVP projects that its 2021 filing will cover 14,848 policyholders, 23,782 subscribers, and 36,980 members. Ex. 1 at 112. By comparison, MVP had 6,614 members as of March 2016. *See* GMCB Docket No. 007-16rr (MVP 2017 VHC rate filing).

20. To develop its 2021 rates, MVP used as its base experience period claims incurred between January 1 and December 31, 2019 and paid through February 29, 2020. MVP restated its incurred medical claim estimates to complete the claims through March 31, 2020. Ex. 1 at 113.

21. COVID-19 is a potentially life-threatening disease caused by a recently discovered coronavirus (SARS-CoV-2). On March 7, 2020 and March 11, 2020, the first two cases of COVID-19 were detected in Vermont. On March 11, 2020, the World Health Organization characterized COVID-19 as a pandemic. On March 13, 2020, Vermont’s Governor declared a state of emergency to help ensure Vermont has the necessary resources to respond to this evolving threat. Executive Order 01-20.

22. Over the weeks and months following the arrival of COVID-19 in Vermont, a number of measures were taken to prevent the spread of the virus, including the closure of schools and childcare centers, the closure of bars and restaurants, and restrictions on the size of non-essential gatherings. Office of Governor Phil Scott, Novel Coronavirus (COVID-19): Vermont State Response & Resources (updated July 15, 2020). To conserve personal protective equipment and other critical resources and to limit exposure of hospital patients and staff to COVID-19, on March 20, 2020, Vermont’s Governor ordered the postponement of all non-essential adult elective surgery and medical and surgical procedures. Addendum 3 to Executive Order 01-20.

23. Actions were taken with respect to health insurance, as well. For example, because knowledge of whether an individual is infected with COVID-19 is critical to limiting that person’s exposure to others—and thus the spread of the disease—DFR directed health insurers to cover any medically necessary COVID-19 testing with no co-payment, coinsurance, or deductible requirements for members. *See* Reg. H-2020-03-E (April 14, 2020). DFR required health insurers to provide coverage for clinically appropriate health care services delivered remotely or through telehealth or audio-only telephone visits on the same basis as in-person consultations. Reg. H-2020-02-E (March 30, 2020). DFR also encouraged insurers to provide policyholders with a reasonable grace period to pay insurance premiums to avoid cancellation for non-payment and directed insurers to suspend all routine provider audits. Insurance Bulletin #211 (March 18, 2020).

24. MVP also took other actions to make it easier for its members to access health care during the pandemic, for example by waiving all cost sharing for telemedicine services and standing up a virtual emergency room telemedicine service that allows MVP members to connect with trained emergency providers from the comfort of their home 24/7. *See* Ex. 9 at 7-10.

25. In June 2020, 9.4% of Vermonters in the labor force were unemployed. By comparison, in June 2019, 2.4% of Vermonters in the labor force were unemployed. HCA Ex. 26.

26. The most recent data available from the U.S. Census Bureau's Household Pulse Survey show that approximately 48% of Vermonters surveyed have lost employment income from March 13, 2020 through June 30, 2020. Ex. 20.

27. Health care providers' revenues have also been substantially affected by the pandemic and the pandemic response. For example, on a system-wide basis, the operating margin of the 14 community hospitals in Vermont was -\$52,766,000 for the month of March 2020 alone. Green Mountain Care Board, May 2020 Year-to-Date Hospital Performance, 3 (July 15, 2020).

28. The federal and state governments have acted to help individuals, businesses, state and local governments, and health care organizations deal with the economic effects of the pandemic and the pandemic response. For example, the \$2 trillion CARES Act that the federal government enacted on March 27, 2020 authorized one-time direct cash payments to individuals and married couples, increased unemployment insurance benefits and expanded unemployment insurance eligibility, provided grants and low-interest loans to businesses, provided payments to hospitals and other health care providers, and created a Coronavirus Relief Fund to provide \$150 billion in direct assistance to state and local governments. Pub. L. 116-36. Vermont's allocation of the \$150 billion Coronavirus Relief Fund is \$1.25 billion. In Act 136, the Vermont Legislature appropriated \$275 million of this \$1.25 billion to the Agency of Human Services (AHS) to distribute needs-based grants to health care providers. Act. No. 136 (2020), Sec. 7. AHS will accept grant applications through August 15, 2020 from providers that experienced revenue losses or increased expenses due to COVID-19. Vermont Agency of Human Services, Health Care Provider Stabilization Grant Program Frequently Asked Questions (July 31, 2020).¹

29. In this filing, MVP projected the experience period claims forward to the rating period using an average annual allowed medical trend factor of 7.0%. As initially filed, the medical trend incorporated a 1.0% utilization trend and unit cost trend of 6.0% (unit cost trend is 3.8% for 2020 and 6.1% for 2021). Ex. 1 at 116-117; *see also* Ex. 10 at 6-8. In response to an interrogatory requesting that the company provide support for the medical unit cost trend assumptions for Vermont providers that are governed by the GMCB and all other providers, MVP provided the information weighted by facility and physician trends on a confidential basis. *See* Ex. 2, 2a.

30. As initially filed, MVP's unit cost trend resulted in a 6.2% unit cost trend increase for Vermont facilities and providers impacted by the Board's hospital budget review, and a 5.5% increase for other facilities and providers. Ex. 10 at 7. Vermont hospitals submitted their FY21 budgets in late July/early August 2020, after MVP submitted its 2021 Individual and Small Group Rate Filing. Hospitals will present their budgets to the Board from mid- to late-August 2020. *See* FY 2021 Abbreviated Hospital Budget Guidance and Reporting Requirements (eff. May 31, 2020). The Board will establish each hospital's budget by September 15, 2020, pursuant to 18 V.S.A. § 9456. Because at the time it developed its rates MVP had not finalized its negotiations with Vermont hospitals and proposed hospital budgets had not been submitted to the Board, MVP

¹ <https://dvha.vermont.gov/sites/dvha/files/documents/News/Frequently%20Asked%20Questions.pdf>

assumed in its initial filing that 2021 hospital budget increases would match 2020 approved increases with a few additional increases for specific facilities. These expected assumptions for hospital budget increases are based on information from MVP's contracting department. Ex. 10 at 7; Tr. at 61-62; *see also* Executive Session Tr., 4-7.

31. MVP included within its rates non-claim expense plan level adjustments that do not vary by plan, including a 1.1% decrease for federal and state taxes and fees, a 1.5% increase for contribution to reserves (CTR), and a general administrative costs increase from \$42.00 per member per month (PMPM) to \$43.75 PMPM. Ex. 1 at 119-120; Ex. 10 at 14-15.

32. MVP's initial filing assumed a 1.3% increase to rates due to the impacts of COVID-19. Specifically, MVP first assumed that a vaccine to prevent COVID-19 will be approved and widely available in early 2021. To account for the costs immunizations would add to claim cost, MVP assumed that a vaccine would be covered in full at the cost of \$75 per dose. MVP also assumed that 80% of the population would obtain the vaccine (based on an analysis published by Wakely Consulting), which corresponds to a PMPM claim cost of \$5.00 PMPM. Ex. 1 at 115-116. Second, MVP assumed that 2 months of elective surgeries have been canceled in 2020 and that beginning in August 2020 providers will perform 110% of their prior elective service volume until 80% of deferred services were fully performed. These assumptions combine to add \$4.51 PMPM in claim cost for the time period of January to April 2021 (at which point all deferred services would be made up and providers would return to normal utilization levels). MVP is reflecting \$1.50 PMPM in this filing to account for the increased utilization. *Id.* at 5-6. The result of MVP's assumptions for vaccine costs and increased utilization is an overall rate increase of 1.3%. Ex. 10 at 10-11.

33. MVP adjusted rates at the plan level by 0.4% of premium for an increase in bad debt, based on historical data. Ex. 1 at 120.

34. MVP has targeted a traditional medical loss ratio (MLR) of 90.1% and a federal MLR of 91.1%. Ex. 1 at 121-122.

35. MVP sued the federal government to recover unpaid cost sharing reduction (CSR) payments for 2017 and 2018, and the federal government and MVP have not yet come to an agreement on the amount of 2019 reconciliation payments. Ex. 4 at 2-3.

36. MVP proposed a 1.5% CTR to meet statutory reserve requirements for MVP's VT block of business and to protect against adverse experience relative to pricing assumptions. Ex. 1 at 131. DFR issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency. *See* Ex. 11. Noting that in 2019 MVP's Vermont book of business accounted for approximately 5.7% of its total premiums written, DFR opined that the rates as proposed would not have a negative impact on the company's solvency, but that "adequacy of rates and contribution to surplus are necessary for all health insurers in order to maintain strength of capital that keeps pace with claims trends." *Id.* at 1-2.

37. Notwithstanding the significant growth of MVP's Vermont membership, Vermonters' PMPM costs for administrative expenses in this year's filing have increased from

\$42.00 to \$43.75. Ex. 10 at 14-15. This is the second year in a row where MVP's Vermont membership has increased but the administrative expenses are increasing on a PMPM basis. *See* GMCB Docket No. 005-19rr (MVP 2020 VHC rate filing), Findings ¶¶ 32, 43 (“Notwithstanding the significant growth of MVP's Vermont membership, Vermonters' PMPM costs for administrative expenses in this year's filing have increased from \$39.80 to \$42.00”). MVP spreads its fixed costs “enterprise-wide” across its Vermont and New York business, and many functions, such as the claims operating system, are located and performed in New York where the company is headquartered and where its membership—though still significantly larger than Vermont's—is still declining. MVP believes its fixed costs represent approximately 50% of the administrative expenses. Tr. at 116.

38. Based on its review of the filing, L&E recommended three modifications which would affect the proposed rates, lowering the average overall rate from 7.3% to approximately 5.5%. *See* Ex. 10 at 16.

39. First, L&E recommended decreasing the total COVID-19 adjustment from 1.3% to 0.7%, decreasing the overall rate by approximately 0.5%. Ex. 10 at 16. With regard to pent up demand for the deferred 2020 utilization, L&E does not believe that the assumption that providers will run at 110% capacity is adequately supported based on: (1) providers have had an opportunity to receive financial assistance from the government to alleviate financial hardship, which reduces the financial incentive to run at greater than 100% capacity in the future; (2) there is an immense uncertainty regarding how long social distancing, cleaning, and other safety guidelines will continue into 2021, which limits provider capacity; (3) Vermont had a quicker than average turnaround from shelter-in-place to reopening, which potentially sets the stage for all deferred care to be recouped in 2020. *Id.* at 10. Further, with regard to the vaccine costs, L&E believes that the assumed vaccination rate of 80% is not adequately supported. L&E considered the 80% vaccination rate used in the Wakely report to be a sample scenario, not the expected scenario. L&E asserted that the filing does not consider that there could be constraints in supply of a vaccine, once available, which could restrict access to only the most vulnerable population initially. L&E recommended a vaccination rate assumption of 55%, consistent with flu vaccination rates. *Id.* at 11.

40. Second, L&E recommended that the projected risk adjustment receivable be changed to reflect L&E's estimate of the 2019 risk transfers, decreasing the overall rate by approximately 1.2%. If L&E's estimate does not ultimately agree with the Centers for Medicare & Medicaid Services' (CMS) final published transfers, L&E recommended the CMS values should be used in the rate increase calculation instead. Ex. 10 at 13, 16.

41. Third, L&E recommended modifying the premiums due to statutorily required benefit changes. This increases the projected premiums by approximately 0.02%. Ex. 10 at 16.

42. L&E also recommended updating the assumed unit cost trends for 2019 to 2020 if updated information regarding unit cost trends is known at the time the Board issued its decision in this filing. Ex. 10 at 16.

43. MVP reviewed the modifications recommended by L&E and determined that the precise impact of these modifications would result in an overall rate increase of 5.4%, compared to L&E's estimate of 5.5%. *See* Ex. 13. L&E concurred with MVP's calculation of 5.4%, indicating that MVP has access to a greater level of data and 5.4% is a reasonable estimation of the impact of L&E's recommended modifications. Ex. 15 at 7.

44. At the July 21st hearing, L&E opined that the rates, as modified, are actuarially sound; they are adequate because they would cover member claims, administrative costs, taxes and fees, and allow for a reasonable CTR; the rates are not excessive because they do not exceed the amount needed to pay for such costs; and they are not unfairly discriminatory because they do not produce impermissible differences in premiums among insureds within similar risk categories. Ex. 10 at 16; Ex. 15 at 4-5; Tr. at 161.

45. As relayed at both the hearing and in the post-hearing brief, MVP agrees with L&E's recommendations to modify the following rate components: (a) the projected risk adjustment receivable be changed to reflect L&E's estimate of the 2019 risk transfers, decreasing the overall rate by approximately 1.2%; (b) modifying the premiums due to statutorily required benefit changes, increasing the projected premiums by approximately 0.02%; (c) the assumed unit cost trends for 2019 to 2020 should be updated if more information regarding unit cost trends is known at the time the Board issues its decision in this filing; and (d) the assumption for the federal high cost member program be moved in the URRT from Risk Adjustment to "Net Reinsurance" (with no impact on rates). *See* Tr. at 30-31; Ex. 10 at 16; MVP Brief, 2.

46. MVP testified at the hearing that it did not agree with L&E's recommendation to decrease the total COVID-19 adjustment from 1.3% to 0.7%. MVP reiterated its pre-filed testimony, asserting that its filing assumes providers will operate at 110% capacity from August 2020 through April 2021 to make up for 80% of the deferred utilization in March, April, and May 2020, but noted that there is a lot of uncertainty as to how 2020 will ultimately play out. *See* Ex. 14 at 21-24; Tr., 33-39. In addition, MVP testified that even without a financial incentive to make up for lost revenue from deferred 2020 utilization, providers would operate at 110% capacity for the indicated months because providers care for their patients and want to see that they are getting the treatment they need. Tr. at 34. Regarding a COVID-19 vaccine, MVP reiterated its pre-filed testimony as to cost and vaccination rates and testified that the filing assumed that there would be a vaccine approved and widely available by early 2021. Tr. at 40-43. When asked by the Board which Vermont providers had been consulted about being able to operate at 110% capacity, MVP could not say but agreed to follow up with this information. Tr. at 114.

47. Jackie Lee of L&E testified at the hearing that, having reviewed MVP's filing submissions, pre-filed testimony and new exhibits and listened to all of the day's testimony, her recommendations remained the same as in L&E's July 7, 2020 Report. Tr. at 158-59. In addition, Ms. Lee testified that based on her own research she believed there would be a vaccine in 2021 but was not optimistic that it would be in early 2021. *Id.* at 190-91. Ms. Lee expanded upon her pre-filed testimony and L&E's report, noting that there's likely going to be a priority system that comes out making sure that the people who are in the greatest need and the highest risk categories get the vaccine first, with the young and healthy individuals getting it last, and noting that MVP

does have the younger and healthier members based on the risk transfer assumption and adjustment that MVP pays out. *Id.* at 206-07. As to the rebound of utilization in 2021, Ms. Lee stated that Exhibit F showed that there were scenarios that showed a rebound of utilization in 2021, with the exception of the scenario of successful suppression of the virus, which showed the rebound only in 2020, and noted later that there were many possible scenarios when using the model and that L&E used the model to look at scenarios when making its recommendations to the Board. *Id.* at 187-88, 207-08. When asked whether L&E would have considered a 0.0% rate increase for COVID-19 assumptions to be reasonable, as was assumed by the other QHP company, Ms. Lee stated she would consider that reasonable. *Id.* at 202-03.

48. MVP testified at hearing that it had a number of programs and initiatives in place to lower costs, promote the quality of and access to care, and increase the affordability of rates by managing care and medication, managing administrative costs and contracts, and managing the plan and membership, though MVP did not quantify a decrease in rates due to these initiatives. *See* Exs. 13, 13a; Tr. at 120-21. MVP is currently engaged in negotiations with OneCare Vermont Accountable Care Organization to enter into a contract for the 2021 plan year. Executive Session Tr., 2-3.

49. On July 28, 2020, MVP submitted its post-hearing brief, in which it asserted that: an 80% vaccination rate assumption falls between the 55% vaccination rate for the flu and the vaccination rate for Measles, Mumps and Rubella, which is greater than of 90%; and that daily news reports of people contracting and dying from COVID-19, daily work and family COVID-19 discussions, the necessity of working remotely, and having this year's hearing remotely all support the general proposition that Vermonters are more scared about spreading, contracting, and dying from COVID-19 than the flu, and will seek out and take the COVID-19 vaccine at much higher rates than the flu vaccine. MVP Brief, 4.

50. MVP's brief also asserted that health care providers will operate at 110% capacity from August 2020 until April 2021 in order to eliminate backlog, treat patients who have put off important non-emergency procedures as a result of Vermont's stay-at-home orders, and recoup lost revenue. MVP stated that it is reasonable to assume that all providers desire to promptly provide patients the care they need and are willing to work a reasonable number of additional hours to ensure their patients' health. MVP Brief, 3.

51. The HCA also submitted a post-hearing brief on July 28, 2020, in which it argued that the Board should implement no rate increase for 2021. The HCA asserted that the proposed rate impedes Vermonters' access to care and noted that premium growth in this market has far outpaced growth in wages and gross domestic product. The HCA highlighted the economic impacts of the pandemic by pointing to increases in the cost of food, the high unemployment rate, and survey results indicating that a large percentage of Vermont adults have lost income due to the pandemic. *See* HCA Brief. The HCA also highlighted the growing unaffordability of MVP's plans, noting that for those purchasing an MVP Standard Reflective Silver plan, in order to pay their premiums, individuals, couples, and households of four at 401% FPL (\$50,085, \$67,809, and \$103,258, respectively), must pay roughly 15%, 23%, and 21% of their income, respectively. HCA Brief, 6; *see also* Exs. 16, 17, 32.

52. The HCA strongly disagreed with MVP's assumptions around vaccine costs related to COVID-19, stating that "MVP's assumption that a vaccine will be given to 80% of MVP's policyholders on January 1, 2021—five months from now—is simply unreasonable. First, MVP misleadingly attempts to support the 80% assumption with a Wakely paper that simply provided an example of what the total vaccine costs would be if 80% of members were vaccinated. There is nothing in the paper that supports or recommends an 80% vaccination rate assumption. Further, in order for the vaccine to be given to MVP's members on January 1, 2020, not only does the vaccine have to be developed and federally-approved, but an adequate amount of it needs to be produced and available and a decision has to be made that MVP's Vermont policyholders are among those who will get the vaccine first. Based on current information, it is much more reasonable to not incorporate vaccine costs for 2021, an assumption Blue Cross Blue Shield of Vermont made, and L&E agreed with." HCA Brief, 8-9.

53. Lastly, the HCA urges the Board to assume a medical utilization trend in the center of the -7.5% to 4.9% range rather than accepting MVP's proposed 1% trend and to consider "MVP's rate base to include the \$1.75 million that MVP is certain to get because of the Supreme Court's recent decision regarding risk corridor payments" and order MVP to lower its PMPM administrative costs. HCA Brief, 9.

54. On July 31, 2020, in response to post-hearing questions from the Board, MVP stated that Vermont-specific recoveries conducted by MVP's Special Investigations Unit totaled \$23,757 for the four-year period 2016 through 2019. Year-to-date recoveries total \$9,005 and MVP expects to recover approximately \$3,000 for the remainder of 2020 which would put total 2020 recoveries at approximately \$12,000. MVP Response to GMCB Request for Supplemental Information, Question 2. MVP also confirmed that conversations regarding providers operating at 110% capacity to make up for deferred 2020 services have taken place with New York providers, but have not taken place specifically with Vermont providers. *Id.*, Question 7. The federal rule requiring separate billing for certain abortion services has recently been set aside in *California, et al. v. U.S. Dept. of Health and Human Services, et al.*, Case No. 20-cv-00682-LB, Order on Motions for Summary Judgment (July 20, 2020). MVP confirmed its administrative expense increase associated with separate billing for abortion services is \$0.43 PMPM, which is approximately 1% of MVP's total administrative expense assumption in this filing (but noted there is still a possibility that the rule requiring separate billing would be reinstated for the 2021 plan year). *Id.*, Question 4. MVP stated that its administrative expense increase associated with personnel expenses is \$0.09 PMPM, translating to an increase in aggregated personnel expenses of 0.2% and increasing the overall premium rates by approximately 0.02%. *Id.*, Question 3.

55. On August 5, 2020, after reviewing the Vermont hospitals' FY21 budget materials, MVP submitted its supplemental analysis regarding its anticipated impact of FY2021 hospital budget submissions. MVP's actuaries analyzed the available hospital budget proposals and asserted that these budgeted trends increase the 2021 inpatient unit cost trend from the originally-filed 7.0% to 7.4%, the 2021 outpatient unit cost trend from the originally-filed 6.5% to 7.5%, and decrease the 2021 physician unit cost trend from the originally-filed 4.6% to 4.0%. MVP's analysis

showed these changes combine to modify the proposed rate increase from the 6.1% presented by MVP at the rate hearing to 6.4%. MVP Supplemental Brief (Aug. 5, 2020), 1.

56. On August 5, 2020, the HCA submitted its analysis of the FY21 hospital budget submissions. The HCA noted that qualified health plans are the only option for Vermonters who do not have employer or government-provided insurance and often the only option for small Vermont businesses. The HCA asserted that it is essential that these plans are as affordable as possible, because these two groups are Vermont's most financially vulnerable commercially insured populations. The HCA requested that if the Board chooses to approve substantial commercial rate increases for any hospitals for 2021, that these increases not be applied to the individual and small group plans. HCA Supplemental Brief (Aug. 5, 2020), 1.

57. On August 7, 2020, L&E submitted an addendum to its July 7, 2020 L&E Report, advising that, having reviewed MVP's Supplemental Brief, the company's calculations are accurate, but only recommending that the Board's decision take into account the new information received in the hospital budget submissions. L&E also stated that CMS released the "Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year" on July 17, 2020, and there was little difference between L&E's calculation and the final provided by CMS, resulting in minimal to no impact on the rates. *See* L&E Report Addendum (Aug. 7, 2020), 1-2.

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). In addition, proposed rates cannot be excessive, inadequate, or unfairly discriminatory. Rule 2.000, § 2.301(b). The Board is required to consider changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); Rule 2.000, § 2.401. The Board must also 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), (a)(3), and any public comments received on the filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201.

The Board's review is plainly not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that the Legislature granted the Board review standards that 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 burden falls on the insurer proposing a rate change to justify the requested rate. Rule 2.000 § 2.104(c).

Conclusions of Law

Before we analyze MVP's requested rate increase, we wish to address the unique circumstances in which we find ourselves as we review this year's rate filings. Vermont is facing

a public health emergency of a magnitude not seen in 100 years, our health care system and economy are trying to adjust to the realities of the COVID-19 pandemic response, and individuals, businesses, and governments are experiencing an unprecedented level of financial hardship and uncertainty.

As we have noted in prior decisions, there is a tension inherent in our standard of review. On the one hand, we are required, without specific statutory guidance or a standardized definition, to consider whether an insurance rate is affordable for Vermont consumers; on the other hand, we must consider whether the rate protects insurer solvency and is adequate to cover the costs of paying for members' claims and administering the plan. The failure of a rate to meet either criterion could imperil Vermonters' access to care, implicating another one of our review criteria. Our job is to find the most appropriate balance amongst the interrelated criteria that we must consider.

I.

We first address several issues on which MVP and our actuaries are in agreement. Upon review of the record—including but not limited to L&E's recommendations, the evidence presented at the July 21st hearing, and the post-hearing briefs—we find the following recommendations reasonable in light of all evidence in the record and approve the following rate filing modifications: (1) change the projected risk adjustment receivable to reflect CMS's final published numbers on the 2019 risk transfer, (2) increase the overall rate due to statutorily required benefit changes, and (3) move the assumption for the federal high cost member program in the Uniform Rate Review Template (URRT) from Risk Adjustment to "Net Reinsurance." Findings, ¶¶ 40-41, 45, 57.

These three modifications decrease the proposed rate by approximately 1.3%.

II.

Second, we address MVP's request for a 1.3% increase to the overall rate to compensate for COVID-19 impacts, which is based on two assumptions: (1) that a vaccine for COVID-19 will be widely available beginning early 2021, and (2) that providers will perform 110% of their prior elective service volume from August 2020 until April 2021. Findings, ¶¶ 32, 46, 49-50. In its July 7, 2020 report, L&E recommended decreasing the total COVID-19 adjustment from 1.3% to 0.7%, decreasing the overall rate by approximately 0.5%. This recommendation was based on the company's assumptions failing to take into account variables that would limit the vaccination rate of COVID-19 in 2021 and L&E's analysis of different utilization scenarios for deferred elective services. *See* Findings, ¶ 39. L&E also testified, when questioned by the Board, that a COVID-19 impact on rates of 0.0% would be a reasonable assumption. *Id.*, ¶ 47.

With regard to increased 2021 utilization, we agree with our actuaries that there is a good chance that MVP will not see an increase in utilization in 2021 to make up for the deferred 2020 elective services. We believe it is equally, if not more, likely that providers will not exceed 100% utilization, as deferred services from Spring 2020 may be made up in 2020 given Vermont's successful COVID-19 suppression or because providers may not have the ability to run at 110%

due to enhanced safety protocols for testing, distancing, and more frequent cleaning requirements. *See Findings, ¶¶ 39, 47.* Further, we find MVP's reasoning that providers will either have financial incentive to perform services at 110% or that they will run at 110% because they care for their patients, is also overly speculative, particularly given that MVP has not spoken with any Vermont providers about their ability, expectation, or desire to perform services at more than 100% capacity in 2021. *See Findings, ¶¶ 39, 46-47, 54.*

With regard to vaccine costs, we echo the hopes expressed by all witnesses at hearing that a vaccine will be approved and widely available by early 2021 so that 80% of MVP's membership is vaccinated in 2021. However, we do not find there is enough evidence to support this assumption. First, we agree with our actuaries and the HCA that a vaccination rate of 80% of MVP's membership during 2021 is unlikely. L&E recommended a vaccination rate assumption of 55%, similar to flu vaccination rates, and noted that an 80% vaccination rate does not take into account constraints in supply of a vaccine, once available, which could restrict access to only the most vulnerable population initially. *Findings, ¶¶ 39, 47.* As noted by L&E and the HCA, there is likely to be a priority system to ensure that the people who are in the greatest need and the highest risk categories are going to get the vaccine first, with the young and healthy individuals getting it last, and that Wakely's estimate of an 80% vaccination rate is an example, not a prediction of what could happen. *Findings, ¶¶ 47, 52.*

L&E's review and recommendations are based on the company's assumptions that a vaccine will be approved and widely available in early 2021 and that the cost of the vaccine will be borne by the company and consumers. However, we do not find that the company has provided sufficient evidence to support the timing of a vaccine in early 2021 or that the company will experience the assumed costs of a vaccine. The timing of a vaccination being widely available and the cost per vaccine are at this point, again, only speculation. We must take into account the unknown factors that will affect the timing of the vaccine and ultimate cost to the company—the vaccine approval process may not be as fast as people hope; people may be wary of a COVID-19 vaccine given the speed at which it was developed compared to customary vaccine timelines (with development over multiple years); the effectiveness and side effects of a future vaccine are unknown and will affect how many people choose to be vaccinated; if the most effective vaccine is developed by another nation we do not know how long it will be before our country is able to get a sufficient supply of the vaccine; and there is the possibility that the federal government will set aside money to cover most or all of vaccine costs. These are only some of the variables and no doubt there are other unknown variables.

We do not find the company has provided enough support to overcome the possible supply constraints noted by our actuaries and the many variables we note above that will significantly affect the company's base assumptions as to timing and cost. There is no doubt for us that many Vermonters are experiencing an extreme level of financial difficulty and the cost of small group and individual plans continue to rise to increasingly unaffordable rates. *Findings, ¶ 51.* We are faced with the difficult decision of how to account for the unknown timing and use of a potential COVID-19 vaccine in 2021; depending on how the many variables play out, there might be costs to the company in 2021 or there may not be.

Upon review of the record—including L&E’s recommendations, the evidence presented at the July 21st hearing, and the post-hearing briefs and responses to Board questions—we find the company’s assumptions for the impacts of COVID-19 to be too speculative and that MVP has failed to sufficiently justify this component of its requested increase. Given these considerations, we reduce the company’s requested overall rate to remove the COVID-19 assumptions (a reduction of approximately 1.3%). Recognizing that we are putting the risk of the potential vaccine costs and additional utilization on the company, we will not reduce the company’s requested CTR to 0.0% (as requested by the HCA), as discussed further below.

III.

Third, we address MVP’s request for a 0.3% increase in rate resulting from its recalculation of unit cost trend that incorporates information from the recently filed Vermont hospital budget submissions. *See* Findings, ¶ 55. Our actuaries have advised that the company’s calculations are accurate but have not opined on what rate increase the Board should approve and recommended that our decision take into account the new information we received in the hospital budget submissions. Findings, ¶ 57. We do not know what will ultimately happen in the FY21 hospital budget process, nor do we find it would be fair or accurate to speculate as to what we will approve. We acknowledge that we must approve a unit cost for this filing that is as accurate as possible; therefore, we begin this discussion with what we do know.

We know the Board has actively sought to control the growth in hospital spending by consistently ordering reductions to hospitals’ initial budget submissions, both in terms of net patient revenues and commercial rate increases. *See* GMCB Docket No. GMCB-005-19rr, Conclusions, 12. We also know that this year is unlike prior years in that hospitals, to varying degrees, experienced unexpected losses in revenue due to deferred utilization this Spring and the Board is permitting the hospitals to request a time-limited COVID-19-related charge increase in addition to the customary charge increase.² Given these considerations, we do not believe it is reasonable to assume that we will approve FY21 hospital budget increases equal to those for FY20. On the other hand, we do not believe it is reasonable to assume, as the company has, that the Board will approve the hospital budgets as submitted, which we have never done in the past. *See* Fiscal Year 2020 Vermont Hospital Budget: Compilation of GMCB Staff Presentations (Oct. 2019), 4-5.³

Furthermore, as to what we do not know, we cannot be certain of the budget requests at this time. These budgets, which we received at the end of July 2020 rather than at the beginning of July as is usually the case, are preliminary and have not yet been verified or vetted by Board staff. The Board will not hear testimony on the budgets until after this decision has been issued so we do not know whether hospitals will be able to provide sufficient support for their requests or whether they will amend their requests after Board staff has verified the information.⁴ Moreover,

² *See* FY 2021 Abbreviated Hospital Budget Guidance and Reporting Requirements (eff. May 31, 2020).

³ [Fiscal Year 2020 Vermont Hospital Budget: Compilation of GMCB Staff Presentations \(Oct. 2019\)](#)

⁴ [FY 2021 Hospital Budget Hearing Schedule](#)

unlike prior years, there is also uncertainty as to whether additional stimulus money from the state or federal government will affect hospitals' revenue needs for the upcoming fiscal year. AHS has implemented the Vermont Health Care Provider Stabilization Grant Program, a \$275 million program to assist Vermont health care and human service providers affected by COVID-19. Hospitals are eligible for grants if they experienced revenue losses or increased expenses due to COVID-19. Applications for these grants will be accepted through August 15, 2020. *See Findings, ¶ 28.* If hospitals receive these grants, it could reduce their FY21 charge requests.

Given all of the above, while we do not approve MVP increasing the overall rate to 6.4% as requested in its Supplemental Brief, we will allow the company to assume that the unit cost for GMCB-regulated facilities for FY21 will be the midpoint between last year's approved hospital budget rates and this year's submitted hospital budget rates, and permit MVP to adjust its overall rate in accordance with this assumption.

We believe the approximate impact of this decision to be a decrease of approximately 0.6% from the overall rate.

IV.

Fourth, we wish to address MVP's administrative expenses assumptions set forth in this filing.

In light of the financial challenges facing Vermonters and the cost saving measures that businesses, schools, and state and local governments are implementing, such as furloughs and wage freezes, we disagree with MVP's choice to increase its administrative expenses by \$1.75 PMPM this year. Related to the affordability criterion in the Board's rate review process is the expectation that MVP provide benefits and services at minimum cost under efficient and economical management. *See* 8 V.S.A. §§ 4513(c), 4584(c), 5104(b). Notwithstanding the significant growth of MVP's Vermont membership since 2016, including membership growth from last year to this year, Vermonters' PMPM costs for administrative expenses have increased the past two years, last year from \$39.80 to \$42.00 and this year from \$42.00 to \$43.75. Findings, ¶¶ 19, 31, 37. As 50% of administrative costs are fixed and Vermont's book of business has continued to grow, MVP should be able to spread its fixed costs over the increased Vermont membership to further reduce the administrative expense on a PMPM basis. *See Findings, ¶ 37.* We note that MVP can also decrease its personnel expenses and decrease its assumption for separate billing for abortion services requirement (\$0.43 PMPM).⁵ Findings, ¶ 54. In a time when so many Vermonters are struggling financially, we find MVP can and should work harder to lower its administrative costs.

In light of the above considerations, we reduce the overall annual rate increase by 0.3% to reflect our reasonable expectation that MVP lower its administrative costs this year.

⁵ The company has noted that the court case setting aside the requirement for separate billing could be successfully appealed to result in the requirement being effective for 2021, however, it is our belief that the Department of Health Access is continuing to bill QHP customers through 2021 and MVP will not be taking on premium billing responsibility before 2022.

V.

Fifth, we address MVP's request for a 1.5% contribution to reserve.

Before turning to our discussion on CTR, we want to briefly highlight that MVP's fraud, waste, and abuse (FWA) recovery program has failed to produce significant, or even small or moderate, recoveries in the past four years and does not seem to be on track to do any better this year. Findings, ¶ 54. We expect MVP's FWA recovery program to perform better in coming years and note that a more efficient FWA recovery program will lead to lower reserve needs over time.

Turning to the CTR request for this year, as with each year but especially with the rate filings this year, we are mindful of the need to keep rates as affordable as possible. The concept of affordability, unlike our actuarial review standards, is fluid and open-ended, *see In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16, and requires a balancing of statutory considerations—unaffordable rates will hamper Vermonters' ability to access quality care, while affordable rates that imperil an insurer's solvency will likewise threaten Vermonters' access to care. Given our present circumstances, as the nation and the world are responding to a global pandemic, we find that appropriately striking the balance of affordability and solvency, as required by our statutory directives, is harder than ever.

The HCA has recommended that the Board approve a 0.0% overall rate increase this year in light of the financial situation of Vermonters, the economic impacts of the pandemic, and the rising cost of health care. Findings, ¶¶ 51, 56. While we have determined that affordability requires a significant reduction to CTR when the company is not facing solvency concerns, we will not reduce the company's overall rate or its CTR to 0.0% given a number of uncertainties related to the COVID-19 pandemic. As noted above, there are potential additional COVID-19-related increases in hospital budget submissions this year for which we are requiring MVP to take on a portion of the risk. In addition, we are requiring MVP to assume the risk of increased utilization in 2021 for deferred elective services in 2020 and the potential costs of a COVID-19 vaccine in 2021. While we did not find the company has sufficiently supported these assumptions such that we approve those requested increases, we cannot ignore that actuarial science is not precise and there is a chance these costs will have to be borne. This requires the company to have reserves to cover unexpected costs.

In light of the above considerations, we reduce the company's proposed CTR from 1.5% to 0.5%, which we conclude will not materially impact or pose a threat to the company's solvency. Despite capturing a growing share of the Vermont individual and small group market, the company's Vermont membership remains a small percentage of its overall business at approximate 5.7% of its total written premiums. *See* Findings, ¶ 36.

The above 1.0% reduction in CTR reduces the proposed rate by approximately 1.0%.

Order

For the reasons discussed, we modify and then approve MVP’s 2021 individual and small group market rate filing. Specifically, we order that MVP: (1) change the projected risk adjustment receivable to reflect CMS’ final published numbers on the 2019 risk transfer, (2) increase the overall rate due to statutorily required benefit changes, (3) move the assumption for the federal high cost member program in the URRT from Risk Adjustment to “Net Reinsurance”, (4) remove the COVID-19 assumptions, (5) decrease the unit cost for GMCB-regulated facilities for FY21 to the midpoint between last year’s approved hospital budget rates and this year’s submitted hospital budget rates, (6) decrease the overall rate by 0.3% to reflect our reasonable expectation that MVP lower its administrative costs this year, and (7) decrease the CTR from 1.5% to 0.5%.

As modified, we approve an average annual rate increase of approximately 2.7%, with plan level increases ranging from -3.9% to 4.7%.

We note that many Vermonters will receive federal subsidies to cover the increased costs in 2021, and we encourage Vermonters to use VHC’s Plan Comparison Tool⁶ (available beginning this Fall) when determining their best plan options.

SO ORDERED.

Dated: August 14, 2020 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Maureen Usifer)
)
s/ Tom Pelham)

Filed: August 14, 2020

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

⁶ Available at <https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action>

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