STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

MVP Health Plan, Inc. 2024 Individual Market Rate Filing	)	GMCB-004-23rr SERFF No. MVPH-133660955

MVP Health Plan, Inc. 2024 Small Group Market Rate Filing	)	GMCB-005-23rr SERFF No. MVPH-133660956

OFFICE OF THE HEALTH CARE ADVOCATE POST-HEARING MEMORANDUM

The Office of the Health Care Advocate (HCA) offers the following memorandum to assist the Green Mountain Care Board (Board) in its deliberations regarding MVP Health Plan, Inc.'s (MVP) 2024 Individual and Small Group rate filings. MVP has asked the Board to approve rate increases averaging 13.81% in the Individual market and 14.29% in the Small Group market.[1]

MVP does not offer sufficient evidence to justify the proposed rate changes. Consistent with prior practice, MVP offers mainly actuarial predictions as evidence to justify the proposed rates. However, in addition to actuarial soundness, the Board must evaluate whether MVP's rate requests are affordable and promote access. MVP's evidence of these non-actuarial factors consists of marketing-type statements, not facts. Regardless, MVP bears the burden to justify the rate requests. Having only meaningfully addressed a subset of the rate review factors, MVP has failed to meet its burden. The HCA therefore urges the Board to find that MVP has failed to justify the asked for double-digit rate increases and to modify the rates downward to the lowest practicable level.

[1] Ex. 49.

I. MVP BEARS THE BURDEN TO JUSTIFY ITS PROPOSED INCREASES.

Prior to selling a major commercial health insurance policy in Vermont, a health insurer must submit proposed rate changes to the Board for review.[2] The health insurance company "bear[s] the burden to justify the rate request."[3] Because this "burden to justify" is not defined by statute or by Board rule, it is appropriate to look to the courts for a standard.[4] The Vermont Supreme Court notes that a "preponderance of the evidence is the usual standard of proof in state administrative" proceedings.[5] Therefore, to meet its burden and justify approval of a proposed rate as filed, a health insurance company must establish, by a preponderance of the evidence, facts connected to the rate review criteria.

The rate review criteria are an assortment of factors, often in tension, which the Board must balance and the carrier must prove.[6] They include statutory factors—that the 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" Vermont.[7] And they include actuarial factors—that the proposed rate is not "excessive, inadequate, or unfairly discriminatory."[8] To justify the rate request, an insurer must offer evidence regarding these factors and prove, by a preponderance of the evidence,[9] that a balancing of the factors weighs in favor of the Board approving the proposed rate.

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[2] 8 V.S.A. 4062(a).
[3] Code Vt. R. 80-280-002, 2.104(c).
[4] E.g., In re Smith, 169 Vt. 162, 169 (1999).
[5] Id.
[6] E.g., GMCB-009-18rr, Decision at 17.
[7] 8 V.S.A. 4062(a)(2)(A).
[8] Code Vt. R. 80-280-002, 2.301(b).
[9] Additional sources of evidence in rate review proceedings include the Department of Financial Regulation's solvency opinion, the analysis of Board's actuary, and evidence offered by the HCA.

The Board examines the sufficiency of the evidence presented, engages in a balancing test, and ultimately determines the rate. The Board must adequately explain its reasoning for any modification in a written decision.[10] This process of examining, balancing, and explaining in writing is hampered when an insurer does little more than file an actuarial memorandum—which speaks to only a subset of the rate review criteria—to justify the rate. As the Board has acknowledged, the review criteria must be viewed holistically and it "cannot view one [factor] in isolation, without regard for the others."[11] Thus, when a carrier offers little or no evidence on a review factor, it hinders the Board from fully evaluating the proposed rate change. In such instances, the Board should find that the carrier has failed to justify the rate.

II. MVP'S EVIDENCE DOES NOT JUSTIFY THE PROPOSED INCREASES.

MVP offered some evidence that the proposed rate increases protect insurer solvency and are not excessive, inadequate, or unfairly discriminatory. It failed, however, to offer evidence that meets its burden to prove that the proposed rate increases are affordable or promote access.

As a preliminary matter, we challenge the oft made distinction between the "hard" data used by actuarial projections and the "fuzzy" data that speaks to affordability and access. Actuarial predictions are far from certain. Indeed, as the Board's own actuary admitted, the universe of methods that actuaries find professionally acceptable is "limitless".[12] Similarly, even when one amongst these numerous methods is chosen, that method produces a range, and a number of estimates could be selected and still be actuarially reasonable.[13] Given these facts, what once appeared as a mathematical fact is just one prediction within a range that is derived by

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[10] In re MVP Health Insurance Co., 2016 VT 111, ¶¶ 18–24.
[11] GMCB-009-18rr, Decision at 17.
[12] Hr'g Tr. at 248, line 10–13.
[13] E.g., Ex. 21 at 18 (stating a range within which any specific value would be actuarially reasonable).

an acceptable method which, itself, is just one method within a vast universe of acceptable methods.

In contrast, affordability and access data points and the conclusions drawn from them are more certain. For instance, inflation data is from the U.S. Bureau of Labor Statistics, and the inference that Vermonters will have less money in their household budgets due to inflation requires far fewer assumptions than actuarial predictions. Similarly, estimates generated by surveys such as the Vermont Household Health Information Survey have the weight of decades of knowledge and research on survey methods and design behind them to ensure accuracy.

Having addressed that issue, we now turn to MVP's failure to meet its burden related to affordability and access.

A. MVP failed to demonstrate that the proposed increases are affordable.

MVP is required to prove that their proposed rates are affordable. MVP's actuary, Christopher Pontiff, states the proposed rates comply with state law yet at the same time admits that he has no academic training or professional experience related to assessing affordability.[14]

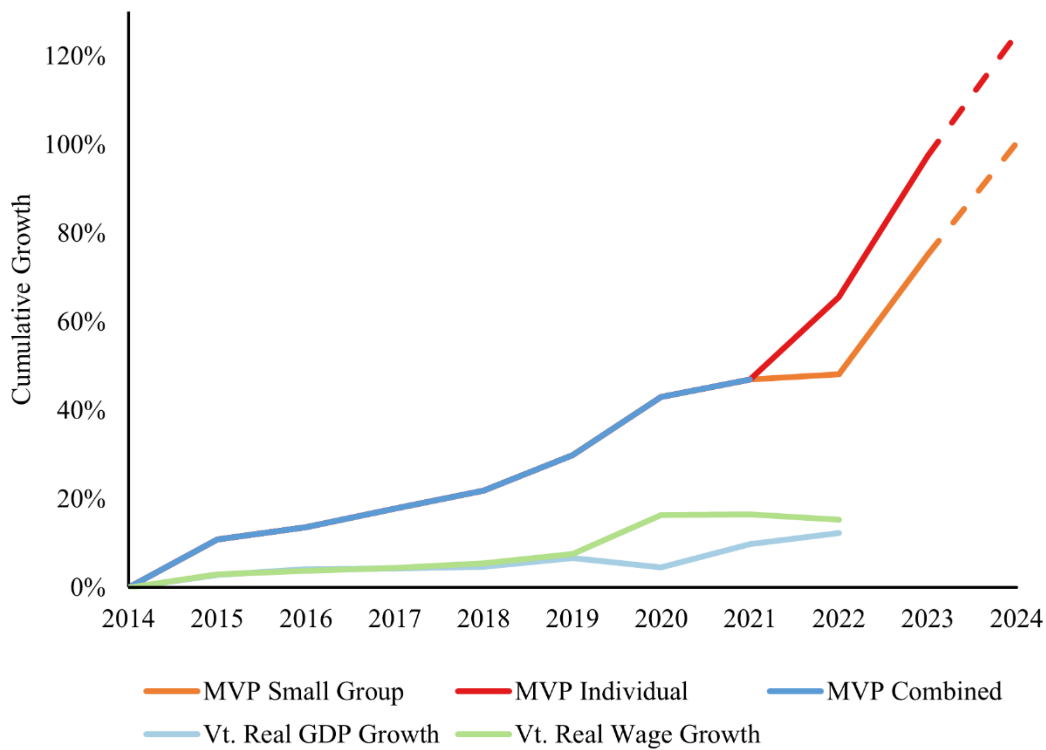
Public comments from roughly 140 Vermonters speak, however, to the current affordability crisis, the high rate at which premiums and cost sharing are outpacing Vermonters' ability to pay, and the high percentage of Vermonters' incomes being taken up by premiums and deductibles.[15] These comments fill in MVP's lack of evidence on affordability and demonstrate that MVP's proposed rates are not affordable. There is also a weight of quantitative data that demonstrates the proposed rates are not affordable.

[14] Hr'g Tr. at 89, lines 14–17 (Q: …do you have professional or academic training in assessing affordability. A: No.).

[15] Pub. Comment at 1–26, 28–66, 68–88, 91–128, 130–147.

If MVP's 2024 13.81% individual rate increase and 14.29% small group rate increase are approved, MVP's rates will have cumulatively increased 125% and 100% since 2014, respectively.[16] As we show in Chart 1, MVP's rate increases for these books of business have far outpaced both Vermont real GDP and Vermont real wage growth for the period between 2014 and 2022. The proposed rates, indicated by the dashed line, only accelerate this trend.

Chart 1. MVP VHC premium price growth, Vermont real GDP growth, and Vermont real wage growth.[17]



[16] Ex. 49; GMCB-005-22rr & GMCB-006-22rr, Decision; GMCB-007-21rr & GMCB-008-21rr, Decision; GMCB-006-20rr; Decision; GMCB-005-19rr, Decision; GMCB-008-18rr, Decision; GMCB-007-17rr, Decision; GMCB-007-16rr, Decision; GMCB-007-15rr, Decision; GMCB-017-14rr, Decision [collectively, hereinafter referred to as 2014–2022 GMCB MVP Rate Decisions].

[17] Exs. 27, 29, 30, 39, 49; 2014–2022 GMCB MVP Rate Decisions. We postulate that the wage "bump" in 2020 is due to low-wage workers exiting the employment market. Additionally, we used a different deflator to convert GDP to real terms this year. Rather than using national inflation statistics, we used Northeast Region inflation. This has the effect of deflating GDP growth less (i.e., favors MVP).

These macroeconomic indicators align with the on-the-ground impacts of rate growth on Vermont small businesses and the Vermonters who have plans in this book of business, members who are not eligible to receive federal or state premium or cost sharing subsidies. Although it is difficult to estimate premium and deductible burden of members in the small group market, the numerous public comments speak to the challenges small business have of balancing their books[18] and the issues members have of balancing their household budgets.[19]

Given the inaccuracy of measuring affordability by looking at premium costs alone, we offer a metric that captures the dual burden of premiums and deductibles on Vermonters. The metric combines (1) the ACA maximum percentage of the required consumer share for premiums for the applicable year, and (2) the Vermont Household Health Insurance Survey's underinsurance standard.[20] An insurance plan is affordable if a household (1) does not pay more than 8.5% of its income for premiums and (2) the plan has a combined deductible equal to or less than 5% of gross income.[21]

Using this metric, the 2023 MVP Standard Silver plan[22] is unaffordable to large numbers of Vermonters not income-eligible for Medicaid whose income is less than or equal to 500% of the 2022 Federal Poverty Limit (FPL). Specifically, after accounting for premium subsidies, cost-sharing benefits, and Dr. Dynasaur eligibility, the plan is unaffordable to individuals whose income is between \$20,390 and \$67,950. It is unaffordable for couples whose income is between \$27,480 and \$91,550. And it is unaffordable for families whose income is between \$41,630 and

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[18] E.g., Pub. Comment at 9, 17, 20, 31, 32, 46, 99, 125, 133, 136.
[19] E.g., Pub. Comment at 5, 15, 37,106, 117, 132.
[20] Ex. 35.
[21] We assume that households that are income-eligible for PTC receive PTC and purchase an on-Exchange plan.
[22] This analysis cannot be done on the proposed rates as the 2024 benchmark plan is not known. Any prediction of the 2024 benchmark would involve a problematic host of assumptions.

$138,750.[23] The proposed rate increases will make the 2024 MVP Standard Silver plan unaffordable to even more Vermonters.

This fact of unaffordability is compounded by the lingering impacts of the pandemic, high inflation, and (although not yet in the data) costs associated with the recent flood destruction. Recovery from the pandemic continues to be slow in sectors that lower- and middle-income Vermonters depend on for work. For instance, the Accommodation and Food Services sector is still down in June 2023 9% from 2019 levels, a period that covers both before and after the worst days of the pandemic. In contrast, the Professional and Business Services supersector grew 13% between 2019 and June 2023.[24] The growth in this higher-wage sector compared to the decline of the lower-wage service sector is one example of how the recovery has been different for different Vermonters.

In addition to employment issues, inflation is at high levels straining Vermonters' budgets.[25] Although inflation is hopefully cooling down, price growth over the last 12 months is troubling—for instance, among food staples, canned vegetables are up 5.5%, rice is up 7.5%, and bread is up 11.5%.[26] There is likely a connection between such high costs and the fact that 38,500 Vermonters sometimes or often did not have enough to eat,[27] that 14% of Vermont renters are behind on rent,[28] and that 139,000 Vermonters find it somewhat or very difficult to pay for usual household expenses.[29]

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[23] The assumed family composition is two adults and two dependent children under 19.
[24] Exs. 28, 30.
[25] E.g., Pub. Comment at 29, 30, 117, 126, 136, 139, 143.
[26] Ex. 36. It should be noted that, fortunately, eggs, meat, and heating fuel costs are decreasing relative to the historic highs reached during the pandemic.
[27] Ex. 42.
[28] Ex. 43.
[29] Ex. 44.

In summary, MVP failed to show adequate evidence that the rates are affordable. In the most charitable light, they offered evidence that the rates are actuarially reasonable and that they have made some efforts to contain costs but no evidence that they are affordable. In fact, they did not even present a witness who had relevant expertise or personal knowledge to speak on this topic. Numerous comments from Vermonters show that the rates are not affordable. In addition, quantitative data from Vermont and federal agencies show that the rates are not affordable. Lastly, it is true that members in the individual market are partially protected from rate increases in 2024, but Vermonters in the small group market are not. Further, any increases approved this year will be felt by many individual market members when the "cliff" at 401% FPL returns in 2026.[30]

B. MVP has not demonstrated that the proposed increases promote access.

Rates that force a significant number of people to self-ration care do not promote access to care. Numerous public comments speak to the fact that Vermonters cannot afford to use their insurance.[31] Further, claims data that carriers use cannot speak to this issue as it only captures members who overcame the cost barrier to access and used services (i.e., have at least one claim). MVP has introduced no evidence related to how cost impacts care-seeking decisions of Vermonters, members who, but for cost, would have sought care.

III. MVP'S PROPOSED RATES ARE JUST ONE OF MANY ACTUARIALLY REASONABLE RATES.

The Board must consider whether MVP has proven that the proposed rates are not excessive. MVP has failed to meet this burden. However, even assuming they have met their

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[30] Pub. Comment at 55.
[31] E.g., Pub. Comment at 30, 107, 116, 134.

burden of proof, they could only show that the proposed rates are just one rate amongst a set of actuarially reasonable rates.

Actuaries determine a reasonable range of rates and, in developing the rate, none of the assumptions a carrier makes are the only reasonable assumptions that could be made (whether related to the selection of a point estimate or related to the specific method used). This begs two questions. What is an actuarially reasonable rate given the wide range of possibly actuarially reasonable ranges? Further, how do actuaries pick a specific rate? The answer to the first question, circularity aside, is easy. An actuarially reasonable rate is one that falls within the actuarially reasonable range of one of the large number of methods that are professionally accepted by actuaries. There is no specific algorithm to determine the range and no specific way to pick the method used. Rather, actuaries exercise their professional judgement to arrive at the range. The second question appears thornier at first glance given the assumption that complicated math is needed to arrive at an actuarily reasonable range. However, it is simple. Good actuaries pick a rate within the actuarially reasonable range. They consider the totality of circumstances and make a guess.

The implementation of a method is something actuaries are qualified to determine—they are trained to exercise professional judgement to arrive at one amongst many possible actuarially reasonable ranges. The precise value selected within the reasonable range, however, is something that any person with subject-area expertise can do. The Board's determination of a rate or rate component within the actuarially reasonable range is just as sound as MVP's guess. In fact, the Board's selection will likely be better than MVP's as it has a full grasp of the totality of circumstances including a clearer understanding of the affordability and access crisis facing

Vermont due to cost and the perspective gained by regulating a large percentage of the health care system.

IV. CONCLUSION

MVP has not justified rate increases of 13.81% in the individual market and 14.29% in the small group market. Under Vermont's rate review standards, MVP must prove that the rates are affordable, and they have not done so. The rates also undermine access and are excessive, but affordability is the fundamental problem.

MVP essentially asserts that the rates are not excessive and therefore that they are affordable. But vast numbers of Vermonters cannot afford the 2023 rates. Approving double digit increases for the second year in a row will only make health insurance even more unaffordable for Vermonters.

It will be difficult, but the Board must significantly trim these rates. We urge the Board to carefully consider the certainty of affordability facts compared to the uncertainty of actuarial estimates. With the pressures facing Vermonters, the possibility of triggering a crisis in the market by forcing consumers out of the market due to cost, and the wide latitude given to the Board by the tremendous uncertainty of this year's requested rates: the Board should approve rate changes for MVP that produce the lowest practicable rate increases.

Dated at Montpelier, Vermont this 28th Day of July, 2023.

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CERTIFICATE OF SERVICE

I, Eric Schultheis, hereby certify that I have served the above OFFICE OF THE HEALTH CARE ADVOCATE POST-HEARING MEMORANDUM on Michael Barber, Laura Beliveau, Geoffrey Battista, and Tara Bredice of the Green Mountain Care Board; and Gary Karnedy, Ryan Long and Maggie Kushner, Primer Piper Eggleston & Cramer PC, representatives of MVP, by electronic mail, return receipt requested, this 28th day of July, 2023.

/s/ Eric Schultheis
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