STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.	)	
2025 Small Group and Individual Group	)	DOCKET NOS. GMCB-005-24rr
Vermont Health Connect Rate Filing	)	GMCB-006-24rr
	)	
SERFF Nos. MVPH-134081005	)	
MVPH-134081032	)	

PREFILED TESTIMONY OF ERIC BACHNER

1. WITNESS QUALIFICATIONS AND BACKGROUND

Q1: Please state your name and employer for the record.

A1: Eric Bachner, I work for MVP Health Care.

Q2: What is your position at MVP Health Care?

A2: Director, Commercial Market & Valuation Actuary. *See **Exhibit 1***, Eric Bachner's CV.

Q3: The filing was authored by MVP Health Plan, Inc. What is MVP Health Plan, Inc. and how does it relate to MVP Health Care?

A3: MVP Health Plan, Inc. is MVP's Health Maintenance Organization ("HMO") subsidiary. It is a legal entity, a non-profit HMO company that falls under the umbrella company of MVP Health Care.

Q4: Are you a member of any professional associations?

A4: Yes. I am an Associate of the Society of Actuaries.

Q5: How long have you been employed in the health insurance industry?

A5: Approximately 11 years.

Q6: What are your job duties as Director, Commercial Market & Valuation Actuary?

A6: In addition to overseeing premium rate setting, manual rates, and rating factors for commercial fully insured plans in New York and Vermont, I am also responsible for managing our incurred but not reported amounts ("IBNR"), overseeing financial forecasting, and performing budget-to-actual trends.

Q7: How many Green Mountain Care Board rate filings have you worked on for MVP, and explain your level of involvement?

A7: This is the 40th Green Mountain Care Board rate filing I have worked on for MVP. For eight of the last eleven years, I have worked on the small and individual rate filing, and then the large group filing. I have worked on the filings in a supervisory role, as the primary analyst, and in a support role. This is the first year I am the actuary in charge.

Q8: Has your involvement with the Green Mountain Care Board rate filings always been while you were employed with MVP?

A8: Yes. I worked at MVP from June 2013 through December of 2021. I then moved to Cigna Healthcare for two years before returning to MVP in January 2024 in my current

role. While at Cigna Healthcare I was not involved with the Green Mountain Care Board rate filings.

2. RATE FILING SUMMARY

Q9: What was MVP's initial average proposed rate increase for the Vermont Small Group 2025 exchange filing, dated May 13, 2024?

A9: The average proposed rate increase for the Vermont Small Group 2025 market filing on the Vermont Exchange was 9.34% (hereinafter "Small Group Exchange Filing"). *See **Exhibit 2***, MVP Small Group VHC 2025 Rate Filing, p. 2.

Q10: What was MVP's initial average proposed rate increase for the Vermont Individual 2025 exchange filing, dated May 13, 2024?

A10: The average proposed rate increase for the Vermont Individual 2025 market filing on the Vermont Exchange was 11.68% (hereinafter "Individual Exchange Filing"). *See **Exhibit 3***, MVP Individual Exchange 2025 Rate Filing, p. 2.

Q11: Has your proposal for rate increases changed since the original rate filing? If so, why?

A11: Yes. The Vermont Governor signed bill H.890 into law on June 28, 2024. MVP has assumed the implemented portions of H.766 (which include restrictions on prior authorization, step therapy and pre-payment reviews) will increase trended paid claim expense by 0.9% in the rate filings. This results in an average rate increase of 10.27%, instead of the 9.34% initially filed for the Small Group, and 12.63% instead of 11.68% for

the Individual. *See* ***Exhibit 4***, MVP Response to Small Group Objection #5; ***Exhibit 5***, MVP Response to Individual Rate Objection #5.

For prior authorization, MVP's actuarial team was provided cost estimates for the prohibition of health plans "imposing prior authorization requirements on any admission, item, service, treatment or procedure ordered by a primary care provider." *See* H.766, Gen. Assemb., 2023-2024 Sess. (Vt. 2024).

For step therapy, MVP's pharmacy team informed the actuarial team that there would be minimal disruption to our current policies and procedures and therefore no cost impact. For pre-payment review, MVP's actuarial team was provided with data that estimated the value of a [redacted]

In the rate filings, MVP has assumed that trended paid claim expenses will increase by 0.9% (with the assumption that these payment policies will cost more in 2025 than in 2023 due to unit cost and utilization trend increases consistent with paid claims). This will also increase MVP's assuming risk adjustment payment, as bill H.766 will increase the claim cost of the entire market in total.

Q12: Did MVP file two separate filings again this year for Small Groups and Individuals?

A12: Yes.

Q13: What is the book of business affected by the Small Group Exchange Filing?

A13: The book of business affected by the Small Group Exchange Filing is 1,209 policyholders, 9,306 subscribers and 15,027 members, based on February 2024 membership. *See* ***Ex. 2***, p. 10.

Q14: What is the book of business affected by the Individual Exchange Filing?

A14: The book of business affected by the Individual Exchange Filing is 7,689 policyholders, 7,689 subscribers and 10,616 members, based on February 2024 membership. *See* ***Ex. 3***, p. 10.

Q15: Can you explain the difference between subscribers, policyholders, and members?

A15: Policyholders are contract holders, such as an employer. Subscribers are the contract holder for a parent-child or family contract. Members are individual insureds.

Q16: Can you explain the difference between standard and non-standard plans?

A16: Standard plans provide consumers with an apples-to-apples shopping experience between carriers. Non-standard plans give the carriers the ability to offer different products, such as different cost sharing elements (deductibles or copays), or to offer additional benefits.

Q17: Do the MVP Small Group and Individual 2025 Non-Standard Plans provide additional benefits to members not included in the Standard Plans?

A17: Yes, members purchasing a non-standard plan will receive MVP's Member Wellness Incentive. This is an enhancement to the current wellness benefit whereby primary subscribers can be reimbursed up to $600 per subscriber, per year for wellness-related rewards for items that will improve the health of our members. Additionally, MVP has a $500 reimbursement for acupuncture services on its non-standard plans in 2025 which is another benefit enhancement provided in our non-standard plans. These rewards show a commitment by MVP to improve the health of its members in all facets of their life.

There are too many overlapping cost drivers that make it impossible to measure the claim-cost impact of wellness. While there is no direct data to support the claim that the program is lowering claim costs overall, it is designed to incent behavioral changes that will improve the health of our members and reduce the morbidity of chronic conditions and reduce complications of those conditions.

Q18: What is MVP proposing for contribution to reserves in 2025 for the Individual Exchange and Small Group Exchange Filings?

A18: MVP is building a 1.5% contribution to reserves/risk charge into the Vermont Exchange premium rates for 2025. *See* ***Ex. 2***, p. 15; ***Ex. 3***, p. 15.

Q19: And what did MVP propose last year?

A19: 1.5% was proposed and approved last year as well.

Q20: Why did MVP use 2023 data in calculating its proposed Small Group Exchange Filing and Individual Exchange Filing 2025 rates?

A20: For an actuarially sound premium rate, MVP used the best data available to project claim costs for 2025—2023 historical claims data. Per Actuarial Standards of Practice ("ASOP") #26:

> "premium rates are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital."

MVP used actual data from the previous year—2023—to calculate Small Group and Individual 2025 rates. MVP assumes 2023 historical claims data, which includes all Affordable Care Act ("ACA") compliant individual data in the experience period, is fully credible and represents the most accurate and up to date information available for purposes of setting actuarially sound rates for MVP's book of business in Vermont in 2025.

3. NON-ACTUARIAL STATUTORY CRITERIA (8 V.S.A. §4062): AFFORDABLE, PROMOTES QUALITY CARE, PROMOTES ACCESS TO HEALTH CARE.

Q21: What steps has MVP taken to lower costs and establish that its proposed rates promote affordability, access to care and quality of care for Vermonters?

A21: MVP has taken multiple steps, including but not limited to:

1. MVP strives to put forth the lowest premium possible relative to the benefits we are covering.
2. MVP promotes an affordable rate with a quality product.
3. MVP promotes primary care. See Q & A 22–23.
4. MVP employs a comprehensive staff of clinicians. See Q & A 24.
5. MVP administers over 10 specific care management programs directly with our members. See Q & A 25-26.
6. MVP engages in a competitive bidding process. See Q & A 27.
7. MVP contracts with a Pharmacy Benefit Manager ("PBM"), to get the best prices on prescription pharmaceuticals. See Q & A 28.
8. MVP has sought to increase member engagement and cost transparency via its website. See Q & A 29.
9. MVP supports the use of telemedicine. See Q & A 22.
10. MVP maintains a nationwide network of providers. See Q & A 32.
11. MVP offers both standard and non-standard plans. See Q & A 16.
12. MVP has 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. These medical policies undergo continuous review and are vetted by community physicians throughout our service area. Vermont physicians serve as representatives on MVP's Medical Management Committee, Pharmacy and Therapeutics Committee, and Quality Improvement Committee.

13. MVP supports and guides taxpayers who may be eligible for premium assistance, cost-sharing incentives or subsidies. See Q & A 30.

14. MVP reduces out-of-pocket costs for enrollees earning from 100% to 500% of the federal poverty level through cost sharing reductions and premium tax credits. See Q & A 30.

15. MVP's New York and Vermont business is accredited by The National Committee for Quality Assurance ("NCQA"), which employs a large set of robust quality standards and requires reporting in more than 40 areas. MVP believes that it offers quality services and that the providers with which it has contracted are high performing.

16. MVP uses current technology to manage costs and improve affordability, access to care and quality of care. See Q & A 29.

17. MVP employs stacked deductibles leading to a reduction in out-of-pocket costs for families. See Q & A 35.

18. MVP encourages consumers toward plans that suit their needs, including through Silver-loading. See Q & A 30 and 36.

Q22: How has telehealth affected access to healthcare and affordability?

A22: The following response was prepared with the help of our Clinical team. Virtual care, including urgent care, Behavioral Health, and routine everyday care, continues to be a well-utilized resource by our MVP members. We continue to see an increase in utilization of service through our mobile app, Gia. Comparing full year 2020 utilization to full year 2023, utilization has increased 143%, proving that Gia continues to be a critical

resource for expanding access to care for our members. MVP is committed to evolving Gia to meet members' needs by focusing on increasing access to in-person care that has been historically limited, e.g., dermatology, aligning our roadmap to our clinical strategy to support members with top health care issues, and building out a pathway focused on keeping members healthy. Additionally, MVP is focused on making Gia a cost-effective alternative to care for both our members and employer partners. Our partnerships will expand as we align with the right resources to support the roadmap. Overall, Gia continues to be a 24/7, 365-day convenient, robust, and coordinated resource for our members to get the care they need, when they need it, and in the way they want to receive it.

Q23: How does MVP promote affordability by encouraging strong relationships with primary care physicians ("PCPs")?

A23: The following response was prepared with the help of our Clinical team. MVP is a strong believer that primary care should be central to a patient's medical experience because having a consistent relationship with a PCP can avoid future higher costs. Regular contact with a PCP helps establish a relationship where efficiencies are created because the PCP knows your medical history, and the PCP can delegate or refer care in the most efficient way possible. MVP aligns fees to increase access to primary care physicians in the community and makes efforts to incentivize members to seek care from primary care physicians.

Q24: How does MVP's hiring and use of clinician staff improve affordability, quality and access to care?

A24: The following response was prepared with the help of our Clinical team. MVP offers medical and behavioral health care management programs to members tailored to their needs. Drawing on the combined strengths of our registered nurses, social workers, respiratory therapists, behavioral health professionals, wellness teams, physicians, pharmacists, and community providers, MVP provides a highly focused, integrated approach to management that promotes quality, cost-effective health care throughout the care continuum.

Q25: Describe MVP's case management programs.

A25: The following response was prepared with the help of our Clinical team. The goal of MVP's case management programs is to help members regain optimum health or improved functional capability, in the right setting and in a safe, cost-effective manner. It includes comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with self-management goals, monitoring, assessing for barriers, and follow-up. A Case Manager will ensure that members have access to information to support the selection of providers and facilities that will move members into systems in which standards of care are utilized effectively and will provide cost-effective outcomes. Throughout the case management process, the Case Manager acts as a guide, helping members and families navigate the health care system. When necessary, the Case Manager will assist in performing discharge-planning activities, initiating appropriate referrals (including

necessary standing referrals, specialists as PCP's, and referrals to specialty care centers), and identifying alternate care options to facilitate appropriate delivery of care and services. All of these services are intended to help the member regain optimal health or improved functional capacity in the right setting, and in a safe and cost-effective manner. Clinical goals include navigation of the health system, assuring medical compliance, improving and maintaining safety, quality of life, continuity and coordination of care. The Case Manager performs six essential case management activities throughout the health care event: assessment, planning, implementation, coordination, monitoring, and evaluation.

The Case Manager also works collaboratively with members, caregivers, providers, and others to support complicated medical and psychosocial needs and to create a case management plan. In developing the plan, the goals, preferences, and desired level of involvement of the member and caregiver are taken into consideration to design a person-centered plan. The case management plan includes prioritized goals, resources, services and collaborative approaches to be utilized, plans to ensure continuity of care, development and communication of self-management plans, as well as timeframes for reevaluation. Barriers to care are also identified and addressed in the case management plan. If no barriers exist, the assessment with no findings is documented. While actively working with members, the Case Manager optimizes opportunities to educate the member on preventive care screening in addition to closing identified gaps in care. The member's progress in meeting their individualized goals and overcoming barriers to care is continually assessed and documented and care plans are adjusted and communicated as needed.

Q26: How do MVP's case management programs help create efficiencies that improve affordability, quality, and access to care?

A26: The following response was prepared with the help of our Clinical team. Case management helps create efficiencies that improve affordability, quality, and access to care, by assisting members locate and utilize lower-cost high quality care, and redirecting overutilization of high-cost services towards more efficient options.

Q27: What steps does MVP take to manage costs and contracts to improve affordability?

A27: MVP engages in a competitive bidding process to obtain the best terms possible as a way of keeping administrative costs down when contracting out for a vendor or a service. MVP negotiates rates that reflect appropriate reimbursement levels across all provider types in MVP's network. MVP keeps indirect costs down through equitable and cost-effective contract negotiations with our providers, while still remaining competitive in the Vermont market and maintaining a robust network.

MVP constantly reviews and regularly updates its information technology infrastructure to increase efficiency and reduce administrative expenses and overhead. Administrative cost includes credentialing and accreditations. MVP also maintains a nationwide network of providers, reducing costs paid for services rendered outside of MVP's service area.

MVP has continued to undertake its Lean Initiative to identify areas where it can replace manual intervention electronically. Furthermore, MVP does regularly review our

policies, contracts and financial data to determine areas where we can increase cost efficiency.

Q28: How does MVP managing prescription drug utilization improve affordability, access, and quality of care?

A28: This response was provided with support from our Pharmacy team. MVP has contracted with the same highly regarded and competitive PBM for several years to obtain the best prices on prescription pharmaceuticals. Cost containment estimates in the MVP filings are based on our PBM's proven track record. MVP's pharmacy team works with the PBM through negotiating unit cost reductions and/or increasing rebates from the manufacturer. MVP continuously analyzes its formulary to make sure the most effective and cost efficient medications are on it.

MVP incentivizes members to use lower cost generic drugs where possible. Generic prescriptions accounted for 91.7% of all prescriptions to MVP members in 2023. We project that generic prescriptions will stay nearly the same at 92.2% of all prescriptions by 2025. *See* ***Ex. 2*** at Ex. 2b p. 78; ***Ex. 3*** at Ex. 2b p. 79. MVP's pharmacy benefit provides consumers with a high quality product. In recent years, there have been a number of high cost specialty drugs that have been approved by the FDA. While these drugs are costly, they are expected to provide positive outcomes for members.

Q29: How does MVP use current technology to manage costs and improve affordability, access to care and quality of care?

A29: The following answer was authored with support from our Marketing team. MVP is committed to increasing member engagement, access to care, and cost transparency via its website and 24/7 virtual care services through Gia by MVP.

MVP aims to increase member engagement on our website by including website links and digital resources in all communications. MVP's website had approximately 2.72 million users logging 4.2 million sessions in 2023. This reflects a 68% increase in overall users from 2022. Web sessions in 2023 grew by 2% compared to 2022. Additionally, MVP's "Shop for a Plan" tool had approximately 109,000 visitors shopping for individual and family plans in 2023. MVP's dedicated VT webpage, mvphealthcare.com/vermont also had 6,103 visitors in 2023.

All MVP members have access to Gia virtual care services through their MVP plan. Gia connects members to the right care, right away, including 24/7 urgent and emergent care, mental health and psychiatry, primary care, mobile lab test collection, lactation consultants, nutritionists, and more. MVP virtual care services through Gia are available at no cost-share for all members. Gia is available through the Gia by MVP mobile app or phone call. Since its launch on January 1, 2021, there have been more than 61,700 Gia virtual consults and more than 136,590 MVP members registered for a Gia account. Gia features and functionality will continue to evolve to meet our member's needs.

MVP also has various online cost transparency tools for our members to help steer members toward affordable and quality care. Our online cost calculator tool allows

Vermont members to enter their location and the procedure or test to be performed and the tool will estimate the cost of the procedure, MVP's contractual arrangement with providers in the location selected, and whether the member has satisfied their deductible and how much they will pay out of pocket. This also allows members to compare prices across different providers and access lower cost high quality care. This tool helps remove some of the cost unknowns which may have prevented members from seeking preventative treatment, potentially lowering the cost of treatment.

In addition, our prescription drug search in partnership with our PBM allows Vermont members to view the prices of prescription drugs at different pharmacies and compare their out-of-pocket costs. MVP has online tools to help members with several health and well-being activities, such as quitting smoking and eating healthier.

Q30: How does MVP increase affordability by helping lower the cost of premiums for subscribers?

A30: MVP works with its members to help members take advantage of federal and state cost-sharing incentives or subsidies in the individual market to help members maximize their benefit and pick the right cost plan. MVP supports and guides taxpayers who may be eligible for premium assistance through federal Advanced Premium Tax Credits ("APTC") in the individual market, which further increases affordability.

MVP reduces out-of-pocket costs for enrollees earning from 100% to 500% of the federal poverty level through cost sharing reductions. Vermont cost sharing reductions lower enrollees' deductibles, co-payments, and out-of-pocket maximums. Vermonters at or below 300% of the federal poverty level may also be eligible for Vermont premium

assistance that reduces their premium contribution by 1.5% of their household income. Furthermore, individuals earning at or below 500% of the federal poverty level qualify for APTC. This tax credit can be applied to premiums each month or can be filed with a federal tax return. The federal government has cancelled reimbursement of incurred claims under the cost-sharing reduction ("CSR") program effective October 2017. However, members are still eligible for the reduced cost sharing plans in the program.

The State of Vermont's solution to this problem was to create two sets of Silver plans: one set for non-CSR members with premiums that do not reflect the CSR defunding and one set for CSR members that do reflect the CSR defunding in the premium. This was done so that the second-lowest cost Silver plan on the exchange would have an increased premium, which is the plan used to determine how much lower-income members will receive in premium subsidies through federal APTC. This ensures that premium increases for CSR defunding will be met with corresponding increases in APTC subsidies and the net policyholder premium increase will be minimized.

What this means is that individuals under 500% FPL can purchase a silver plan for 8.5% of their income, with even lower contribution percentages as income level decreases.

Q31: What efforts has MVP taken to implement fixed prospective payments and describe any plans MVP has to implement fixed prospective payments?

A31: MVP has actively participated in workgroup discussions with Vermont payers and regulators to explore and standardize fixed prospective payments for Vermont hospitals leading up to the announcement of Vermont's selection into the CMS AHEAD model. We look forward to learning more about the opportunities for fixed prospective payments

within the AHEAD model, understanding these opportunities are dependent on provider and health system interest as well as operational and financial readiness and capabilities.

Q32: Do MVP plans cover providers that are not under the Green Mountain Care Board's jurisdiction, which improves access to health care and quality of care?

A32: Yes, MVP's benefits and products offered in this filing cover a nationwide network of providers outside the state of Vermont. This includes direct contractual relationships with Dartmouth Hitchcock in New Hampshire and providers in Northern New York, as well as a national carrier which serves member access needs, no matter their location at no additional cost share above their benefits. MVP also offers Telehealth services via our Gia platform and contracts with providers that render telehealth services from another state, contingent on Vermont licensure.

Q33: What is the main driver of the cost of health insurance?

A33: Health insurance costs are driven by health care costs, including, medical costs and utilization, healthcare provider reimbursement, administrative costs, healthcare utilization patterns, regulatory requirements, research & development, and advancements in medical technology.

Q34: How do hospital costs impact health care costs?

A34: Hospital budgets, once approved, and the costs resulting from them make up roughly 45% of health care costs. The Green Mountain Care Board has been concerned about what they view as a troubling trajectory of hospitals in Vermont since at least 2018. Medicare

and Medicaid have not been keeping pace with inflation, and employers and households cannot continue to afford the hospital price increases year after year. There are serious concerns about patient access to care, hospital sustainability, and the sustainability of the overall health care system.

[redacted]

Q35: How do stacked deductibles impact the affordability of health insurance?

A35: Stacked (embedded) deductibles are a great benefit for plans that cover more than one member. Stacked deductibles apply plan benefits to each family member once they meet their individual deductible and to all family members once the family meets the deductible. The family will spend less money in total than they would with an aggregate deductible. This is particularly beneficial for families with one member who incurs the majority of the medical spend. Since cost sharing will begin sooner, the financial impact

of high-cost claimants is mitigated. This reduction in out-of-pocket costs makes health insurance more affordable.

Q36: What drives the cost of your metal plans (i.e., Bronze, Silver, etc.)?

A36: The Affordable Care Act created the metal level groups which are made up of levels of out-of-pocket medical costs, deductibles, and premiums balanced against richness of benefits. MVP is only able to build plan designs to offer in the Individual and Small Group markets that fit within restrictions implemented by the government which track the various metal levels. In many cases, government-created safety nets pay subsidies based on whether an individual can afford a metal-level plan determined as a percent of income. Plans are structured to maximize the benefit of subsidies for eligible individuals within the parameters set by the government for plan design.

MVP has no control over the statutory requirements created by the Affordable Care Act and the state implementation of the same. It would be up to Congress and the Vermont legislature to shift restrictions on plan structure in order to make the cost of insurance plans lower. Among other things, by regulation, the federal government sets the actuarial value each metal-level plan must meet - (1) A bronze health plan is a health plan that has an AV of 60 percent; (2) A silver health plan is a health plan that has an AV of 70 percent; (3) A gold health plan is a health plan that has an AV of 80 percent; and, (4) A platinum health plan is a health plan that has as an AV of 90 percent. Also by regulation, the government

requires issuers to calculate AV through HHS's AV Calculator to determine whether plans offered meet the above percentage AV.

The structure of metal plans year-to-year directly impacts affordability. According to the Green Mountain Care Board, Vermont has the highest premium for average low cost silver plans among New England states and out of pocket maximums have increased alongside the rising premiums. This kind of growth admittedly creates affordability concerns. However, under the existing regulatory framework, MVP's discretion is extremely limited with respect to its metal-level plan offerings all of which are set months before this rate review process. In that process, DVHA and the GMCB consider affordability. Similarly, hospital budget review, which drives costs, proceeds in near-parallel, but separate, review proceedings which are not concluded until after this rate review. While affordability is a concern in this rate review process, the rates are designed to balance actuarial considerations when setting the overall rate for the following year, while implementing plan structures approved months prior, and in anticipation of hospital budgets approved later.

Q37: What other steps has MVP taken with the metal plans to promote affordability?

A37: As in 2024, MVP has filed Silver plans to be sold off exchange known as "reflective" Silver plans. The plans are equivalent to the corresponding on exchange plan with the exception of a $5 copay or 5% coinsurance change to the ambulance benefit or a modification to the deductible/maximum out of pocket for the plan which has no cost sharing after the deductible. *See* **Ex. 2** p. 52; **Ex. 3** p. 34. This approach allows MVP to direct consumers towards plans that make the cost of health insurance more affordable.

Q38: What is the impact of hospital care and hospital spending on affordability?

A38: According to the Green Mountain Care Board, approximately 50% of hospital spending is for hospital care. *See* June 19, 2024 GMCB Presentation on Act 167, p. 15. This is a very high percentage, and thus has a profound impact on affordability. According to the Green Mountain Care Board, hospital system transformation is necessary to simultaneously address two problems: (1) hospitals' financial health, particularly in rural areas, is poor and continuing to deteriorate and (2) increasing commercial process to sustain hospital prices is no longer a viable option. *See* June 19, 2024 GMCB Presentation on Act 167, p. 9. Additionally, the Green Mountain Care Board notes that "Vermont per capita health care spending has grown and is now among the highest" in the United States. *Id.* at 14–15.

Q39: How are hospital affordability concerns being addressed?

A39: The hospital budget process provides an opportunity to address health care costs and affordability concerns more directly. According to the Green Mountain Care Board, guidance has been provided to hospitals in an attempt to help curb their spending and create sustainability. *See* June 19, 2024 GMCB Presentation on Act 167, p. 23, 26.

Q40: What venues other than the insurance rate review process are better suited to address affordability?

A40: According to the GMCB, hospitals have limited capacity to solve these problems on their own; the problems with hospital spending would be better addressed by systemic changes to the overall health care system. Therefore, the more impactful venue to take

concrete steps to address affordability is in the insurance plan design process that takes place prior to the insurance carrier rate review. The insurance plan design process considers affordability to ensure that all benefit scenarios considered to improve affordability are compliant with the limits of federal law.

Q41: What does the U.S. Department of Health and Human Services consider a reasonable increase in premiums, and how does that compare to MVP's proposed rates for 2025?

A41: MVP's rate filings this year with increases of 9.3% and 11.7% (or as revised, 10.27% and 12.63%, respectively, with the implementation of H.766 and H.890) are reasonable and actuarially sound. The U.S. Department of Health and Human Services ("HHS") defines an "unreasonable" rate increase to be an increase of 15% or more.

Q42: What is the primary driver of premium increases?

A42: Provider costs are the primary driver of premium increases.

Q43: What can rate review standards take into account?

A43: Rate review standards may take into account factors including increases in unit costs for provider services in excess of inflation, or provider-payer contracts that include anti-competitive rates or clauses.

Q44: How does Vermont Health Connect define the term, "affordable"?

A44: The Vermont Health Connect determines whether a plan is "affordable" based on how much of a person's income is required to pay for the lowest cost plan. Plan affordability is determined by how much of your income is needed to pay for the lowest cost plan, and is framed as a percentage. Thus, it views affordability for each Vermonter on a case by case basis.

Q45: How does the design of the plans themselves relate to the affordability of rates?

A45: The Green Mountain Care Board considers affordability before approving plan designs months before the rate review process begins. In doing so, the Board balances the impact of the proposed plan on the premium alongside the consumer cost-share impact. MVP must then create rates that fit within the plans that have been approved.

Q46: What is the impact of government subsidies on affordability?

A46: Federal Advanced Premium Tax Credits ("APTC") ensure that individuals can purchase a plan they can afford. The subsidy is calculated for each subscriber based on their gross income and the second lowest cost silver plan in the market. An individual at 500% of the FPL is expected to contribute 8.5% of their income for that silver plan, with the rest subsidized by the government. Alternatively, they can take the dollar amount of the subsidy and apply it towards the premium of a more expensive plan, or purchase a less expensive plan at little or no cost. The contribution percentages become even lower as income level decreases. For example, an individual earning 200% of the FPL will only need to pay 2% of their income to purchase the second lowest cost silver plan. Even as

rates increase, these subsidies guarantee that individuals will not have to pay more than a defined percentage of their income for health insurance premiums.

Q47: Provide some examples of what MVP is doing to help increase affordability among individuals who are eligible for premium/cost sharing subsidies.

A47: MVP is taking part in a workgroup meeting with stakeholders from around the state (including Blue Cross Blue Shield of Vermont, state agencies, and the Health Care Advocate) that will help members in the individual market take advantage of the increased subsidy amounts available because of the state's "Silver loading" strategy. This "Silver loading" strategy makes plans with higher benefits (Gold and Platinum metal levels, with lower out-of-pocket spending) more affordable than current Silver metal level plan offerings (even after accounting for cost-sharing reduction subsidies). Members are either being automatically enrolled into a plan that has better benefits and lower premiums, or encouraged to review their plan options to choose the plan that is best for them. This outreach and coordination will ensure that members choose the plan with the lowest combination of premium (after tax credits) and benefits (after subsidies), which will increase affordability on a case-by-case basis.

Q48: Why is a Contribution to Reserves necessary in 2025?

A48: MVP is building a 1.5% contribution to reserves/risk charge into the Small Group Exchange and Individual Exchange premium rates for 2025. This charge is added to premium rates to meet statutory reserve requirements for MVP's Vermont book of business

and protect against adverse experience relative to pricing assumptions. *See* **Ex. 2** p. 15; **Ex. 3** p. 15.

Q49: What, if anything, is MVP's assumption regarding level of COVID-related services in 2025?

A49: An adjustment was made for cost sharing once again which will shift back to the members in 2025 with the continued unwinding of the public health emergency. Additionally, the total cost of the COVID vaccine has increased from $40 to $140. The cost of the COVID vaccine has increased because MVP is required to cover both the administration cost and the ingredient cost of the vaccine.

Q50: Provide any other examples of steps MVP has taken to promote affordability.