STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Insurance Company Third Quarter 2014 and Fourth Quarter 2014 Small Group Grandfathered Rate Filing	)))))	GMCB-009-14rr SERFF No.: MVPH-129389265

DECISION & ORDER

Introduction

As of January 1, 2014, Vermont law requires that health insurers submit major medical rate filings to the Green Mountain Care Board which shall approve, modify, or disapprove the filing within 90 calendar days of its receipt. 8 V.S.A. § 4062(a)(2)(B) (*as amended by* 2013, No. 79, §5c). On review, the Board must 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 Vermont law. 8 V.S.A. § 4062(a)(3).

Procedural History

On January 24, 2014, MVP Health Insurance Company (MVPHIC) submitted its Third Quarter 2014 (3Q14) and Fourth Quarter 2014 (4Q14) Small Group Grandfathered Rate Filing to the Board via the System for Electronic Rate and Form Filing (SERFF). http://ratereview.vermont.gov/sites/dfr/files/MVPH-129389265_Final.pdf. The Office of the Health Care Advocate (HCA), representing the interests of Vermont consumers of health insurance, entered an appearance as a party to this rate filing.

On March 25, 2014, the Board posted to the web an actuarial memorandum provided by its contract actuaries, Lewis & Ellis (L&E), and the Vermont Department of Financial Regulation's (Department) analysis and opinion regarding the impact of the proposed filing on the insurer's solvency. *See* http://ratereview.vermont.gov/sites/dfr/files/MVPH-129389265_ActMemo.pdf (L&E Memo); http://ratereview.vermont.gov/sites/dfr/files/MVP_129389265_Solvency.pdf (DFR Solvency Analysis). The Board received no comments during the public comment period that ran from January 27 through April 9, 2014.

The parties have waived a hearing pursuant to GMCB Rule 2.000 and each has filed a memorandum in lieu of hearing.

Findings of Fact

1. MVPHIC is a for-profit New York health insurer that provides PPO[1] and EPO[2] products to individuals and employers in the small and large group markets in New York and Vermont. MVPHIC is owned by MVP Health Care, Inc. (MVP), a New York corporation that transacts health insurance business in New York and Vermont through a variety of for-profit and non-profit subsidiaries.

2. This filing sets forth proposed rates for MVPHIC's 3Q14 and 4Q14 small group grandfathered products,[3] comprised of both high deductible health plans (HDHP) and non-high-deductible health plans (non-HDHP).

3. The rates proposed by this filing impact 746 policyholders and 4,633 covered lives. There are 4,870 lives covered by HDHP products, and 746 by non-HDHP products.

4. With this filing, MVPHIC proposes a 4.4% average annual rate increase. More specifically, MVPHIC proposes a 4.8% increase for 3Q14 for policyholders with HDHP products and a 6.3% increase for non-HDHP products. For 4Q14, the proposed increases are 3.3% and 5.1%.

5. In developing its rates, MVPHIC utilized grandfathered and non-grandfathered small group claim data from August 1, 2012 through July 31, 2013, with claims paid through October 31, 2013 as the base period experience. MVPHIC has changed its handling of large claims in this filing by removing those in excess of $100,000 and replacing them with a pooling charge.

6. MVPHIC projected medical claims forward using an 8.0% trend for HDHP products and a 7.2% trend for non-HDHP products. An assumed physician trend of 16.6% has a significant impact on the trend and requested rate increase, and is the result of a revised contractual arrangement between MVPHIC and a major provider group. According to L&E's

[1] A PPO (preferred provider organization) is a health care plan that contracts with medical providers to create a network of participating (preferred) providers. Members pay less if they use network providers, but can use providers outside of the network for an additional cost.

[2] An EPO (exclusive provider organization) is a managed care plan that only covers services provided by network providers, except in an emergency.

[3] Pursuant to the Affordable Care Act, a grandfathered health plan is one created or purchased on or before March 23, 2010. These plans are exempted from many changes under the ACA, but may lose their "grandfathered" status if the issuer makes significant changes that reduce benefits or increase consumer costs. For a more detailed description, *see* https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan/.

calculations, if MVPHIC had settled contracts at a more typical unit cost trend of 5%, the aggregate physician trend level would drop from 16.6% to 2.4%.

7. MVPHIC did not use historical claim experience, which results in high volatility, to form assumptions for the prescription drug trend. Using best estimates supplied by its pharmacy vendor, Express Scripts, MVPHIC trended claims forward utilizing a 7.8% trend for HDHP products, and 7.5% for non-HDHP products.

8. Although MVPHIC's 2012 NAIC statutory statement indicates a general administrative expense load of 11.7%, the company proposes a 9.5% load in its current filing. When questioned by L&E about this discrepancy, MVPHIC explained is that it is working to reduce administrative spending and to position itself for membership growth through participation in the health care exchange and Medicaid expansion.

9. MVPHIC has included a proposed 2.0% contribution to surplus in this filing.

10. For the current filing, MVPHIC's anticipated federal medical loss ratio is 95.1%. For the last several years beginning August 2010 and ending July 2013, the annual medical loss ratios have been 83.1%, 88.0%, and 91.2% respectively.

11. On review, L&E determined that MVPHIC's methodology and proposed trend rates are reasonable and appropriate, and that the filing does not produce rates that are excessive, inadequate or unfairly discriminatory. L&E recommends approving the rate filing as submitted.

12. Pursuant to 8 V.S.A. § 4062(a)(2)(B), the Department assessed the impact of the proposed filing on the carrier's solvency. Noting that it is not MVPHIC's primary regulator and that all of MVP's health operations in Vermont account for approximately five percent of its total premiums earned, the Department determined that the carrier's proposed rate "will likely have no impact on MVPHIC's solvency." *See* http://ratereview.vermont.gov/sites/dfr/files/CIGNA_%20129378424_SolvencyOpinion.pdf.

Standard of Review

1. The Board reviews rate filings to ensure that rates are not "excessive, inadequate or unfairly discriminatory," that they promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. § 4062. In addition, the Board considers changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6).

2. In arriving at its decision, the Board will consider the analysis and opinion of the Department of Financial Regulation on the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(3).

3. The insurer proposing a rate change has the burden to justify the requested rate. GMCB Rule 2.000: Rate Review, § 2.104(c).

Conclusions of Law

1. While we are mindful of the HCA's concerns about the affordability of the grandfathered products covered by this filing, we conclude that the carrier has met its burden to justify its request and accept the actuarial recommendation to approve the filing as proposed. As an initial matter, MVPHIC has provided sufficient support to show that its revised contractual arrangement with a major provider group has resulted in an elevated trend level, which has a significant impact on the required rate increase.

2. We further note that MVPHIC has tempered the increase to some extent by including a lower administrative load than it has realized historically, and has stated it will continue to work to lower administrative expenses.

3. Finally, in light of the above, we decline the HCA's suggestion to reduce MVPHIC's contribution to reserve to 1%,[4] and conclude that MVPHIC's 2% assumed contribution is reasonable and appropriate at this juncture.

Order

For the reasons discussed above, the Board approves MVPHIC's 3Q14 and 4Q14 Small Group Grandfathered Rate Filing as submitted.

So ordered.

Dated: April 24, 2014 at Montpelier, Vermont.

s/ Karen Hein

s/ Cornelius Hogan

s/ Betty Rambur

s/ Allan Ramsay

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[4] The HCA requests that the contribution be decreased from 3% to 1%; the carrier has requested only a 2% contribution to surplus. http://ratereview.vermont.gov/sites/dfr/files/009_HCA_Memo.pdf at 3.

Board member Al Gobeille did not participate in this decision.

Filed: April 24, 2014

Attest: s/ Janet Richard
Green Mountain Care Board, Administrative Services Coordinator

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (E-mail address: Janet.Richard@state.vt.us).
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 with the Clerk of the Board within ten days of the date of this decision and order.