STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Insurance Company First Quarter 2018 and Second Quarter 2018 Grandfathered Small Group EPO/PPO Rate Filing	)))))	GMCB-010-17rr SERFF No.: MVPH-131146158

DECISION AND ORDER

Introduction

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)(A). 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 August 7, 2017, MVP Health Insurance Company (MVPHIC or "the carrier") submitted its First Quarter 2018 (1Q18) and Second Quarter 2018 (2Q18) Grandfathered[1] Small Group EPO/PPO Rate Filing to the Board via the System for Electronic Rate and Form Filing (SERFF).[2] On August 14, 2017, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid representing the interests of Vermont health insurance consumers, entered an appearance as a party to this filing.

On September 19, 2017, the Board posted to the web the Department of Financial Regulation's (DFR) analysis regarding this filing's impact on the insurer's solvency. On October 6, 2017, the Board posted to the web an actuarial memorandum provided by its contract actuaries, Lewis & Ellis (L&E). The Board accepted written public comments on this filing through October 21, 2017. Pursuant to GMCB Rule 2.000, § 2.309(a)(1), the parties waived hearing and filed memoranda in lieu thereof.

Findings of Fact

1. MVPHIC 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 carrier 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, and provides EPO and PPO

[1] Grandfathered may not include some rights and protections provided under the Affordable Care Act. To qualify as a grandfathered plan, a health plan must have been in effect on or before March 23, 2010, and have not been materially changed to reduce benefits or employer contributions since that time. 45 C.F.R. § 147.140.

[2] The contents of the SERFF filing and all other documents referenced in this Decision & Order are available at http://ratereview.vermont.gov/MVPH-131146158.

products to individuals and employers in the small and large group markets in New York and Vermont.

2. The present filing reflects the proposed 1Q18 and 2Q18 rates for MVPHIC's grandfathered small group EPO/PPO block of business. There are 213 Vermont policyholders and 1,711 covered lives, the vast majority of whom will renew their policies in 1Q18. The block of business is closed, and its membership is declining.

3. In this filing, MVPHIC proposes a 4.2% average annual rate increase for members renewing in 1Q18 and a 3.1% average annual increase for those renewing in 2Q18. The quarterly changes proposed by this filing are a 2.4% rate decrease for 1Q18 and a 1.3% increase for 2Q18.

4. To form a credible experience base for projecting its 1Q18 and 2Q18 rates, MVPHIC used grandfathered small group claim data for the period from January 2016 through December 2016 and paid through May 2017, excluding groups that terminated coverage as of May 2017. MVPHIC adjusted the data to reflect incurred but not reported paid claims (IBNR), and replaced high-cost claims (in excess of $100,000) with a pooling charge of 18%.

5. As in previous filings, MVPHIC modified its rating methodology to use current snapshots of enrollment distribution by age and tier to adjust for changes in enrolled population that have occurred since the end of the experience period. Because the average age of the block increased 1.3 years during the experience period, these changes resulted in a 1.7% increase in the proposed rates.

6. MVPHIC proposes an effective paid medical trend of 3.9%, based in part on the 2018 hospital budget submissions. This trend also assumes a 0.6% increase in utilization.

7. The carrier proposes a paid pharmacy trend of 15.3%, based on a "best estimate" of allowed pharmacy trends provided by its pharmacy benefits manager (PBM). In addition, it provided historical claims data to L&E supporting its PBM's estimate.

8. MVPHIC assumes a general administrative expense load of 8.4%, and proposes a 2.0% contribution to reserve (CTR).[3]

9. MVPHIC anticipates that the proposed rates would generate a traditional loss ratio of 84.8%, and a federal loss ratio of 89.7%.[4] The carrier asserts that the billback imposed by 18 V.S.A. § 9374(h)(1) and the HCA assessment should be counted as claims for loss ratio purposes. As it does not impact rates for this filing, L&E did not opine on the appropriateness of this methodology.

[3] In this Decision and Order, we use the term "contribution to reserve" for consistency and because the funds at issue are "reserved" solely to cover anticipated future claims.

[4] As opposed to calculation of the traditional loss ratio, calculation of the federal minimum loss ratio under the ACA allows insurers to adjust for quality improvement activities and expenditures on taxes, licensing and regulatory fees.

10. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR assessed the impact of the proposed filing on the carrier's solvency. Noting that it is not MVPHIC's primary regulator, that New York State regulators have expressed no concerns about the carrier's solvency, and that all of MVP's health operations in Vermont account for approximately 2.2% of its total premiums written in 2016, DFR determined that the carrier's Vermont operations pose little threat to the carrier's solvency. DFR nonetheless opined that the rates as filed will promote MVPHIC's solvency absent a finding by L&E that they are inadequate.

11. On review, L&E recommends the Board make no modifications to this filing and approve the proposed rates, opining that the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory.

12. L&E makes no specific recommendation concerning MVPHIC's proposed 2.0% CTR, noting that the Board has reduced the contribution in past filings. L&E recommends that the Board consider the Department's solvency analysis when making changes to the proposed CTR.

13. The HCA expresses concern that MVPHIC's proposed rate for this block of business continues to outpace economic growth indicators, but does not recommend modification of the filing, citing the uncertainty faced by the carrier and Vermont's health system.

Standard of Review

The Board reviews rate filings to ensure that a 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); GMCB Rule 2.000, § 2.301(b). Although the first several terms—excessive, inadequate, or unfairly discriminatory—are defined actuarial standards, other standards by which the Board reviews rate filings 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 Board additionally takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000 at § 2.401. In particular, the Board reasonably expects the insurers to negotiate rates with providers in a way that reflects actual costs of care rather than site of service. *See* 2016, No. 143 (Adj. Sess.), § 5; 2015, No. 54, § 23; 2014, No. 144 (Adj. Sess.), § 19.

In arriving at its decision, the Board must consider the Department'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), (3). The Board must also consider any public comments received on a rate filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id.* § 2.104(c).

Conclusions of Law

We first agree with and adopt our actuary's opinion that MVPHIC's proposed medical trend figures are appropriate, and that MVPHIC's selected experience period, assumptions, utilization trend, and adjustments to reflect up-to-date enrollment patterns are actuarially reasonable. Although the carrier's proposed unit cost trend does not reflect our final 2018

hospital budget orders—which would have produced a negligible rate decrease, it incorporates the best information available at the time of filing. In the future, however, we will expect MVPHIC to modify its filings to account for hospital budget orders issued while a filing is pending, prior to expiration of the 90-day review period.

We next turn to administrative expenses and CTR. As this filing represents a closed block of business with declining membership, we agree with and adopt our actuary's opinion that MVPHIC's proposed administrative expense figure of 8.4% accurately reflects the costs associated with administrating claims for a shrinking population. We further conclude that the carrier's proposed 2.0% CTR is appropriate and reasonable. Our conclusion is primarily driven by the fact that closed blocks have no influx of new members to improve the overall health of the pool and spread risk, and require additional regulatory scrutiny to guard against both inequitable pricing and future rate volatility and rate shock. In addition, the current uncertainty in the commercial insurance market cautions in favor of approving the proposed CTR. We have also considered DFR's analysis and opinion that the rates as filed will promote MVPHIC's solvency.

We conclude that MVPHIC's proposed rates are neither excessive nor inadequate and are safely within the range of actuarial reasonableness, and that they therefore strike an appropriate balance between fairness and equity to policyholders on one hand and rate stability and insurer solvency on the other. We believe this balance will promote future pricing stability and thereby promote policyholders' access to and quality of care.

Order

Accordingly, for the reasons discussed above, the Board approves MVPHIC's 1Q18 and 2Q18 Grandfathered Small Group EPO/PPO Rate Filing without modification.

SO ORDERED.

Dated: November 6, 2017 at Montpelier, Vermont

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

Filed: November 6, 2017

Attest: s/ Erin Collier, Administrative Services Coordinator
Green Mountain Care Board,

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: marisa.melamed@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 with the Clerk of the Board within ten days of the date of this decision and order.