STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Insurance Company First Quarter 2018 and Second Quarter 2018 Large Group EPO/PPO Rate Filing	)))))	GMCB-011-17rr SERFF No.: MVPH-131148723

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 9, 2017, MVP Health Insurance Company (MVPHIC or "the carrier") submitted its First Quarter 2018 (1Q18) and Second Quarter 2018 (2Q18) Large Group EPO/PPO Rate Filing to the Board via the System for Electronic Rate and Form Filing (SERFF).[1] 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 the filing's impact on the insurer's solvency. On October 12, 2017, the Board posted to the web an actuarial memorandum provided by its contract actuaries, Lewis & Ellis (L&E). On October 17, 2017, the carrier amended the filing to keep certain plans within this block of business certified as Qualified High Deductible Health Plans (QHDHP).[2] The Board accepted written public comments on this filing through October 23, 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 products to individuals and employers in the small and large group markets in New York and Vermont.

---

[1] The contents of the SERFF filing and all documents referenced in this Decision and Order can be found at http://ratereview.vermont.gov/MVPH-131148723.

[2] A qualified high-deductible health plan is a tax-favored health plan with a higher annual deductible and lower annual premium than typical health plans.

2. The filing includes the proposed manual rates for MVPHIC's large group EPO/PPO products for 1Q18 and 2Q18.[3] These rates will affect approximately 1,995 Vermonters covered under 16 group policies.

3. MVPHIC proposes a 5.8% average annual decrease in rate for members renewing in 1Q18, and an average annual rate increase of 4.7% for those renewing in 2Q18. The quarterly changes proposed by this filing are a decrease of -2.9% for 1Q18 and an increase of 1.4% for 2Q18.

4. MVPHIC developed the proposed manual rates using large group claim data for the period from January 2016 through December 2017 and paid through May 2017. The carrier 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 9.2%. In accordance with the Board's order in Docket No. GMCB-003-17rr, the manual rate cap included in prior filings has been removed.

5. 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. In this filing, the carrier decreased the average age/gender factor of the covered population by 0.1%, which combined with the normalization factor from the previous filing for this block of business, results in a 1.4% rate decrease.

6. MVPHIC proposes a paid medical trend of 3.6%, based in part on 2018 hospital budget submissions. The trend also assumes a 0.6% increase in utilization. The carrier proposes a paid pharmacy trend of 13.1% based on annual trend factors by drug category and drug rebate forecasts supplied by its pharmacy benefits manager (PBM) accounting for the carrier's Vermont-specific block of business.

7. MVPHIC assumes a general administrative expense load of 9.7%, and proposes a 2.0% contribution to reserve (CTR).[4]

8. MVPHIC anticipates that the proposed rates would generate a traditional loss ratio of 81.2%, and federal loss ratio of 86.1%.[5]

9. 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

[3] A manual rate is a baseline rate structure that a carrier will blend with a specific group's claims experience to produce the group's actual rates. Its weight in calculating rates for a specific group will vary according to the group's size and actuarial credibility.
[4] 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.
[5] 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.

operations in Vermont account for approximately 2.2% of its total premiums written in 2016, the Department 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.

10. 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.

11. Although L&E noted that it has been several years since high-dollar claims in this block of business reached the 9.2% pooling charge, it agreed that the charge is reasonable due to the small size of the block and the highly volatile nature of the assumption.

12. L&E further noted that the ratio of premiums between MVPHIC's plans, or "plan relativities," is based on claims data that is several years out-of-date. However, because the plan relativities are likely to result in reasonably equitable results across plans, L&E does not recommend any changes at this time.

13. L&E makes no specific recommendation concerning MVPHIC's proposed 2.0% CTR, noting that the Board has reduced the contribution in past filings from 2.0% to 1.0%. L&E recommends that the Board consider the Department's solvency analysis when making changes to the proposed CTR.

14. 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, § 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); GMCB 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

At the outset, we agree with and adopt our actuary's opinion that MVPHIC's proposed medical trend figures, including unit cost trend, selected period and demographic adjustments, and pharmacy trend are appropriate and 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.

Turning to administrative expenses, we agree with and adopt our actuary's opinion that MVPHIC's proposed 9.7% administrative expense figure accurately reflects the costs associated with administrating claims for this relatively small block of business. We further conclude that the 2.0% CTR proposed by MVPHIC is reasonable and appropriate to stabilize pricing for this relatively small population. While we have ordered reductions to the carrier's proposed CTR in the past to make rates more affordable for policyholders, the current uncertainty in the commercial insurance market cautions in favor of approving the carrier's proposed CTR. Finally, we have considered DFR's analysis and opinion that the rates as filed will promote MVPHIC's solvency.

Because MVPHIC's proposed rates are neither excessive nor inadequate and are safely within the range of actuarial reasonableness, they strike an appropriate balance between fairness and equity to policyholders on one hand and rate stability and insurer solvency on the other. In a period of market uncertainty, these rates will promote future pricing stability for policyholders in this block of business and thereby improve their access to and quality of care.

Order

For the reasons discussed above, the Board approves MVPHIC's 1Q18 and 2Q18 Large 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.