STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.	)	GMCB-007-15-rr
2016 Vermont Health Connect Rate Filing	)	
	)	
SERFF No. MVPH-130053210	)	
	)	

DECISION & ORDER

Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) requires that health insurance exchanges—marketplaces where individuals, families and small businesses can shop for qualified health insurance coverage—be established in each state by January 2014. In Act 48 of 2011, Vermont's seminal health care reform law, the Vermont legislature created this state's exchange, Vermont Health Connect (VHC).

The Green Mountain Care Board, also created by Act 48, is the independent board tasked with ensuring that changes in the health system improve the quality and accessibility of health care while stabilizing its costs. Among its regulatory tasks,[1] the Board reviews major medical health insurance rates. The Board first reviewed rates offered on VHC in 2013 when MVP Health Plan, Inc. (MVP) and Blue Cross and Blue Shield of Vermont (BCBSVT) each filed proposed rates to be effective in 2014; accordingly, this is the third year that the Board has reviewed health insurance rates offered through the exchange.

In this filing, MVP proposes a 3.0% average annual rate increase for health plans offered on VHC with coverage beginning January 1, 2016. Based on our review of the record and the testimony and evidence provided at hearing, we modify the rates as explained below, and then approve the filing.

Background

1. Starting in January 2014, the ACA requires that individuals and families have qualifying health insurance coverage or pay a penalty on their personal income tax returns. Qualifying coverage includes coverage from an employer, health insurance purchased through

[1] The Legislature assigned the Board three main responsibilities: regulation, innovation, and evaluation. In its regulatory role, the Board regulates health insurance rates, hospital budgets and major health care expenditures.

the exchange, or government-sponsored coverage that meets federally mandated minimum levels of coverage.

2. Vermont Health Connect offers qualified health plans (QHPs) to individuals, families and small employers with rates based on a single risk pool that includes the individual and small group markets. *See* 33 V.S.A. §§ 1803 ("Vermont Health Benefit Exchange"); 1811 ("Health benefit plans for individuals and small employers"). For plan years 2014 and 2015, a small employer was defined as employing up to 50 employees. Beginning in 2016, Section 1304(b) of the ACA expands the small employer definition to include employers with 51-100 employees. *See also* 33 V.S.A. §1811 (a)(3)(B) (defines small employer to include up to 100 employees as of January 1, 2016).[2]

3. Plans are offered to consumers in four "metal levels": bronze, silver, gold and platinum. In addition to the metal level plans, catastrophic coverage is available primarily to persons under thirty years of age.[3]

4. In order to make health insurance plans offered on the exchange more affordable, individuals enrolling for coverage who do not have employer-sponsored insurance may be eligible for federal premium assistance depending on their household income. *See* 26 U.S.C. § 36B ("Refundable credit for coverage under a qualified health plan"). In addition, Vermont caps the percentage of household income that eligible individuals and families pay for health insurance premiums and offers subsidies for lower deductibles[4] and copayments.[5]

5. The ACA requires that all exchange plans include ten categories of services, called "essential health benefits" (EHBs): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and

[2] Small employers with 51-100 employees may also choose to self-insure, particularly if their populations are young and healthy. *See* American Academy of Actuaries Issue Brief, *Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees* (March 2015) at 5-6, *available at* http://www.actuary.org/files/Small_group_def_ib_030215.pdf

[3] Catastrophic coverage is characterized by low premiums and high deductibles. Individuals enrolled in catastrophic plans do not qualify for income-based subsidies.

[4] A deductible is the amount a patient pays for covered services before his or her health plan begins to pay.

[5] A copayment is a fixed amount a patient pays for a covered health care service, usually at the time the service is delivered.

habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

6. The ACA includes three risk spreading mechanisms intended to stabilize costs and provide incentives for insurers to participate in the exchanges. The transitional reinsurance program is funded through fees levied on health insurance plans and ends with the 2016 plan year. Under this temporary program, the federal government reimburses an insurer for a percentage of an individual's high cost claim that falls within specified parameters.

7. The risk corridors program, also ending in 2016, protects against pricing uncertainty by requiring insurers to calculate allowable costs and targets for each QHP based on a specific formula. If a plan earns a profit under the formula, the insurer must share it with the federal government; conversely, if a plan shows a loss, the federal government shares some of the loss.

8. The risk adjustment program applies to ACA-compliant plans in both the individual and small group markets. Under this program, plans with an enrolled population with lower than average actuarial risk will make payments to those plans that have an enrolled population with higher than average actuarial risks. The program is intended to protect against adverse selection among QHPs.

Procedural History

9. On May 15, 2015,[6] MVP filed its 2016 Vermont Health Connect Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The SERFF filing outlines the development of proposed exchange rates for coverage commencing January 1, 2016. *See* Exhibit 1;[7] *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_007_15rr_SERFF_7_8_15.pdf.

10. On May 27, 2015, the Office of Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of consumers of Vermont health care, entered a Notice of Appearance as an interested party to the proceeding. *See* http://ratereview.vermont.gov/sites/dfr/files/GMCB_007_15rr_HCA_NOA.pdf.

11. On July 6, 2015, the Vermont Department of Financial Regulation (Department) issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency.

[6] Prior to the date of filing, both Vermont insurance carriers stipulated to a May 15, 2015 filing date. MVP, however, submitted its rate filing through SERFF on May 14, 2015.
[7] The exhibits referred to in this decision were either stipulated to by the parties or admitted into evidence upon motion at hearing.

Noting that MVP is one of two Vermont-licensed insurers domiciled in New York that are members of MVP Health Care, Inc. holding company system, the Department opined that the rates as proposed would not materially impact the solvency and surplus of MVP or of the holding company. Exhibit 8, *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_007_15rr_Solvency_Analysis.pdf.

12. Lewis & Ellis (L&E), the Board's contract actuary, conducted an actuarial review of the filing and on July 13, 2015 issued a memorandum summarizing its analysis and recommendations for modification. The memorandum was posted to the Board's rate review website on July 14, 2015. *See* Exhibit 9; *also available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_007_15rr_Actuarial_Memorandum.pdf.

13. On July 19, 2015, the HCA filed with the Board the actuarial opinion of its contract actuary, Donna Novak. Exhibit 10, *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_007_15rr_HCA_ActuarialMemo_Redacted.pdf.

14. The Board held a public administrative hearing on July 28, 2015. Judith Henkin served as hearing officer by designation of Board chair Al Gobeille. Gary F. Karnedy, Esq. of Primmer Piper Eggleston & Cramer PC represented MVP. MVP Vice President and chief actuary Kathleen Fish testified for the carrier. Kaili Kuiper, Esq. appeared for the HCA and presented testimony of independent actuary Donna Novak, principal of NovaRest Actuarial Services. Ryan Chieffo, Assistant General Counsel for the Department, testified regarding the Department's solvency analysis and opinion. Mike Donofrio, General Counsel, represented the Board and conducted the examination of L&E actuary Jackie Lee, who testified about the firm's actuarial review and recommendations for modification.

15. The Board accepted public comments on the proposed rates from May 15, 2015 through July 29, 2015.[8] The Board received 484 comments referencing both MVP's and BCBSVT's filings; 450 of those comments were based on a template provided to consumers by the Vermont Public Interest Research Group (VPIRG). Of the remaining 34, six written comments specifically address MVP's proposed rate increase, and two comments addressing MVP's proposed increase were verbally submitted to the Board during the rate hearing. The

[8] Although the deadline for accepting comment expired on July 29, 2015, additional comments were received and reviewed by the Board subsequent to that date.

comments overwhelmingly address the issue of affordability for Vermonters and oppose any increase in premium rates. *See* Public Comments, *available at* http://ratereview.vermont.gov/sites/dfr/files/VPIRG_Rate_Comments_2015.pdf; http://ratereview.vermont.gov/sites/dfr/files/Public_Comment_2016_Exchange_Final.pdf.

Findings of Fact

Nature of the Filing

1. MVP is a non-profit health insurer domiciled in New York and licensed as a health maintenance organization (HMO) in New York and Vermont. MVP 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. MVP offers HMO products to individuals and employers in the small and large group markets in Vermont.

2. There are 3,324 policyholders, 4,227 subscribers and 6,417 covered lives affected by this filing. Exhibit 1 (SERFF filing) at 9. MVP estimates its enrollment and market share will increase for 2016 because of the expansion of the small employer market, the movement of members into ACA-compliant plans, and the competitive pricing of its exchange products.

3. Enrollment for 2016 exchange plans begins in November 2015 for coverage beginning on January 1, 2016.

Summary of the Data, Analysis, and Testimony Presented at Hearing

4. To form a credible experience base for projecting its 2016 VHC rates, MVP used 2014 combined experience claim data from its non-ACA compliant and ACA-compliant individual and small group books of business, and groups with 51-100 members. MVP adjusted these claims to reflect the impact of cost sharing reductions, incurred but not reported paid claims (IBNR) and pharmacy rebates, and replaced high cost claims with a pooling charge. Exhibit 1 at 10.

5. Because a large portion of its members did not enroll in ACA-compliant plans until April 2014, MVP adjusted the experience period claims for the impact of membership not representing a full 12-month contract. Adjustments were also made for benefits added to and removed from coverage. MVP then applied a 2.0% morbidity improvement factor and adjusted

for Vermont's prescription drug out-of-pocket (OOP) maximum[9] and the 2016 leap year. *Id*. at 11-13.

6. MVP projected the experience period claims forward to the rating period using an average annual allowed medical trend factor[10] of 3.9%, or 4.4% paid trend,[11] and annual allowed pharmacy trend of 10.6%, or paid trend of 12.6%. *Id*. at 13-14.

7. MVP estimated its transitional reinsurance recovery for individual members in 2016 at 4.2% by calculating 50% of the annual average value of claims between $90,000 and $250,000 for members in the single risk pool between 2012 and 2014. *Id*. at 15.

8. Once MVP determined the projected paid index rate—the starting net claim cost used to set premium rates—it made plan-specific adjustments to account for benefits in excess of EHB and the per member per month (PMPM) and percent-of-premium expense loads, and to determine the actuarial value (AV) of each plan and its metal level. *Id*. at 16-17.

9. MVP added to the index rate non-claim expense adjustments that do not vary by plan, including an administrative expense load of $36.60 PMPM. Plan-specific gross claim cost PMPM is then converted to per contract premium rates using a single conversion factor. Unlike previous years, MVP has not included any profit margin in this filing. *Id*. at 17-19.

10. L&E reviewed the filing and recommends four modifications. L&E first recommends that MVP base its demographic adjustment factor on its March 2015 enrollment data, rather than on its actual 2014 enrollment data. If this modification is made, MVP must also make a corresponding adjustment to its single conversion factor. These two modifications, taken together, produce a 0.3% increase in the rate. Exhibit 9 at 7, 9.

11. L&E also recommends that the carrier adjust for Blueprint[12] payment changes, which reduces rates by $1.35 PMPM (a -0.4% decrease), and that it correct an error in the average policy duration factor for groups of 51-100, which reduces rates an additional $0.38 PMPM. *Id*. at 7, 10.

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[9] Section 4089i(c) of Title 8 limits the amount an insured will pay out-of-pocket for prescription drugs, including specialty drugs.

[10] In basic terms, trend refers to the change in the cost of health care and consists of utilization (frequency of use of the product or service) and unit cost.

[11] Allowed cost trends are based on charges that reflect the total amount of claims paid by both the carrier and the policyholder. Paid trends reflect the actual claim payment made by the carrier only.

[12] Pursuant to Vermont law, insurers are required to participate in the Blueprint for Health, Vermont's initiative to improve population health and control costs by promoting prevention and care coordination. 18 V.S.A. § 706 ("Health insurer participation"); § 703 ("Health prevention; chronic care management").

12. For this filing, L&E does not recommend—as it has in past years—that MVP develop its pharmacy trend assumptions using historical pharmacy claim experience, rather than solely on unadjusted national trends provided by its pharmacy benefit manager (PBM). Although it does not agree with MVP's methodology, the pharmacy trend used by MVP is lower than L&E's trend calculation, and therefore results in lower rates. *Id*. at 6.

13. L&E also notes that MVP made no upward adjustment to its rates to account for an approximate $2.7M payment it will make to BCBSVT under the Centers for Medicare and Medicaid Services' (CMS) risk adjustment program.[13] *Id*. at 8.

14. After the recommended modifications, L&E calculates that the overall rate change will decrease from 3.0% to 2.7%. *Id*. at 10.

15. Donna Novak, the HCA's independent actuary, maintains that MVP made two errors in its filing. First, Novak believes that the carrier failed to follow instructions for completing the Uniform Rate Review Template (URRT), and as a result, may have "overstated its paid to allowed ratio, which may impact its rates." In her actuarial report, Novak opined that the rates could be overstated by 3.8%. Exhibit 10 at 7-9.

16. At hearing, however, Novak testified that she does not believe the rates may be overstated by 3.8%. TR at 100-108. Novak explained: "Because I really didn't think the rates had been developed inappropriately, I didn't feel comfortable asking for an adjustment in the rates ... I didn't feel that the rates were incorrect." *Id*. at 102.

17. Notwithstanding Novak's statements at hearing and L&E's opinion that the URRT is accurate, *see* TR at 74-75, the HCA requests that the carrier be required to provide additional documentation to justify its rate, asserting that a "discrepancy in MVP's federal spreadsheet and its lack of compliance with federal rules are a warning that there is a mistake somewhere in the filing." HCA Post-Hearing Memorandum (HCA Memo) at 5, 9, *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_007_15rr_HCA_Post_Hearing_Memom.pdf.

18. In addition, the HCA recommends that the carrier be required to base its demographic adjustment on first quarter 2015 enrollment data, instead of 2014 enrollment data, and correspondingly adjust its single conversion factor. Although the HCA suggests the use of

[13] The amount of the risk adjustment payment was not known by MVP as of filing date; CMS issued a report that disclosed the payment amount on June 30, 2015.

slightly different enrollment data than used by L&E, the effect on the rate is the same. *Id*. at 9-10.

19. At hearing, MVP witness Kathleen Fish testified that she disagrees with the use of an enrollment "snapshot" to calculate the demographic adjustment, but that both MVP's methodology and that used by L&E are actuarially reasonable. TR at 21-28. Similarly, L&E's actuary, while providing credible support for its own calculation, also concluded that both methodologies are reasonable. *Id*. at 70, 75. Fish requested that the Board reject a 0.3% increase for demographics as recommended by L&E because "MVP is very concerned about premium rates and affordability and wants to be a player in Vermont," and does not consider a 0.3% modification material or a threat to its solvency. Consequently, MVP requested that the Board approve a 2.4% rate increase—the 2.7% recommended by L&E, minus the 0.3% demographic adjustment— which "represents MVP's best estimate of the required premiums based on the actuarial assumptions," to produce a "break even premium rate." TR at 28-34.

20. Ryan Chieffo, witness for the Department, testified that if the Board were to reduce the rate increase to 2.4%, the Department's opinion that the insurer's solvency will not be impacted remains the same. *Id*. at 56 ("[A]n average 2.4 percent increase to MVP's rates should operate to maintain its current level of solvency.").

21. Two days after the hearing, MVP advised the Board that it made an error in its calculations, and that "[d]ue to an unfortunate oversight," the 2.4% proposed rate increase should have been a 2.6% increase. *See* http://ratereview.vermont.gov/sites/dfr/files/GMCB_007_15rr_7_30_15_Letter_to_Judith_Henkin.PDF. MVP elaborated on its mathematical error in its post-hearing memorandum and now requests that the Board approve a 2.6% increase. MVP's Post-Hearing Memorandum (MVP Memo) at 3, *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_007_15rr_Post_Hearing_Memo.PDF.

Standard of Review

1. Vermont law provides that the Board shall review health insurance rate filings to ensure that rates are affordable, that they 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. §§ 4512(b); 4062(a)(2), (3); GMCB Rule 2.000, *Rate Review*, §§ 2.301(b), 2.401. In

addition, the Board 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).

2. As part of its review, the Board will consider the Department's analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2), (3). The Board shall also consider any public comments received on a rate filing. Rule 2.000, § 2.201.

3. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id*. § 2.104(c).

Conclusions of Law

I. MVP Must Adjust its Rates to Account for Blueprint Payments and to Correct its Policy Duration Factor.

L&E determined that MVP should adjust its proposed rates for Blueprint payments and to correct its policy duration factor. Both MVP and the HCA agree to the adjustments. The Blueprint adjustment reduces rates by $1.35 PMPM (-0.4%); the adjustment to the average policy duration factor reduces rates by $0.38 PMPM (-0.1%).

II. MVP's Use of 2014 Data to Determine the Demographic Adjustment and Single Conversion Factor Produces More Affordable Rates for Vermonters.

Because MVP's 2015 actual enrollment is the basis for its projected 2016 enrollment, L&E recommends that the carrier recalculate the demographic adjustment to the index rate and the single conversion factor utilizing enrollment data from March 2015, rather than from 2014. Finding of Fact (Finding) ¶ 10. The HCA similarly requests that the carrier use more recent, albeit slightly expanded enrollment data, which yields the same result.

In response, MVP counters that its actual 2014 enrollment data produces a more accurate demographic adjustment and single conversion factor than does the use of enrollment from a single point in time. MVP Memo at 4. At hearing, however, both MVP and L&E agreed that both methods of calculation are actuarially reasonable. Finding ¶ 19. In support of not adopting L&E's recommendation that would result in a 0.3% rate increase, MVP presented testimony that a 0.3% rate difference is not material, will not impact the company's solvency, and will help MVP remain competitive in the Vermont market while making premiums more affordable to

Vermont consumers. MVP consequently requested that the Board approve 2.4% overall rate increase, rather than the 2.7% increase recommended by L&E. *Id*.

Notwithstanding that last year we concurred with our actuaries' view that the most recent enrollment data best reflects the population for the coming plan year, we decline to impose the recommended modification in this particular filing. *See* GMCB 017-14rr, *In re MVP Health Plan, Inc. 2015 Vermont Health Connect Rate Filing* at 10-12, *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_017_14_rr_Decision.pdf. Unlike last year, calculating the demographic adjustment and single conversion factor using the more recent enrollment data results in an increase, rather than a decrease in rates. In addition, both MVP and L&E agree that the other's methodology is actuarially reasonable; MVP and the Department agree that a 0.3% decrease in rates will not affect the insurers' solvency. Accordingly, we conclude that our statutory obligation to ensure that health care is affordable for Vermonters tips the balance in favor of declining L&E's recommendation that we modify the demographic adjustment and single conversion factor.

III. The HCA Has Not Shown that MVP Made a Reporting Error on its URRT or That its Rate is Not Properly Calculated.

According to the HCA, MVP has failed to adequately document its rate calculation for federal reporting purposes and a discrepancy on the URRT signals the possibility of an error in the rate. HCA Memo at 5. We find no support in the record for the HCA's claims.

First, our actuaries have thoroughly reviewed the filing and find no error in the URRT. Finding ¶ 17. Even the HCA's independent actuary was equivocal regarding this issue, testifying at hearing that MVP's inclusion of certain data elements in the document "seemed inappropriate." TR at 101.

Second, and determinative of this issue, even if we were to accept that MVP failed to adequately document its rate development for federal reporting purposes, none of the actuarial witnesses at hearing—including the HCA's witness—testified that such an error would have impacted the rate development or resulting rates. To the contrary, the HCA's witness expressly withdrew her written opinion that rates might have been overstated by 3.8% due to a reporting error, and testified that she "didn't think the rates had been developed inappropriately . . . [and] didn't feel that the rates were incorrect." Findings ¶ ¶ 15, 16.

In light of our statutory directive to issue "a decision approving, modifying or disapproving the proposed *rate*," 8 V.S.A. § 4062(a) (emphasis provided), and the absence of evidence that MVP's rate development or resulting rate proposal are incorrect, we decline to require MVP to provide additional rate documentation as a condition of our decision and order.

IV. The Testimony and Evidence Presented at Hearing Support a 2.4% Rate Increase.

Last, we consider MVP's post-hearing request that it be allowed to correct a mathematical error and revise its rate request from 2.4%, as discussed at hearing, to 2.6%. For the reasons outlined below, we approve a 2.4% rate increase, as presented by MVP at hearing.

This Board, pursuant to statute and by rule, adheres to a strict culture of transparency and holds rate review hearings that are open to the public and allow Vermonters to both listen to, and participate in, our decision-making process. While we commend MVP's effort to provide its membership with a "break even" premium—MVP expects to collect from its members enough in premium dollars to pay their claims and cover the company's costs, without achieving a profit—in making our decision here, we must consider MVP's consistent position, voiced at a public hearing, that it does not consider a 0.3% difference in rates material, and that a downward modification in that amount poses no threat to MVP's solvency.

Accordingly, we deny MVP's post-hearing request to correct a mathematical error and conclude that MVP must reduce its post-hearing calculation of a 2.6% rate increase by 0.2%. The resulting 2.4% rate increase is consistent with MVP's hearing testimony and evidence, does not pose a threat to MVP's solvency, and produces more affordable rates for Vermonters.

Conclusion

The Legislature has charged this Board with ensuring that all Vermonters gain access to affordable, quality health care. Exerting downward pressure on health insurance rates is one of the ways that we continue to move closer to achieving that goal. As a result of our decision today, MVP's average annual 2016 Vermont Health Connect rate increase is reduced from 3.0% to 2.4%.

Order

Based on the reasons discussed above, the Board modifies MVP's 2016 Vermont Health Connect Rate Filing, and then approves the filing. Specifically, we order that MVP make an adjustment for Blueprint payments, correct an error in the average policy duration factor, and

thereafter reduce the resulting rate by an additional 0.2%. As modified, the average annual rate increase is reduced from the proposed 3.0% to 2.4%.

So ordered.

Dated: August 13, 2015 at Montpelier, Vermont.

s/ Alfred Gobeille)
)
s/ Cornelius Hogan) GREEN MOUNTAIN
) CARE BOARD
s/ Jessica Holmes) OF VERMONT
)
s/ Betty Rambur)
)
s/ Allan Ramsay)

Filed: August 13, 2015

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@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.