STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Insurance Company First Quarter 2015 and Second Quarter 2015 Grandfathered Small Group EPO/PPO Rate Filing	)))))	GMCB-020-14rr SERFF No.: MVPH-129662230

DECISION & 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)(B). 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 July 31, 2014, MVP Health Insurance Company (MVPHIC) submitted its First Quarter 2015 (1Q15) and Second Quarter 2015 (2Q15) Grandfathered[1] Small Group EPO/PPO[2] Rate Filing to the Board via the System for Electronic Rate and Form Filing (SERFF). http://ratereview.vermont.gov/sites/dfr/files/020_14rr_SERFF_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 September 29, 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/GMCB_020_14rr_Actuarial_Memorandum.pdf (L&E Memo); http://ratereview.vermont.gov/sites/dfr/files/GMCB_020_14rr_Solvency_Analysis.pdf (DFR Solvency Analysis). The Board received no comments during the public comment period that ran from August 4 through October 14, 2014.

[1] 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. Grandfathered plans are exempt from many changes required under the Affordable Care Act. 45 CFR 147.140.

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

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

Nature of the Filing

1. MVPHIC is a for-profit New York health insurer that provides PPO and EPO 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 is a grandfathered small group EPO/PPO plan. There are approximately 2,806 members, 2,604 of whom are in high deductible health plans (HDHP).

3. This filing covers member renewing in 1Q15 and 2Q15. Fifty-seven percent of the plan's membership will renew in 1Q15, and eleven percent will renew in 2Q15.

4. MVPHIC is requesting a 10.1% annual rate change for plan members renewing in 1Q15, and a 10.2% increase for those renewing in 2Q15.[3]

Summary of the Data and Analysis

5. As its base experience period, MVPHIC used grandfathered and non-grandfathered small group EPO/PPO and HDHP incurred claim data for the period January 1, 2013 through December 31, 2013, completed through May 31, 2014. MVPHP removed claims in excess of $100,000 and added a pooling charge, based on its historical experience.

6. The adjusted claims were projected forward using a 7.2% annual effective medical trend assumption for non-HDHP products and a 7.9% trend for HDHP products.

7. Prescription drug claims were projected forward using a 9.7% annual effective drug trend for non-HDHP products and a 10.2% trend for HDHP products. The annual trend factors by drug category were supplied by the carrier's pharmacy vendor, and rely on national, rather than Vermont-specific, data. In addition, MVPHIC increased the 2015 specialty unit cost trend to account for the drug Sovaldi, a high cost drug approved for use in December 2013 to treat Hepatitis C.

[3] As initially filed, MVPHIC requested an 8.7% average annual rate increase. In response to a question from L&E, MVPHIC acknowledged that its proposed rates were incorrect, and were derived from using the 3Q14 rates in its calculations, rather than the 4Q14 rates. As amended by MVPHIC, the proposed aggregated annual rate increase is 10.1% for 1Q15 and 10.2% for 2Q15.

8. MVPHIC increased the claim cost for fees and surcharges, retention expenses of 11.75% which include 9.5% for administrative costs and a 2.0% contribution to reserves, premium taxes of 2.00%, ACA insurer tax of 2.0%, VT vaccine pilot charge of 0.6%, transitional reinsurance fee of $3.67 PMPM and Patient Centered Research Fee of $0.17 PMPM.

9. MVPHIC utilized 2013 enrollment to project age and gender assumptions needed to calculate the single conversion factors[4] of 1.192 for non-HDHP and 1.208 for HDHP products.

10. MVPHIC's medical loss ratio for its entire small group market in the experience period was 88.0%; for grandfathered small groups, the loss ratio was 92.1%. MVPHIC's 2014 anticipated medical loss ratio is 99.5% for all small groups, and 105.3% for grandfathered small groups.

11. MVPHIC's 9.5% assumed administrative load in this filing is lower than its actual expense ratio for small group products, which for years 2010 to 2013 has been 11.5%, 9.8%, 10.2%, and 11.8%, respectively.

12. On September 24, 2014, the Department issued an opinion and analysis of the impact of this rate filing on MVPHIC's solvency. Noting that it is not the primary regulator of MVPHIC and that it has conferred with the company's primary regulators in New York State, DFR concluded that MVPHIC's Vermont operations pose very little risk to the company's overall solvency. DFR Solvency Analysis at 2.

13. On review, L&E recommends that the carrier utilize its most recent contract distribution information (June 2014 enrollment) to project age/gender assumptions and to calculate the 2015 single conversion factors. L& E also recommends that MVPHIC use the prescription drug trend approved by this Board in the Vermont Health Connect Filing because the data used by the carrier to calculate the trend is not Vermont-specific. *See* MVP Vermont Health Connect Rate Filing, Docket no. GMCB 017-14rr at 9-10, *available at* http://ratereview.vermont.gov/rate_review/MVPH-129560321. Because MVPHIC used its own experience to adjust the specialty drug trend for the impact of Sovaldi, however, L&E opines that the adjustment is reasonable.

14. In addition to the modifications recommended by L&E, the HCA asks that the Board allow the carrier an administrative expense increase of no more than 1.7% – equal to the estimate of increase in consumer goods as reflected in the Consumer Price Index (CPI) – and reduce the contribution to

[4] The conversion factor adjusts premium that is developed on a PMPM basis to be on a tiered basis (single, double, parent/children, family).

surplus to 1.0%. HCA Memorandum in Lieu of Hearing, *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_020_14rr_HCA_Memo.pdf.

Standard of Review

1. The Board reviews rate filings to ensure that rates are affordable, 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(a)(2); 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

4. We accept L&E's recommendation that MVPHIC utilize its more recent enrollment distribution in its rate change development and calculation of the single conversion factor. In light of the shift in membership in this closed block of business, the June 2014 contract distribution is a more accurate indicator of projected enrollment distribution than is the 2013 data.

5. We also conclude that MVPHIC should utilize the same pharmacy trend we approved in its 2015 Vermont Health Connect Rate filing, which, unlike the trend proposed in this filing, is derived from Vermont specific population and data. *See* In re: MVP Health Plan, Inc. 2015 Vermont Health Connect Rate Filing, Docket no. GMCB 17-14-rr at 9-10 (discussing why pharmacy benefit manager's trend does not reflect Vermont population.) We agree with L&E that MVPHIC's adjustment to the trend due to the impact of Sovaldi and based on its own experience, however, is appropriate.

6. We decline the HCA's request to reduce the charge for administrative expenses at this time. This is a closed and declining book of business, actual administrative costs are higher than requested, and the carrier's anticipated loss ratios for 2014 are near or exceed 100.0%. *See* Findings of Fact ¶ 10, 11. As we have previously noted, MVPHIC has "tempered its rate increase to some extent" by including an administrative expense charge that does not meet its costs, and should continue to seek ways to reduce its costs. *See* MVPHIC Third and Fourth Quarter 2014 Small Group Grandfathered

Rate Filing, Docket no. GMCB 009-14 at 4, *available at* http://ratereview.vermont.gov/sites/dfr/files/009_14rr_Final_Decision.pdf.

7. Last, in light of the small percentage of MVPHIC's overall business attributable to Vermont and to this particular filing, we reduce the contribution to surplus from 2.0% to 1.0%, making the rate more affordable for consumers.

Order

For the reasons discussed above, we modify, and then approve the filing. As a result of the modifications, we estimate the average annual rates for members renewing HDHP plans in 1Q15 and 2Q15 to increase by 8.0%. For non-HDHP plans, the estimated increases are 8.0% and 8.1% for 1Q15 and 2Q15, respectively.

So ordered.

Dated: October 29, 2014 at Montpelier, Vermont

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

Filed: October 29, 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.