STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2022 Individual Market Rate Filing	)	GMCB-007-21rr SERFF No. MVPH-132824950
In re: MVP Health Plan, Inc. 2022 Small Group Market Rate Filing	)	GMCB-008-21rr SERFF No.: MVPH-132824927

DECISION AND ORDER

Introduction

Until recently, Vermont's individual and small group health insurance markets were merged. This meant that carriers were required to develop premiums for their individual and small group plans based on the combined claims experience of their enrollees in both markets. *See* Exhibit (Ex.) 16 at 3; 45 C.F.R. 156.80(c). Because small employers generally have lower claims costs than individual purchasers of insurance, Vermont's merged market resulted in somewhat higher premiums for small groups and lower premiums for individuals compared to what their respective premiums would have been in an unmerged market.

The American Rescue Plan Act (ARPA) expanded the subsidies that will be available from the federal government in 2022 to lower the cost of purchasing a plan in the individual market. Due to these expanded subsidies, Vermont unmerged the individual and small group markets for 2022. This means that carriers developed premiums for their 2022 individual and small group plans using the experience of their enrollees in each market separately. Because of the cost differential described above, this resulted in proposed 2022 premiums for small group plans increasing less relative to proposed 2022 premiums for individual plans.

MVP Health Plan, Inc. (MVP), one of two carriers offering individual and small group coverage in Vermont, filed its proposed 2022 rates on May 7, 2021. MVP requested an average annual premium increase of 17.0% for its individual plans, with average plan-level increases (excluding catastrophic coverage) ranging from 14.4% to 20.2%. MVP requested an average annual premium increase of 5.0% for its small group plans, with average plan-level increases ranging from 3.8% to 6.5%. Unmerging the markets had an impact of approximately +6.1% on the proposed individual rates and approximately -4.8% on the proposed small group rates.

Based on our review of the record, including the testimony and evidence presented at a hearing that was held on July 19, 2021, we modify the proposed individual and small group rates

and then approve the filings. We expect that, as modified, the average annual premium increase for MVP's individual plans will fall from 17.0% to 12.7% and the average annual premium increase for MVP's small group plans will fall from 5.0% to 0.8%. Despite the significant rate increase for individual plans, we expect that net premiums (after subsidies) will actually decrease by 6.4% on average for MVP members who receive premium tax credits.

Procedural History

1. On May 7, 2021, MVP filed its 2022 Individual Rate Filing and its 2022 Small Group Rate Filing with the Board using the System for Electronic Rate and Form Filing (SERFF). The filings outline MVP's development of premiums for individual and small group plans with coverage commencing January 1, 2022, including qualified health plans (QHPs) offered through Vermont Health Connect, Vermont's health insurance exchange (VHC or "the Exchange"), and reflective silver plans offered outside of the Exchange.[1] Ex. 1 at 2; Ex. 2 at 2.

2. On May 14, 2021, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care and health insurance, appeared as an interested party to the proceedings. Notices of Appearance; *see also*, 8 V.S.A. § 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule 2.000, §§ 2.105(b), 2.303.

3. From May 10 through June 28, 2021, the Board and its contracted actuaries at Lewis & Ellis (L&E) asked MVP to respond to a series of interrogatories, including questions suggested by the HCA. *See* Exs. 3 – 10, 11 – 15.

4. L&E reviewed the filings on behalf of the Board and issued a report on July 6, 2021. In its report, L&E summarized its review and analysis and recommended that the Board make seven modifications to the filings. Ex. 17. Also on July 6, 2021, the Vermont Department of Financial Regulation (DFR) issued its analysis and opinion regarding the impact of MVP's proposed rates on the company's solvency. Ex. 18; Ex. 19.

5. On July 15, 2021, L&E posed a final interrogatory to MVP regarding the fiscal year 2022 budgets that Vermont hospitals had submitted to the Board. In its response, MVP explained that if the submitted hospital budget increases were used instead of what MVP initially assumed in the filings, the proposed rates would fall slightly, to 4.92% on average for small group plans and 16.92% on average for individual plans. Ex. 24; Ex. 25.

6. The Board held a hearing on MVP's individual and small group rate filings on July 19, 2021. The hearing was held via Microsoft Teams. Members of the public were able to attend the hearing using Microsoft Teams, their phone, or by going to the Board's offices at 144 State Street in Montpelier, Vermont. The Board's General Counsel, Michael Barber, served as hearing officer by designation of Board Chair Kevin Mullin. MVP was represented by Gary Karnedy, Ryan Long, and Michelle Bennett from the law firm of Primmer Piper Eggleston & Cramer PC. The

[1] Since 2019, MVP has offered silver-level nonqualified health benefit plans in the individual and small group market outside of VHC. These plans are similar in their design to the "silver-loaded plans" offered on VHC. However, unlike the VHC plans, these reflective silver plans do not include any funding to offset the loss of the cost-sharing reduction payments. *See* 33 V.S.A. § 1813.

HCA was represented by Jay Angoff from the law firm Mehri & Skalet, PLLC, as well as HCA staff attorneys Kaili Kuiper and Eric Schultheis. At the hearing, the Board heard testimony from Matthew Lombardo, Senior Leader of actuarial services at MVP; Christopher Pontiff, Leader of actuarial services at MVP; Michael Fisher, Chief Health Care Advocate and Director of the Vermont Office of the Health Care Advocate; Jesse Lussier, Administrative Insurance Examiner at DFR; and Jacqueline (Jackie) Lee, Vice President & Consulting Actuary at L&E, whose testimony was elicited by GMCB Staff Attorney Laura Beliveau. *See* Hearing Transcript (Tr.); Confidential Hearing Transcript (Confidential Tr.).

7. On July 21, 2021, the Board asked L&E to provide a historical analysis comparing proposed hospital budgets to approved hospital budgets. July 21 Post-Hearing Board Questions for Lewis & Ellis. L&E provided the requested analysis to the Board and the Parties on July 27, 2021. L&E Post-Report Addendum.

8. On July 22, 2021, the Board asked MVP a series of follow-up questions from the hearing. July 22 Post-Hearing Board Questions for MVP Health Plan, Inc. MVP responded to the Board's questions on July 27 and July 30, 2021. MVP Responses to Post-Hearing Questions.

9. On July 22, 2021, the Board held a forum from 4:00 to 6:00 p.m. to hear from the public on the 2022 individual and small group rate filings of MVP and Blue Cross and Blue Shield of Vermont. The forum was held via Microsoft Teams with a designated physical location at the Board's offices at 144 State Street in Montpelier, Vermont. Two members of the public provided comments. The comments reflected frustration with rising health insurance rates and concern about the temporary nature of the ARPA subsidies.

10. On July 28, 2021, the Board closed a special comment period it had opened on May 7, 2021, for comments on the 2022 individual and small group rate filings. During the special comment period, the Board received comments from 7 individuals and 6 organizations. The comments expressed primarily two opinions: opposition to the proposed rate increases in the individual market and support for the unmerging of the markets and the beneficial impact to the small group market.

11. On July 27, 2021, the HCA and MVP each filed a post-hearing brief. *See* HCA Brief; MVP Brief. On July 29, 2021, MVP filed an addendum to its brief.

Findings of Fact

12. MVP is a non-profit health insurer domiciled in New York State. MVP is licensed as a health maintenance organization (HMO) in New York and Vermont and is a subsidiary of MVP Health Care, Inc., a New York corporation that transacts health insurance business through a variety of for-profit and non-profit subsidiaries. *See* Ex. 15 at 53; Ex. 16 at 1.

13. As of February 2021, there were 37,229 members enrolled in the plans covered by these filings, with 15,371 members enrolled in individual plans and 21,858 members enrolled in small group plans. *Id.*; *see also,* Ex. 16 at 3. Membership in MVP's individual and small group plans has steadily increased over the past few years, as reflected in the table below, which shows changes in MVP's overall individual and small group membership from 2017 to 2021:

Coverage Year	Members	Percent Change
2017	10,305	55.8%
2018	25,223	144.8%
2019	30,887	22.5%
2020	36,980	19.7%
2021	37,229	0.7%

Ex. 17 at 1.

14. In its individual filing, MVP proposed an average annual rate increase of 17.0%, with average plan-level increases (excluding catastrophic coverage) ranging from 14.4% to 20.2%. Ex. 17 at 3. In its small group filing, MVP proposed an average annual rate increase of 5.0%, with average plan-level increases ranging from 3.8% to 6.5%. *Id.* The tables below show the average proposed 2022 rate increase for each type of plan on a per member per month (PMPM) and percentage basis, as well as the distribution of MVP's membership across the plan types:

2022 PROPOSED RATE CHANGES – INDIVIDUAL

Plan Type	Average 2021 Premium PMPM	Average 2022 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$339.18	$374.43	10.4%	$35.25	0.1%
Bronze	$475.60	$571.53	20.2%	$95.93	33.3%
Silver Loaded	$656.63	$751.35	14.4%	$94.72	33.6%
Silver Reflective	$510.26	$604.61	18.5%	$94.34	5.5%
Gold	$637.28	$743.78	16.7%	$106.50	22.5%
Platinum	$741.01	$883.60	19.2%	$142.59	5.0%
Overall	***$587.86***	***$687.98***	***17.0%***	***$100.12***	***100.0%***

2022 PROPOSED RATE CHANGES – SMALL GROUP

Plan Type	Average 2021 Premium PMPM	Average 2022 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Bronze	$450.56	$479.85	6.5%	$29.28	17.0%
Silver	$523.66	$553.96	5.8%	$30.30	22.7%
Gold	$593.56	$616.23	3.8%	$22.66	44.6%
Platinum	$701.69	$742.33	5.8%	$40.64	15.7%
Overall	***$570.28***	***$598.62***	***5.0%***	***$28.35***	***100.0%***

15. As filed, MVP's expected claims and premiums produce a projected traditional loss ratio of 90.5% for the individual market and 91.1% for the small group market. After adjusting for taxes, fees, and quality initiatives, the 2022 federal medical loss ratio (MLR) is projected to be

91.5% for individual plans and 92.3% for small group plans, which exceeds the 80% minimum required by law. Ex. 17 at 4; 33 V.S.A. § 1811(j).

16. The federal government provides a premium tax credit (PTC) to certain taxpayers purchasing a plan through a health insurance marketplace such as VHC who are not eligible for coverage through a government program such as Medicare or Medicaid and who do not have access to an affordable[2] employer-sponsored plan that provides minimum value.[3] *See* 26 U.S.C. § 36B. Prior to the American Rescue Plan Act (ARPA), the PTC was only available to those with a household income between 100% and 400% of the federal poverty level (FPL). *See* 26 U.S.C. § 36B(c)(1)(A).

17. The PTC covers the difference between the premium for the second-lowest cost Silver plan – the "benchmark plan" – and a specified percentage of household income. For example, in 2021, prior to ARPA, an individual earning 150% FPL would have needed to contribute 4.14% of his or her income[4] towards the premium of the benchmark plan and would have received a PTC to cover the remainder. *See* 26 U.S.C. § 36B(b)(3)(A)(i). The individual could apply the PTC to the cost of a plan at any metal level – Bronze, Silver, Gold, or Platinum. *See* Ex. 17 at 18. The PTC is typically[5] paid directly to the insurance carrier by the federal government.

18. ARPA significantly expands the PTC for 2021 and 2022. First, for those who were already eligible, ARPA increases the amount of the PTC they can receive by reducing the share of income they are expected to contribute towards the cost of the benchmark plan. For instance, under ARPA, the individual in the example above with an income of 150% FPL could purchase the benchmark plan for $0. *See* 26 U.S.C. § 36B(b)(3)(A)(iii). Second, ARPA expands eligibility for the PTC to individuals and households above 400% FPL. *See id.*; *see also,* 26 U.S.C. § 36B(c)(1)(E).

19. ARPA's enhancements to the PTC, while significant, are temporary. Unless extended, they will not be available for plan year 2023. *See* 26 U.S.C. § 36B(b)(3)(iii). They also do not cover everyone. For example, an otherwise eligible individual that enrolls directly with a carrier will not receive the PTC because the PTC is only available for plans purchased through health insurance marketplaces. *See* 26 U.S.C. § 36B(b)(2)(A).

20. To take advantage of ARPA's expansion of the PTC, Vermont unmerged its individual and small group markets for 2022. Act 25 of 2021, § 34. This caused MVP's proposed

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[2] An employer-sponsored plan generally is considered "affordable" if the portion of the annual premium the employee must pay for self-only coverage that satisfies the minimum value requirement does not exceed a certain percentage of the employee's household income. Internal Revenue Service, Questions and Answers on the Premium Tax Credit, Question 11, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit#eligibility.

[3] An employer-sponsored plan provides "minimum value" if it covers at least 60 percent of the total allowed costs of covered services and provides substantial coverage of inpatient hospitalization services and physician services. Internal Revenue Service, Questions and Answers on the Premium Tax Credit, Question 12, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit#eligibility.

[4] In Vermont, the Vermont Premium Assistance would lower the individual's required contribution even further.

[5] Most taxpayers choose to have the credit estimated and paid to the carrier in advance to lower monthly premiums (referred to as advanced premium tax credit or APTC).

rates to decrease by 4.8% for small groups and to increase by 6.1% for individuals compared to what the proposed rates would have been under a merged market structure. Ex. 17 at 17.

21. The approximately 11% differential caused by the unmerging of the markets was driven primarily by the fact that claims experience for small group members was substantially lower than it was for individuals. Ex. 17 at 17. Another factor contributing to the differential is the different distribution of claims within the two populations. The filings use the same trend assumptions for inpatient claims, prescription drugs, etc., but because the distribution of these claim differs between the individual and small group markets, the overall weighted average trend differs slightly between the two populations as well. Other contributing factors are differences in the morbidity of the populations, which impacts risk transfer payments, and differences in benefit packages, which impacts inter-plan subsidies and the impact of induced utilization. Finally, the individual market covers fewer children than the small group market. Because single individuals in Vermont pay higher premiums in exchange for lower premiums for families, unmerging the two markets resulted in the individual market rates decreasing relative to the small group premiums. *See* Ex. 17 at 17; DFR, *In Re: Vermont Health Benefits Exchange*, Docket No. 13-002-I, Order Establishing Tier Rate Structure and Multipliers.

22. Since the unmerging of the individual and small group markets was connected to the subsidy expansion under ARPA, and since this expansion is currently set to expire for 2023, it is unclear whether the market will remain unmerged in 2023. If the markets are remerged for 2023, it is likely to result in a higher rate change for small groups than individuals. *See* Ex. 17 at 18.

23. MVP developed its proposed 2022 individual and small group rates based on historical claims data for its individual and small group membership.[6] Specifically, MVP used claims incurred between January 1 and December 31, 2019, and trended these claims costs forward three years to 2022. Ex. 1 at 11; Ex. 2 at 11. MVP chose to use 2019 claims because it did not believe that 2020 is representative of future years. Ex. 1 at 11; Ex. 2 at 11. However, MVP did use 2020 information to develop certain projections, for example its pharmacy (Rx) trend and telehealth utilization projections. *See, e.g.,* Ex. 4a at 14 – 20; Ex. 9 at 3; Ex. 10 at 3.

24. L&E reviewed the rate filings to assist the Board in determining whether the proposed rates are affordable, promote quality care, promote access to health care, protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the law; and are not excessive, inadequate, or unfairly discriminatory. Ex. 17 at 3. L&E's review focused on factors that are actuarial in nature, namely whether the rate are "excessive, inadequate, or unfairly discriminatory." These terms are defined by Actuarial Standard of Practice (ASOP) No. 8. Ex. 22 at 4. L&E does not review rates for affordability. Testimony of Jackie Lee, Tr. at 221:4.

25. Rates may be considered adequate if they provide for payment of claims, administrative expenses, taxes, and regulatory fees and have reasonable contingency or profit margin. Rates may be considered excessive if they exceed the rate needed to provide for payment of these items. Ex. 22 at 4 – 5. Rates may be considered unfairly discriminatory if they result in

[6] As noted above, because the individual and small group markets were unmerged, individual data was used to develop individual plan premiums and small group data was used to develop small group plan premiums.

premium differences among insureds within similar risk categories that are not permissible under law or regulation or, in the absence of an applicable law or regulation, do not reasonably correspond to differences in expected costs. The term "unfairly discriminatory" does not come into play often in rate review, particularly in Vermont, given its rating rules. *See* Ex. 22 at 5.

26. To allow for consistent comparisons across filings, L&E summarized the carriers' proposed premium changes using the Unified Rate Review Template (URRT) rather than the distinct rating methodology used by each company. *See* Ex. 17 at 5.

27. The URRT is not intended to prescribe a rate development methodology and L&E did not require MVP to develop its 2022 rates using the URRT. *See* Ex. 27 at 3; Testimony of Jackie Lee, Tr. at 251:18 – 25 (stating that, in conducting its review, L&E focused on MVP's exhibits, specifically Exhibit 3, which describes MVP's development of the index rate). Rather, L&E used the URRT as a tool for evaluating and explaining MVP's proposed rates. *See* Ex. 17.

28. To simplify comparisons to MVP's 2021 individual and small group rate filing, L&E explained its review from a combined or merged market perspective. This decision takes the same approach. The table below describes, on a merged market basis, MVP's proposed 2022 individual and small group rates using the rating categories of the URRT and an additional category to capture the impact of unmerging the markets.

	Percentage Change	
Rating Component	**Individual**	**Small Group**
1. 2020 Actual/Projected Claims Experience	-3.3%	
2. Difference in Trend from 2020 to 2021	+0.9%	
3. Trend from 2021 to 2022	+7.9%	
4. Changes to Population Morbidity Adjustment	+1.0%	
5. Demographic Shift	+0.0%	
6. Plan Design Changes	-0.3%	
7. Changes to Other Factors	+6.7%	
8. Changes to Risk Adjustment	-0.5%	
9. Changes in Actuarial Value	-2.1%	
10. Changes in Administrative Costs	-0.8%	
11. Changes in Taxes & Fees	+0.1%	
12. Changes in Contribution to Reserves	+0.9%	
13. Changes in Single Contract Conversion Factor	-0.0%	
14. Impact of Unmerging Markets	+6.1%	-4.8%
Total Proposed Rate Change	**+17.0%**	**+5.0%**

Ex. 17 at 5.

29. Based on its review, L&E recommends that the Board make seven modifications to the proposed rates. Ex. 17 at 20. These recommendations, if accepted, would result in changes to rating components 2 – 4, 7 – 9, and 14 of the above table. *Id.* at 17 – 18, 21.

30. L&E's first recommendation relates to MVP's proposed 2021 to 2022 medical unit cost trend. MVP proposed a total allowed 2021 to 2022 trend of 7.9%, consisting of a 6.7% allowed

medical trend and a 15.3% allowed pharmacy trend. The 6.7% allowed medical trend reflects an anticipated 5.7% increase in the cost of medical services (medical unit cost trend) and an anticipated 1.0% increase in the utilization of medical services by MVP members (medical utilization trend). Ex. 17 at 6.

31. MVP's 5.7% medical unit cost trend from 2021 to 2022 consists of a 5.7% trend for facilities and providers impacted by the Board's hospital budget review process and a 5.4% trend for other medical facilities and providers. Since the Board's fiscal year 2022 hospital budget review is not yet complete, MVP assumed that fiscal year 2022 hospital budget increases will match fiscal year 2021 increases. Ex. 17 at 6 – 7. L&E recommended that once fiscal year 2022 hospital budget requests are submitted, this new information be considered. *Id.* at 20.

32. Hospitals began submitting their proposed fiscal year 2022 budgets to the Board on July 1, 2021. On July 15, 2021, in response to an interrogatory from L&E, MVP provided a supplemental analysis showing that if the submitted hospital budgets were used in the rate filing instead of what was initially assumed, the individual rates would decrease approximately to 16.92% on average, and the small group rates would decrease to 4.92% on average. *See* Ex. 23 at 1; Ex. 24 at 1; *see also,* L&E Post-Report Addendum, 2.

33. In L&E's experience, the Board has never approved every hospital budget as submitted and it would be reasonable to lower MVP's proposed rates to account for the likelihood that the Board will reduce hospital budgets from what was submitted. *See* Testimony of Jackie Lee, Tr. at 277:21. Following the hearing on July 19, 2021, at the Board's request, L&E calculated the difference between submitted and approved hospital budgets each year from 2018 through 2021, as well as the average difference between submitted and approved hospital budgets over the past two-, three-, and four-year periods. L&E Post-Report Addendum, 2. As reflected in L&E's analysis, in each of the past four years, the Board has, on average, approved hospital budgets that are lower than submitted. *Id.* at 3, 7.

34. L&E's second recommendation relates to MVP's projected Rx trend. MVP projects an annualized Rx trend of 15.3% over 2020, 2021, and 2022. *See* Ex. 21 at 2; Testimony of Matthew Lombardo, Tr. at 43:5 – 21. MVP developed its Rx trend projection using a forecast that its pharmacy benefit manager (PBM) developed based on MVP's Vermont experience by drug class. Ex. 17 at 8; *see also*, Ex. 4a at 5 – 6; Ex. 5a at 5 – 6. Specialty trend is the primary driver of MVP's Rx trend assumption, as reflected in the chart below, which breaks down MVP's Rx trend projection by drug type:

Tier	Unit Cost	Utilization	Total Trend
Generic	0.0%	4.9%	4.6%
Brand	7.9%	4.6%	12.9%
Specialty	5.9%	14.0%	20.8%
Total *			***15.3%***

* Due to mix shifts and the order in which the two components can be applied, a weighted average of the trend components would not be accurate.

Ex. 17 at 8.

35. The table below compares the past five years of projected and observed Rx trends for MVP's individual and small group business:

Year	Projected Trend	Actual Trend	Under/(Over) Projection
2020/2019	5.8%	21.7%	+15.0%
2019/2018	7.4%	2.5%	-4.6%
2018/2017	12.4%	5.1%	-6.5%
2017/2016	11.1%	5.2%	-5.3%
2016/2015	8.8%	8.6%	-0.2%
5-year Average	9.1%	8.6%	
4-year Average	9.1%	8.6%	
3-year Average	8.5%	9.8%	
2-year Average	6.6%	12.1%	

Ex. 17 at 9.

36. As reflected in the above table, MVP's 2020 pharmacy trend is unusually high. This unusually high trend was driven primarily by a spike of approximately 20% in specialty drug costs. Ex. 17 at 9. L&E also noted that the prospective trends provided by MVP's PBM have overestimated actual results in four of the last five years. *Id.*

37. Compared to historical Rx trends, L&E believes 2020 was an outlier year that should be mitigated and accounted for when considering future trends. Ex. 17 at 9. L&E recommends that MVP's pharmacy trend assumption be reduced from 15.3% to 9.8% based on a 3-year average of the most recent historical trends. L&E believes a three-year average strikes an appropriate balance in that it does not rely too heavily on the most recent year of trend but includes it as a data point. *Id.*

38. Ms. Lee testified at hearing that a four-year or five-year average of actual Rx trends could be used. Tr. at 271:19 – 21. She also testified that a "rough range" of actuarially reasonable Rx trends would be "say, maybe 9.5 up to maybe that 12.1, which would be the [two-year average]" and that while she did think the bottom end of the range is "a lower number" than the 9.8%, "the general disagreement was with the 15.3% quoted, just stating that that was just too high." Tr. at 280:24 – 281:6.

39. A reduction to MVP's Rx trend assumption would impact projected 2021 and 2022 trends, which are reflected in URRT rating components 2 and 3, as well as projected 2020 trend, which, as described further below, is reflected in URRT rating component 7, "changes to other factors." *See* Testimony of Jackie Lee, Tr. at 224:13 – 25; 237:9 – 238:11; 256:6 – 13.

40. MVP disagrees with L&E's Rx trend recommendation. Ex. 21 at 1. The trends provided by MVP's PBM are calculated based on a static population at the time trends are produced, meaning they assume MVP's membership will remain the same. *See* Ex. 4a at 14; Ex. 5a at 13; Testimony of Matthew Lombardo, Tr. at 49:18 – 21. MVP argues that its actual Rx trends have been impacted by changes in membership and demographic mix and that it would be more

accurate to compare projected and actual trends for the same membership base. *See* Ex. 4a at 6; Ex. 5a at 6; Testimony of Matthew Lombardo, Tr. at 48:13 – 49:1, 49:2 – 21; MVP Brief at 2 – 3.

41. While it would be more accurate to compare projected and actual Rx trends for the same membership base, MVP has not performed such an analysis. *See* Testimony of Matthew Lombardo, Tr. 49:2 – 8; Testimony of Jackie Lee, Tr. at 248:17. MVP has not demonstrated that the observed difference between projected and actual Rx trends is due to changes in MVP's membership and demographic base.

42. L&E's third recommendation relates to MVP's assumptions regarding COVID-19 vaccine booster shots. Ex. 17 at 10. MVP assumed that COVID-19 booster shots will be available by the end of 2021 and administered in 2022 and MVP therefore included $1.27 PMPM in the proposed rates to cover its expected costs for these shots. *See* Ex. 16 at 19. MVP based these projected costs on its flu vaccine uptake of 29% (not including VT Vaccine Pilot utilization) and $52.81 unit cost experience. Ex. 17 at 10.

43. As support for its assumption that a COVID-19 booster shot will be approved and recommended in 2022, MVP cites statements from the CEOs of Moderna and Pfizer and an article from cnbc.com. Ex. 1 at 13, 153; Ex 2 at 13, 152; Ex. 9 at 1 – 2. L&E did not find these sources to be objective and notes that its sources, including the Centers for Disease Control and Prevention (CDC), express uncertainty regarding the need for boosters. Ex. 17 at 10. L&E recommends that the COVID-19 booster shot cost adjustment be removed due to uncertainty. Ex. 17 at 20.

44. On July 8, 2021, two days after L&E issued its opinion, the CDC and the Food and Drug Administration (FDA) issued a joint statement on COVID-19 vaccine boosters. The agencies stated that "Americans who have been fully vaccinated do not need a booster shot at this time" and explained that, together with the National Institutes of Health, they were "engaged in a science-based, rigorous process to consider whether or when a booster might be necessary." U.S. Dept. of Health and Human Services Press Release, Joint CDC and FDA Statement on Vaccine Boosters (July 8, 2021), https://www.hhs.gov/about/news/2021/07/08/joint-cdc-and-fda-statement-vaccine-boosters.html.

45. In last year's filing, MVP requested a 1.3% rate increase for costs it expected to incur in 2021 for a COVID-19 vaccine. Specifically, MVP proposed adding $5.00 PMPM to the rates based on its assumption that 80% of the population would receive a vaccine and that it would cost MVP $75 per dose. Ex. B at 6. MVP based its assumption that 80% of the population would receive a vaccine on an analysis published by Wakely Consulting. MVP based its assumption that it would have to cover the full cost of the vaccine at $75 per dose on the average cost for brand Tamiflu scripts. *Id.* The Board did not allow MVP to include this $5.00 PMPM charge in its 2021 rates, concluding that the assumed costs were too speculative and not sufficiently justified. *See In re: MVP Health Plan, Inc. 2021 Individual and Small Group Market Rate Filing*; GMCB-006-20rr, Decision and Order, 14 (Aug. 14, 2020); *see also*, Testimony of Jackie Lee, Tr. at 257:19. Vaccines were developed and widely administered in 2021; more than 80% of Vermonters have received the COVID-19 vaccine to date. *See* Testimony of Jackie Lee, Tr. at 257:23. However,

vaccine costs have been heavily subsidized by the state and federal governments. *See, e.g.*, Ex. 12 at 2 (noting that the federal government has covered the ingredient cost of the vaccines).

46. L&E's fourth recommendation relates to a balancing adjustment that results from the different experience periods that were used to develop the proposed rates and populate the URRT. As noted above, MVP sought to avoid the impact of COVID-19 on claims by trending 2019 base period experience forward three years. MVP therefore did not make an explicit adjustment for COVID-19. However, because the URRT is based on 2020 experience data, using the categories of the URRT, MVP's decision to use 2019 claims translates to a 6.5% adjustment for COVID-19, which appears under the "changes to other factors" category. *See* Ex. 17 at 12.

47. Because the COVID-19 adjustment reflected on the URRT is highly correlated to MVP's trend assumptions, L&E's recommendation to reduce MVP's Rx trend assumption would, if adopted, decrease the COVID-19 adjustment from 6.5% to 5.4% and result in an additional 0.7% decrease in rates. *Id.* at 13; Testimony of Jackie Lee, Tr. at 237:9-18, 237:24 – 238:11, 256:6 – 13 (explaining how L&E's recommended cut to MVP's three-year Rx trend assumption is translated through the URRT as a reduction to the COVID-19 adjustment), 237:1-3, 238:18 (clarifying that the 5.7% and 0.9% values on page 20 of L&E's report were in error and should be 5.4% and 0.7% respectively, as stated on page 13 of the report).

48. To evaluate the reasonableness of a COVID-19 adjustment of 5.4%, L&E reviewed MVP's normalized incurred claims data by month for 2020. In doing so, L&E observed a clear decrease in claims from March through May of 2020 due to the COVID-19 pandemic. L&E performed an analysis which considered the option of using 2020 modified experience as the base period experience instead of 2019. Based on this analysis, L&E's range for a COVID-19 impact is an increase of 3.5% to 5.5% to calendar year 2020 data. L&E considers a COVID-19 adjustment of 5.4% to be reasonable and appropriate. *See* Ex. 17 at 13.

49. L&E's fifth recommendation relates to projected risk adjustment transfer payments. Under the risk adjustment program established by the Affordable Care Act (ACA), insurers that have an enrolled ACA population with lower-than-average actuarial risk must provide payments to insurers in their market that have an enrolled ACA population with higher-than-average actuarial risk. *See* 42 U.S.C. § 18063. The program is designed to reduce the incentives insurers may have to avoid enrolling individuals who are more likely to incur high health care costs. *See* Katherine M. Kehres, Congressional Research Service, *The Patient Protection and Affordable Care Act's (ACA's) Risk Adjustment Program: Frequently Asked Questions* (Oct. 4, 2018), 1.

50. In developing proposed 2022 premiums, MVP projected its 2022 risk adjustment transfer payment based on an interim 2020 risk adjustment report published by the Centers for Medicare and Medicaid Services (CMS) in March 2021. At the time, this was the most recent data available. However, actual 2020 risk adjustment transfers were published by CMS on June 30, 2021. Based on the final report, MVP owes $21,771,777. Ex. 17 at 13 – 14.

51. Prior to CMS's publication of actual risk adjustment transfers, L&E used confidential reports from both carriers to provide an updated estimate for the individual, small

group, catastrophic, and merged markets. L&E's merged market estimate, which is presented in the table below, matched the actual risk adjustment transfer amounts later published by CMS.

Population	MVP Estimate	L&E Estimate
Merged Market[13]	($20,708,982)	($21,711,777)
Individual	($12,552,869)	($12,437,969)
Small Group	($8,080,407)	($8,750,057)
Catastrophic	($15,359)	($7,559)

Ex. 17 at 14.

52. Given the accuracy of its merged market projection, L&E's fifth recommendation is that MVP's risk adjustment receivable be changed to reflect the final market-wide figure announced by CMS and the market-specific risk transfers estimated by L&E. This would result in an approximately 0.4% increase in rates on a merged market basis, although the impact would vary significantly between the individual and small group markets due to the different risk levels observed by the carriers in the two markets. Ex. 17 at 14, 20.

53. MVP disagrees with L&E's recommendation regarding projected risk adjustment transfer payments. Ex. 21 at 1. MVP asserts that since the intent of the risk adjustment program is to normalize morbidity in the market, the risk adjustment year should align with the experience period. Testimony of Matthew Lombardo, Tr. at 36:19 – 24. Since MVP used 2019 as the experience period for this year's rates, it believes 2019 risk adjustment should be used. *Id.* at 36:25 – 37:4. MVP notes that 2020 was an outlier year and risk adjustment could be skewed, for example because of COVID hospitalizations and diagnoses. *See* Testimony of Matthew Lombardo, Tr. at 37:5 – 14, 39:9 – 12, 63:6 – 20. After listening to testimony from MVP's actuary on this issue, L&E supports adopting MVP's recommendation to use 2019 risk adjustment amounts. Testimony of Jackie Lee, Tr. 226:1 – 6, 276:19.

54. While MVP disagrees with L&E's recommendation regarding projected risk adjustment transfer payments, MVP also asserts that "if the [B]oard adopts L&E's recommendation to use 2020 data," L&E's recommendation should be adopted. Testimony of Matthew Lombardo, Tr. at 37:15 – 19. However, L&E found MVP's use of 2019 experience to be reasonable and reviewed MVP's proposed rates using 2019 experience. Testimony of Jackie Lee, Tr. at 240:17 – 23. While the URRT is based on 2020 data and L&E reviewed 2020 data to evaluate the reasonableness of the COVID-19 adjustment factor reflected in the URRT, L&E did not use or suggest MVP should have used 2020 as the experience period for rate development. *See* Testimony of Jackie Lee, Tr. 24:21 – 23.

55. L&E's sixth recommendation relates to changes in actuarial value. After the filings were submitted, MVP modified the design of the Standard Bronze HDHP plan by reducing the out-of-pocket maximum from $7,100 to $7,050 to comply with final guidance released by the Internal Revenue Service. L&E recommends updating the rates to reflect this change, which will increase rates for the Standard Bronze HDHP plan by approximately 0.18% and will have an

immaterial impact on overall rates. Ex. 17 at 15, 20; Ex. 20; Ex. 21 at 2. MVP agrees with this recommendation. Ex. 21 at 1.

56. L&E's final recommendation relates to population morbidity. As noted above, ARPA will expand eligibility for the PTC for the first time to households above 400% FPL. MVP did not assume any changes in population morbidity in connection with this expansion. Based on data from the most recent Vermont Household Insurance Survey, MVP reasoned that there were only 6,000 uninsured individuals that may elect to purchase coverage due to ARPA. Ex. 10 at 1; Ex. 17 at 11. MVP also believes that new members entering the market due to ARPA will not be healthier than the current population because they will be individuals who needed services but could not afford coverage under the old subsidy structure. Ex. 10 at 1; Ex. 17 at 11.

57. L&E concluded that ARPA would result in an improvement in population morbidity. It reasoned that some individuals who are currently uninsured will enter the market in 2022 and that these individuals will be healthier than the currently insured population because sicker people tend to be more willing to purchase coverage without a subsidy due to the need for services. Ex. 17 at 10 – 11. To analyze ARPA's potential impact, L&E reviewed data to understand the makeup of Vermont's uninsured population. L&E estimated that the new subsidies will affect approximately 6,000 uninsured individuals, which is consistent with MVP's expectation. Ex. 17 at 11; Testimony of Jackie Lee, Tr. at 226:21 – 24; Ex. 10 at 1. L&E observed that uninsured individuals with household incomes just above 400% FPL will see a 40% reduction in premium as a result of ARPA, while the premium reduction becomes smaller as income increases. Based on sensitivity testing it performed, L&E assumed that approximately 800 additional people will enroll in individual plans in 2022 and that this group will be 10% healthier than the currently covered population. If half of these individuals enroll in MVP plans, it would result in a 0.2% decrease in MVP's individual rates. To the extent these new enrollees preferentially enroll with one carrier over the other, the risk adjustment transfer should account and adjust for the difference. Ex. 17 at 11. Therefore, L&E recommends a 0.2% decrease to the individual rates, which translates to a merged market impact of -0.1%. *Id.*

58. In its filings, MVP projects a $1.89 PMPM increase in costs due to increased telehealth utilization. This increases MVP's proposed rates by approximately 0.3%. After reviewing the support provided by MVP for its projection, L&E concluded that it was reasonable. Ex. 17 at 10.

59. During the COVID-19 state of emergency, DFR required commercial health insurance plans to reimburse for health care services provided remotely through telehealth or audio-only telephone at the same rates as for services provided through in-person consultation. *See* Ex. 28 at 7; *see also*, DFR Emergency Rule H-2020-06-E, § 5. MVP developed its projected $1.89 PMPM cost increase for telehealth utilization assuming no change in reimbursements in 2022. *See* Testimony of Matthew Lombardo, Tr. at 73:21 – 74:3. However, beginning January 1, 2022, health insurance plans are allowed to reimburse for services delivered by audio-only telephone at no less than 75% of the rate for equivalent in-person audio/visual telemedicine covered service. Ex. 28 at 8. While MVP may continue to pay for some audio-only services at 100% of the in-person rate, it is strongly considering changing its payment policies and has therefore revised its telehealth

increase from $1.89 PMPM to $0.47 PMPM, a $1.42 PMPM reduction. MVP Reponses to Post-Hearing Board Questions (July 27, 2021), 1.

60. MVP's proposed premiums include an administrative expense load of $47.10 PMPM for individual plans and $38.75 PMPM for small group plans. Ex. 1 at 17; Ex. 2 at 17; Ex. 17 at 23. On a merged market basis, the administrative load included in proposed premiums is $42.26.[7] While this is a decrease relative to the 2021 assumption of $43.75 PMPM, resulting in a merged market impact of -0.8%, it is an increase for the individual market. *See* Ex. 17 at 15.

61. In its review, L&E noted that MVP's actual PMPM administrative costs have averaged $39.02 from 2016 to 2020 and MVP will be taking over billing and payment processing functions in 2022, which adds an estimated $3.32 PMPM to the administrative expenses. *Id*. Based on this, L&E concludes that MVP's assumed 2022 administrative costs are reasonable and appropriate. *Id.*

62. MVP proposes to increase rates by 0.1% for taxes and fees. L&E determined that this assumption appears to be reasonable and appropriate. Ex. 17 at 16.

63. MVP's filings include a 1.5% contribution to reserve (CTR). This is consistent with the CTR that MVP proposed in its 2021 filing, but it is higher than the 0.5% CTR that was approved for 2021. *See* Ex. 17 at 16; *In re: MVP Health Plan, Inc. 2021 Individual and Small Group Rate Filing*, GMCB-006-20rr, Decision and Order (Aug. 14, 2020), 16.

64. As a reasonableness check of MVP's proposed CTR, L&E reviewed public use files published by the Center for Consumer Information & Insurance Oversight (CCIIO). Based on this review, L&E concluded that, out of individual and small group filings nationally, over 70% assumed a CTR higher than 1.5% in 2021, over 80% assumed a CTR higher than 1.5% in 2020, and over 82% assumed a CTR higher than 1.5% in 2019. Ex. 17 at 16. L&E believes MVP's proposed CTR of 1.5% is reasonable and appropriate and recommends that the Board consider the solvency analysis performed by DFR. *Id.*

65. Assuming its recommended modifications are implemented, L&E believes that the filings do not produce rates that are excessive, inadequate, or unfairly discriminatory. Ex. 17 at 20. Ex. 22 at 4.

66. In its solvency opinion, DFR explained that it had communicated with MVP's primary solvency regulator, the New York Department of Financial Services, and had not learned of any solvency concerns. DFR also noted that in 2020, all of MVP Holding Company's operations in Vermont accounted for approximately 7% of its total premiums. DFR determined that MVP's Vermont operations pose little risk to its solvency but noted that adequacy of rates and contribution to surplus are necessary for all health insurers to maintain strength of capital to keep pace with claims trends. Contingent on L&E's finding that the proposed rate is not inadequate, DFR's opinion is that the proposed rates will not negatively impact MVP's solvency. Ex. 18; Ex. 19.

[7] The administrative expense load is $42.26 when weighted by expected total 2021 premium, and $42.20 PMPM when weighted by February 2021 enrollment. Ex. 17 at 15; Ex. 1 at 17; Ex. 2 at 17.

67. In 2020, the most recent full year for which data is available, MVP realized underwriting gains of $2,008,385 on its individual plans and $5,998,421 on its small group plans in Vermont. Ex. 15 at 11.

68. MVP submitted a post-hearing brief on July 27, 2021. MVP urged the Board to reject L&E's recommendations relating to the Rx trend and COVID-19 adjustment, booster shots, and morbidity changes due to ARPA. MVP urged the Board to accept L&E's recommendation regarding risk adjustment transfers if the Board adopts L&E's approach. With respect to the Rx trend assumption and COVID-19 adjustment, MVP argued that MVP's Rx trend assumption is superior to L&E's and that L&E failed to consider MVP's changing membership. With respect to COVID-19 booster shots, MVP argued that its assumption is actuarially sound and that it is relying on the same kinds of information it relied on last year when it projected it would incur COVID-19 vaccination costs. With respect to changes in morbidity resulting from ARPA, MVP characterized L&E's assumptions as speculative and unsupported. MVP also urged the Board not to adjust its proposed administrative expense load or its CTR. MVP characterized its proposed CTR as adequate and lower than nearly all rate filings across the country. It argued that reducing the CTR without justification is not sustainable and would jeopardize the adequacy of the rates. On July 29, 2021, MVP submitted an addendum to its brief warning the Board not to look to evidence outside the record regarding the Board's previous hospital budget decisions.

69. Like MVP, the HCA submitted a post-hearing brief on July 27, 2020. The HCA argued that MVP's proposed rates are contrary to law. The HCA stated that despite making a healthy profit on its individual and small group plans in Vermont and losing tens of millions of dollars on its individual and small group plans in New York in 2020, MVP had filed for 17% individual market increases in both states. The HCA asserted that this was not justified and resulted from MVP making unreasonable assumptions in its filings, or at least assumptions that are on the extreme high end of a reasonable range. The HCA argued that MVP had overestimated the costs of COVID-19 and urged the Board to reduce the COVID-19 adjustment to 3.5%. The HCA argued that MVP's Rx trend is excessive and urged the Board to reduce the trend to 8.6%, which is the four-year and five-year average. The HCA argued that MVP did not incorporate its investment income or expected risk corridor litigation recoveries into its proposed premiums and urged the Board to re-calculate MVP's 2022 rates so that they incorporated these factors. The HCA supported a reduction to the rates for improved morbidity due to ARPA but urged the Board to make a 0.8% reduction based on more aggressive assumptions than those made by L&E, namely that ARPA would result in 1500 new members who are 20% healthier than the current population. The HCA asserted that MVP failed to justify its 1% utilization assumption and urged the Board to require MVP to apply a 0% utilization trend. The HCA supported L&E's recommendation to remove the adjustment for COVID-19 booster shots. The HCA argued the Board should implement affordable hospital commercial rate increases. Finally, the HCA urged the Board to implement a negative CTR factor, arguing that MVP's Vermont operations pose little risk to its solvency and that MVP could not justify identical CTR factors for its Vermont and New York members.

Standard of Review

The Board reviews rate filings to determine whether the proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State, and is not excessive, inadequate, or unfairly discriminatory. 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b). The Board is required to consider 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. The Board must also consider DFR'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), (a)(3), and any public comments received on the filing. 8 V.S.A. § 4062(c)(2)(B); GMCB Rule 2.000, § 2.201.

The Board's review is plainly not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that the Legislature granted the Board review standards that 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 burden falls on the insurer proposing a rate change to justify the requested rate. GMCB Rule 2.000 § 2.104(c).

Conclusions of Law

As we have noted in prior decisions, there is a tension inherent in our standard of review. On the one hand, we are required, without specific statutory guidance or a standardized definition, to consider whether an insurance rate is affordable for Vermont consumers; on the other hand, we must consider whether the rate protects insurer solvency and is adequate to cover the costs of paying for members' claims and administering the plan. The failure of a rate to meet either criterion could imperil Vermonters' access to care, implicating another one of our review criteria. Our job is to find the most appropriate balance we can amongst the interrelated criteria we must consider.

Based on our review of the record, including the testimony and evidence presented at a hearing that was held on July 19, 2021, we conclude that the rates proposed by MVP are excessive. Accordingly, we require MVP to modify its rates. The required modifications and our reasoning for each are described in sections I – VIII below. As modified, the rates are not excessive, inadequate, or unfairly discriminatory. They will also be more affordable for consumers while still protecting MVP's solvency.

I

First, we require MVP to reduce its 2021 to 2022 medical unit cost trend assumptions for Vermont community hospitals by 1.0% from what hospitals proposed in their fiscal year 2022 budget submissions.

By only reducing its unit cost assumptions for Vermont community hospitals slightly in response to hospital budget submissions, MVP assumes that the Board will approve hospital budgets as submitted. *See* Findings of Fact (Findings), ¶¶ 31 – 32. This is an unreasonable assumption. At least in recent years, the Board has never approved every hospital budget as

submitted. It would therefore be reasonable to reduce MVP's proposed rates to account for the likelihood that the Board will reduce the rates requested by hospitals in their proposed fiscal year 2022 budgets. *See* Findings, ¶ 33. Since MVP did not attempt to estimate what a reasonable reduction might be, we must. Based on L&E's historical analysis of submitted and approved hospital budgets,[8] it is reasonable and appropriate to assume a 1.0% reduction in rates from hospitals' submitted budgets and we require MVP to use this assumption. *See id*.

II

Second, we require MVP to reduce its three-year average Rx trend assumption from 15.3% per year to 8.6% per year.

Since 2016, MVP's Rx trend projections have consistently overestimated actual results. Findings, ¶¶ 35 – 36. While it would be more accurate to compare projected and actual Rx trends for the same membership base, MVP has not performed such an analysis and has not demonstrated that the observed difference between projected and actual Rx trends is due to changes in MVP's membership and demographic base. *See* Findings, ¶ 41. Moreover, MVP is not assuming any significant shifts in demographics or changes in the morbidity of its population in the filings. *See* Findings, ¶ 28.

2020 is clearly an outlier year in terms of actual Rx trends and we agree with L&E that this unusually high trend should be mitigated when selecting an Rx trend. *See* Findings, ¶ 37. MVP's proposed trend of 15.3% fails to do this. While the three-year average that L&E recommended is preferable to MVP's 15.3% trend, we feel that it also gives too much weight to the unusually high trend observed in 2020. While the evidence is somewhat conflicting, we find that the four-year average (which is the same as the five-year average) is more reasonable and appropriate, and we therefore require MVP to reduce its Rx trend assumption from 15.3% to 8.6%. *See* Findings, ¶ 38.

III

Third, we require MVP to remove the $1.27 PMPM charge for COVID-19 booster shots.

MVP has not met its burden of justifying its proposed $1.27 PMPM charge for COVID-19 booster shots. It not clear whether and when booster shots will be needed; the CDC, FDA, and NIH are currently studying the issue. *See* Findings, ¶ 44. It is also not clear whether insurers will be responsible for the full cost of boosters, should they be needed, or whether the federal government will cover some portion of those costs, as it has with the vaccines themselves. *See* Findings, ¶ 45. While it is possible that MVP will bear costs in 2022 related to COVID-19 booster shots, these costs are too uncertain at this time to include in the rates. *See* Findings, ¶ 43.

We also disagree with MVP's suggestion that its assumptions regarding a COVID-19 vaccine last year were accurate and support its assumption regarding a booster. While MVP was correct that it would incur costs for COVID vaccines, it was not correct about the magnitude of

[8] In the addendum to its brief, MVP warned that "as a matter of law, the Board would abuse its discretion if it looked outside the evidence in the record and based its decision . . . on what it estimated it will decide in hospital budget hearings later this year." However, L&E's analysis is part of the record. *See* GMCB Rule 2.000, § 2.403.

these costs, which have been less than MVP projected due to subsidization from the state and federal government. *See* Findings, ¶ 45.

IV

Fourth, we require MVP to increase the rates for the Standard Bronze HDHP plan to comply with federal guidance. This has immaterial impact on overall rates. Findings, ¶ 55.

V

Fifth, we require MVP to reduce the proposed individual rates by 0.2% to account for improved population morbidity resulting from ARPA.

L&E estimates that new subsidies under ARPA will impact approximately 6,000 uninsured individuals. Findings, ¶ 57. This is consistent with MVP's expectation. Findings, ¶ 57. L&E also estimates that approximately 800 additional people will enroll in individual plans in 2022 and these individuals will be 10% healthier on average than the current population. Findings, ¶ 58. These projections are conservative and reasonable and are supported by sensitivity testing that L&E performed. *See* Findings, ¶ 57. L&E's assumption regarding the relative health of these newly insured individuals is also consistent with common sense; sicker individuals tend to be more willing to purchase coverage without a subsidy due to their need for services. *See id.*

VI

Sixth, we require MVP to reduce its $1.89 PMPM increase for telehealth utilization to $0.47 PMPM. MVP proposed this reduction, and we appreciate its willingness to reconsider aspects of its filing in light of new information. Findings, ¶¶ 58 – 59.

VII

Seventh, we require MVP to reduce its CTR assumption from 1.5% to 1.0%.

While MVP's proposed CTR compares favorably to the CTRs proposed by other insurers in other years, it is reasonable and appropriate to reduce MVP's proposed 2022 CTR by 0.5%. Individuals and small businesses are still struggling financially as we emerge from the state of emergency. Meanwhile, MVP realized significant underwriting gains on its Vermont individual and small group plans in 2020, the most recent full year for which data is available. Findings, ¶ 68. Furthermore, MVP has proposed very large rate increases. Indeed, for some plans, MVP has proposed increasing rates by over 20%. Findings, ¶ 14. A 0.5% reduction will make rates more affordable and will not materially impact MVP's solvency. DFR has not noted any solvency concerns relating to MVP, and MVP's Vermont operations are a relatively small part of its overall business; in 2020, all of MVP Holding Company's operations in Vermont accounted for approximately 7% of its total premiums. Findings, ¶ 67.

VIII

Eighth, we decline to accept L&E's recommendation to adjust MVP's risk adjustment receivable to reflect the final market-wide figure announced by CMS and the market-specific risk transfers estimated by L&E for 2020. *See* Findings, ¶ 52.

MVP disagrees with L&E's recommendation. MVP asserts that the risk adjustment year should align with the experience period and since MVP used 2019 as the experience period for this year's rates, its 2019 risk adjustment should be used. MVP also notes that 2020 was an outlier year and risk adjustment could be skewed, for example because of COVID hospitalizations and diagnoses. MVP's approach is supported by L&E and is reasonable. *See* Findings, ¶ 53.

While MVP also asserts that the Board should adopt L&E's recommendation regarding the risk adjustment transfer payments if it "adopts L&E's recommendation to use 2020 data," L&E found that MVP's use of 2019 as the experience period was reasonable. Findings, ¶ 54. While the URRT is based on 2020 data and L&E reviewed 2020 data to evaluate the reasonableness of the COVID-19 adjustment factor reflected in the URRT, L&E did not use or recommend using 2020 data as the experience period. *See id*.

IX

Ninth, we wish to express frustration with the $3.32 PMPM included in the rates to pay for MVP's assumption of billing functions from VHC. Findings, ¶ 61. We typically think of the "cost shift" as burdening commercial ratepayers with care delivery costs that are not covered by public payer reimbursements. However, this transfer of billing functions from VHC to the carriers has the same effect. Costs are being shifted from Medicaid, where half or more of the costs are borne by the federal government, to a small population of commercial ratepayers, resulting in a rate impact that is not insignificant. While the carriers will incur these costs and the rates need to support those increased costs, it is a frustrating dynamic.

X

Finally, consistent with our obligation to consider changes in health care delivery and changes in payment methods, we strongly encourage MVP to offer truly fixed prospective payments to health care providers in its network. The more risk MVP is able to share with providers, the less capital it may need to support its operations and the less CTR it may need to request in its rates. To the extent fewer claims need to be processed, administrative expenses may be reduced as well. Providers have also expressed a desire for more truly fixed payments, which they say provide them with greater predictability, stability, and flexibility. We believe that more widespread adoption of fixed prospective payments has the potential to enhance affordability, promote quality care, promote access to health care, and protect insurer solvency.

Order

For the reasons discussed above, we modify and then approve MVP's 2022 Individual and Small Group Rate Filings. Specifically, we order MVP to: (1) reduce its 2021 to 2022 medical unit cost trend assumptions for Vermont community hospitals by 1.0% from what the hospitals proposed in their fiscal year 2022 budget submissions; (2) reduce its three-year average Rx trend assumption from 15.3% per year to 8.6% per year; (3) remove the $1.27 PMPM charge for COVID-19 booster shots; (4) increase the rates for the Standard Bronze HDHP plan to comply with federal guidance; (5) reduce the proposed individual rates by 0.2% to account for improved

population morbidity resulting from ARPA; (6) reduce its $1.89 PMPM increase for telehealth utilization to $0.47 PMPM; and (7) reduce its CTR assumption from 1.5% to 1.0%.

On average, with the modifications required by this order, we expect rate increases for individual plans will be reduced from 17.0% to 12.7% and rate increases for small group plans will be reduced from 5.0% to 0.8%.We note that many Vermonters will receive federal subsidies to cover the increased costs in 2022, and we encourage Vermonters to use VHC's Plan Comparison Tool[9] (available beginning this Fall) when determining their best plan options.

SO ORDERED.

Dated: August 5, 2021, at Montpelier, Vermont

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

Pelham, concurring.

I concur with the Board's decision to modify and then approve MVP's 2022 Individual and Small Group Rate Filings. I understand the disruptions to the rate review process caused by the pandemic and the opportunities afforded by the recent federal changes attributable to the American Rescue Plan Act (ARPA). The former has severely muddied the actuarial information available to the carriers and the Board and the latter has provided the opportunity to favorably adjust small group premiums while leaving net individual premiums, inclusive of expanded federal subsidies, essentially stable. First addressing these unique pressures and opportunities is the responsible approach.

Rate review and ACO and hospital budget review are the most powerful levers available to the Board to foster Vermont's health care reform goals, but each comes just once a year. During the current individual and small group rate reviews, there are a couple of foundational priorities crucial to Vermont's healthcare reform efforts that did not receive the attention they deserve, though hopefully only postponed. These include pushing insurance carriers to engage in payment

[9] Available at https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

reforms more actively, especially reforms such as capitated payments that decouple our current payment systems from fee-for-service, and the Medicaid cost shift that pushes commercial rates higher.

Capitation: From CMS to AHS leadership and on down to presentations to the Board by national experts, fixed prospective payments (FPPs) and capitated payments have been fully embraced. Improvements in health care quality and costs hinge on payment reform. The All-Payer ACO Model Agreement Implementation Plan issued by the Vermont Agency of Human Services in November 2020 recommends taking the following regulatory action to support the Model:

> The GMCB and AHS will request that BCBSVT, MVP, and OneCare Vermont identify clear milestones for including fixed prospective payments in contract model design.

In our Fiscal Year 2021 ACO Budget Order, we required OneCare Vermont to work with payers to propose a target for FPPs, as well as a strategy for achieving those targets. OneCare has responded with very aggressive targets for non-fee-for-service and full capitation-based payments by payers.

During this rate review process, we can clearly see that the carriers embrace the concept of value-based payment reforms but have yet achieved little relative to capitated and true fixed prospective payments in practice. MVP's Mr. Lombardo testified:

> I would agree that they're, you know, it's in the range of 1 to 2 percent, somewhere in that range, and that's probably not going to have a huge influence overall. MVP is fully committed to moving towards those kinds of models, because we believe that that will help improve population health and improve cost efficiencies and increase member satisfaction, because then doctors can . . . provide care rather than fill out charts and do things like that, right, for fee-for-service modeling.

Tr. at 184:13 – 24.

Mr. Lombardo rightfully makes the point that the way forward is a two-sided effort where commercial payers and providers must come to "common terms". He says, "it either has to be both parties are willing to adopt a model and come to common terms, or there has to be a mandate in place." *Id.* at 185:7 – 17.

Cost Shift: The VHC billing provisions in carrier filings are clearly a cost shift from the Department of Vermont Health Access (DHVA) onto ratepayers' premiums and an addition to the massive amounts of Medicaid cost shift already imbedded in ratepayer premiums. For MVP, just the incremental cost shifted onto ratepayers through these filings will be $300,000. Ex. 10 at 5. While this transition may enhance the overall efficiency of the billing process, all the financial benefit accrues to DHVA as the burden gets shifted to ratepayers. I understand how difficult it might be to carve out this particular increase from premiums in the context of unmerging individual and small group premiums, both practically and legally, but hoped we might find a path to that end, which we did not.

While the challenges of COVID-19 and the unmerging of the individual and small group markets have commanded the attention of carriers and the Board, we need to stay mindful that payment reform and the mitigation of the cost shift are foundational elements of Vermont's health care reform effort. These efforts need the persistent attention of all stakeholders if Vermonters are to garner the promised benefits of reform in the near future.

Filed: August 5, 2021

Attest: s/ Jean Stetter, Administrative Services Director
Green Mountain Care Board

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made (email address: Christina.McLaughlin@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 within ten days of the date of this decision and order.