STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Plan, Inc.	)	GMCB-009-21rr
	2022 Large Group HMO Rate Filing	)	SERFF No.: MVPH-132932250
		)	

DECISION AND ORDER

Introduction

Health insurers must submit major medical rate filings to the Green Mountain Care Board, which must approve, modify, or disapprove each filing within 90 calendar days of receipt. 8 V.S.A. § 4062(a)(2)(A). On review, the Board must determine whether the proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law. 8 V.S.A. § 4062(a)(3).

This decision pertains to the 2022 large group rate filing of MVP Health Plan, Inc. (GMCB-009-21rr).

Procedural History

On August 6, 2021, the Board received a rate filing via the System for Electronic Rate and Form Filing (SERFF) from MVP Health Plan, Inc. (MVPHP or MVP) for its 2022 large group HMO products, including benefit riders offered in connection with the products.[1] On August 9, 2021, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid that represents the interests of Vermont health insurance consumers, entered an appearance as a party to the filings.

On October 1, 2021, the Board posted to its website an analysis prepared by the Vermont Department of Financial Regulation (DFR) regarding the impact of the filing on the carrier's solvency. On October 5, 2021, the Board posted to its website an actuarial memorandum prepared by Lewis & Ellis (L&E), the Board's contract actuaries. The Board received no public comment on the filing. Pursuant to GMCB Rule 2.000, § 2.309(a)(1), the parties waived a hearing and filed memoranda in lieu thereof.

Findings of Fact

1. MVPHP is a non-profit health insurer domiciled in New York state and licensed as a health maintenance organization (HMO) in New York and Vermont. MVPHP is a subsidiary of MVP Health Care, Inc, a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries and provides health insurance coverage to individuals and employers in the small and large group markets in New York and Vermont.

[1] The SERFF filings, as well as all documents referenced in this Decision and Order, can be found in the rate review section of the Board's website at https://ratereview.vermont.gov/MVPH-132932250.

2. This filing demonstrates the premium rate development of MVP's large group HMO product portfolio and includes proposed manual rates for all four quarters of 2022. MVP's large group HMO product portfolio is comprised of base major medical high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and benefit riders. L&E Actuarial Memorandum (L&E Memo), 1. The manual rates are composed of a base rate change, an age/gender factor change,[2] and a change in retention. *See* L&E Memo, 1-2.

3. As of May 2021, there were approximately 2,100 members enrolled in MVP large group plans in Vermont. Approximately 80% have renewal dates during the first quarter of 2022 (1Q22). L&E Memo, 1; *see* MVP Actuarial Memorandum (MVP Memo), 1.

4. MVPHP proposes an 8.5% annual manual rate increase for members renewing in 1Q22, consisting of a 7.7% base rate increase and a 0.7% increase in retention. L&E Memo, 2. MVPHP also proposes manual rate increases of 2.1% for each of the remaining quarters of 2022, representing the assumed quarterly trend. L&E Memo, 2. Together, the proposed quarterly increases translate to an average annual manual rate increase of 8.5%. MVP Memo, 1; *see* L&E Memo, 1.

5. In practice, the large groups represented in this filing have premium rates based on an average blend of their own claims experience at approximately 32% and the manual rate at approximately 68%. Therefore, some groups will experience higher increases, and some will experience lower increases. If a group experiences a higher increase, it is because their claims experience deteriorated relative to the other large groups in this block. All groups will experience the effect of changes in retention, as these components of the rate are added to the projected claims, whether those claims came from the manual rate or the group's experience. L&E Memo, 2-3.

6. The federal loss ratio for MVPHP in 2020 is 100.3%, and the rolling three-year average (2018-2020) is 93.4%. L&E Memo, 9; *see also* Response to Objection Letter #1 (August 20, 2021), 10 (MVP experienced federal loss ratios of 104.3% and 75.7% for 2018 and 2019, respectively).

7. MVP utilized large group claim data (constituting HDHP and non-HDHP products) for the period from March 2019 through February 2020 and paid through May 2021 (with incurred estimates updated through June 2021) as the base period experience. MVP elected not to include 2020 incurral months more recent than February due to COVID-19-suppressed claims which are not anticipated to be representative of 2022 expected claim costs. The base period data is 100% credible. Due to claims historical volatility and the impact of COVID-19 on 2020 claims data, it is reasonable and appropriate to utilize data from March 2019 to February 2020 as the experience period. L&E Memo, 3.

8. Claims exceeding $250,000 made up 2.7% of the base period experience. The claims above the pooling limit of $250,000 for the prior 5 years have ranged from 1.4% to 9.3%, with an average of 6.2%. This volatility demonstrates the importance of pooling claims in setting the rates each year. The Vermont-only data is not fully credible and the use of New York data to set the

[2] The age/gender factor change in the filing is 0.0% because MVP used the same experience period as it did in its 2021 large group HMO filing. *See* MVP Actuarial Memorandum, 1.

pooling charge assumption results in more stable premiums. L&E found this pooling practice to be reasonable and appropriate. L&E Memo, 3-4.

9. The adjusted claims were projected forward to the midpoint of the 1Q22 rating period using an annual paid medical trend assumption of 6.7%. MVP's paid medical trend is derived from its proposed allowed cost trend and the impact of cost share leveraging. The prescription (Rx) claims were projected forward to the midpoint of the 1Q22 rating period using an annual paid Rx trend of 16.9%. The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q22. These adjustments included projected cost of capitation, non-FFS claim expenses, Rx rebates, newly added benefits, and COVID-19 boosters. Reflecting these adjustments, the quarterly manual rate change suggested by the data was 1.3% for 1Q22. MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims. This results in manual rate increases of 2.1% in each of the remaining quarters of 2022. That is, groups renewing in April will be charged premiums based on manual rates 2.1% higher than groups renewing in January. As noted above, approximately 80% of groups have 1st quarter renewal dates. L&E Memo, 4; *see supra* Findings of Fact (Findings), ¶ 3.

10. MVP is requesting a utilization trend of 1.0% and a unit cost trend of 4.7% for 2022. This represents a total allowed trend of 5.8% for 2022. MVP adjusted the allowed cost trends to account for the impact of cost share leveraging and derived a total effective paid medical trend factor of 6.7% annually. This effective paid trend factor is used to trend the claim experience from the experience period to the rating period in calculating the projected claim cost for the rating period. For this filing, thirty-four months of trend were used to trend the experience period claims forward to 1Q22. L&E Memo, 5.

11. MVP analyzed its combined Vermont data for 36 months between 2017 and 2019 to assess the utilization trend. However, this data was not considered appropriate for utilization trend analysis due to concerns with the large impact that membership growth in other blocks of business (Vermont Health Connect) was having on the total utilization trend for Vermont. Removing MVPHP data from the calculation would leave a block that was not considered credible. Therefore, MVP utilized the results from the L&E analysis and review of the 2020 QHP filing and used a utilization trend assumption of 1.0%, consistent with utilization trend used in the 2021 and 2022 QHP filing. L&E found the utilization trend of 1.0% to be reasonable and appropriate. L&E Memo, 5.

12. The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. For providers who are not subject to GMCB hospital budget review, unit cost trend assumptions are based on established contracts and best estimates of contract negotiations, depending on availability. For providers subject to GMCB hospital budget review, unit cost trend assumptions were based on proposed cost increases as submitted by providers during the hospital budget review process. Since the filing was submitted, the Green Mountain Care Board has made final decisions regarding fiscal year (FY) 2022 hospital budgets. The approved increases are lower than anticipated at the time of the filing. L&E Memo, 5. L&E recommended revising the trends to reflect the final FY 2022 hospital budget orders, which would decrease the 2022 first quarter rates by 0.6%. L&E Memo, 6.

13. To develop its annual allowed pharmacy trend assumption of 15.3%, which is composed of a utilization trend of 4.7% and a unit cost trend of 10.2%, MVP analyzed its pharmacy data by drug category (Generic, Brand, Specialty). Annual allowed trend factors by drug category were supplied by MVP's pharmacy benefit manager (PBM). The driver of the large pharmacy trend is an outlier increase in specialty drug utilization due to (non-COVID) chronic condition diagnoses that generally require continued Rx use. L&E Memo, 6-7.

14. MVP is using 2022 drug rebate forecasts provided by its PBM. These forecasts assume that drug rebates will equal $32.58 PMPM for 1Q22 renewals and increase with pharmacy trend for later quarters. L&E Memo, 5; *see also* 2022 Vermont Large Group Filing, Ex. 3a-3d.

15. MVP's methodology used an assumed Rx trend for 2020 that was less than half the actual Rx trend because it relied on the PBM's information which was based on a more credible data set that included MVP's VT small group and individual population. The projected gross Rx allowed claims PMPM for 1Q22 is $105.91. The actual gross Rx allowed claims PMPM in 2020 was $110.67 and in the first half of 2021 was $101.32. L&E concluded that although it would prefer a methodology that utilized the actual 2020 trend, the overall projected Rx allowed claims PMPM appear to be reasonable and appropriate. L&E Memo, 7; *see also* 2022 Vermont Large Group Filing, Ex. 3a; Response to Objection Letter 1 (August 20, 2021), 7.

16. MVP included an additional $1.45 PMPM in claim costs in 1Q22 for COVID-19 booster shots, based on MVP's flu vaccine uptake of approximately 29% and $56.00 unit cost experience. L&E Memo, 7; *see also* Response to Objection Letter 1 (August 20, 2021), 7-8. Actual COVID-19 vaccination costs for utilizers of 2-dose vaccinations from December 2020 to May 2021 were $1.39 PMPM, which represents only the cost to administer the vaccine, as the drug ingredient cost was paid for by the federal government. L&E Memo, 8; *see also* Response to Objection Letter 2 (September 7, 2021), 2. MVP points to various sources, including vaccine manufacturers and White House press, as support for the assumption that booster shots will be approved and needed in 2022. As of September 2021, however, boosters had been approved only for moderately to severely immunocompromised adults. As the booster is only one additional dose, and utilization is expected to be half of the initial utilization, L&E recommends reducing the assumed booster costs by one half of the actual expense from December 2020 to May 2021, down to $0.70 PMPM ($1.39*0.5). This reduction would decrease the 2020 first quarter rates by 0.2%. L&E Memo, 8.

17. The rates for these products depend on the demographics of the covered population. The base manual rate projection does not take into account changes in demographics. Therefore, it does not reflect the change in the average demographic factor that results from a younger or older enrolled population. Since this filing utilizes the same experience period as the prior filing, there is no impact to the rates for age/gender normalization. L&E determined that MVPHP's age/gender normalization methodology appears to be reasonable and appropriate. L&E Memo, 4.

18. Retention charges are added to the blended pure premium in deriving the group required premium. The 14.0% total retention load is composed of the following: (a) 8.2% administrative expenses, (b) 3.8% other expenses, and (c) 2.0% contribution to reserves (CTR). The projected administrative expenses of 8.2% of premium is consistent with the average of the most recent two

years (8.1%) and is less than the average of the most recent three years (8.7%). L&E concluded that the administrative expense load appears to be reasonable and appropriate. L&E Memo, 8.

19. The 3.8% projected other expenses are broker load at 2.6%, VT vaccine pilot at 0.5%, bad debt at 0.3%, billback at 0.3%, and comparative effectiveness research fee at 0.1% L&E Memo, 8-9.

20. The federal loss ratio for MVP in 2020 is 100.3%, and the rolling three-year average (2018-2020) is 93.4%. L&E Memo, 9.

21. The proposed contribution to reserves (CTR) is 2.0%, which is consistent with historically proposed CTR. In past orders, the Board has reduced the proposed CTR. L&E found that the proposed CTR appears to be reasonable and appropriate and recommended that the solvency analysis performed by the Department of Financial Regulation be considered if changes are made to this assumption. L&E Memo, 9.

22. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR assessed the impact of the proposed filing on the carrier's solvency. DFR noted that New York State, the primary solvency regulator for MVP, has not learned of any solvency concerns regarding the carrier. DFR noted that MVP currently meets Vermont's foreign insurer licensing requirements. Finally, in 2020, all of MVP Holding Company's operations in Vermont accounted for approximately seven (7) percent of its total premiums written. DFR has determined that MVP's Vermont operations pose little risk to its solvency. Nonetheless, adequacy of rates and contribution to surplus are necessary for all health insurers to maintain strength of capital that keeps pace with claims trends. Based on its entity-wide assessment and contingent upon the Board's actuary's finding that the proposed rate is not inadequate, DFR's opinion is that the proposed rate will not have a negative impact on MVP's solvency. DFR Solvency Analysis for MVP's 2022 Large Group HMO Rate Filing.

23. L&E reviewed the filing and recommends that the Board adjust the proposed rate increase to reflect three adjustments. The first is to reflect the correction of the error found in the calculation of the rates during L&E's review, resulting in a -0.3% decrease to the rates. The second is to revise the trends to reflect the final FY2022 hospital budget orders, resulting in a decrease to the 2022 first quarter rates by -0.6%. The third is to reduce assumed COVID-19 booster costs from $1.45 PMPM to $0.70 PMPM, resulting in a decrease to the 2022 first quarter rates by -0.2%. L&E Memo, 10.[3]

24. With L&E's recommended modifications, the revised rate increases for 2022 would be as follows:

Reason for Change	**1Q '22 Annual Increase**
Manual Rate Change	6.6%
Age/Gender Factor Changes	0.0%
Change in Retention	0.7%
Total Manual Rate Change	7.3%

[3] L&E's bulleted recommendations on page 10 discuss decreases to 2021 first quarter rates; the correct date is 2022 first quarter rates.

L&E Memo, 10.

25. L&E concludes that if its recommended modifications are made, the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. L&E Memo, 11.

26. In its Memorandum in Lieu of Hearing (MVP Brief), MVP "accepts L&E's recommendation of an additional downward adjustment of 0.3% to reflect a calculation error in the presentation of MVP's proposed rate increase[,]" although MVP disputes whether the adjustment has an impact on rates. MVP "also accepts L&E's second recommendation, a reduction of 0.6% to revise the trends to reflect the final orders on FY2022 hospital budgets[;]" this adjustment reduces the proposed annual increase to 7.6%. MVP Brief, 1.

27. MVP disagrees with L&E's third recommendation to reduce the COVID-19 booster adjustment, stating that "MVP's COVID-19 booster adjustments are reasonable and actuarially sound[,]" that "there is no evidence to suggest that the federal government will continue to pay for booster ingredient costs or will do so in perpetuity[,]" and that Vermonters will increasingly receive their vaccination and boosters at pharmacies instead of mass vaccination sites. MVP Brief, 1. MVP also argues against any reduction to its CTR. MVP Brief, 3.

28. The HCA, in its Memorandum in Lieu of Hearing (HCA Brief), "agrees with L&E's recommendations to reduce MVP's proposed premium to correct an error in MVP's rate increase calculation, to account for recent hospital budget orders, and to more accurately predict costs to the insurer from future Covid-19 booster shots." HCA Brief, 4.

29. The HCA asserts that MVP's proposed premium increase should be reduced because its proposed 2% CTR is unaffordable and is unnecessary to protect insurer solvency. The HCA notes that the ongoing COVID-19 pandemic has eroded the financial stability of many Vermont businesses and that "[t]his climate is not the time to ask Vermonters and Vermont businesses to pay more than is absolutely necessary for their insurance premiums." HCA Brief, 1. The HCA observes that DFR and MVP's New York regulators have not expressed any concerns regarding MVP's solvency. The HCA notes that "MVP's Vermont population makes up less than 10% of MVP's overall population and, as such, a reduction to its proposed Vermont premium increase will have a *de minimus* impact on MVP's solvency position." The HCA requests the Board "to reduce the CTR in this filing from 2% to 1% given the current financial hardships facing Vermonters and Vermont businesses, MVP's strong solvency position, and the *de minimus* impact of such a reduction on the insurer's solvency position." HCA Brief, 3.

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, and is not unjust, unfair inequitable, misleading, or contrary to the laws of this State." 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b). Although the first several terms—excessive, inadequate, or unfairly

discriminatory—are defined actuarial standards,[4] other standards by which the Board reviews rate filings are "general and open-ended," the result of "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16. The Board additionally takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000, § 2.401.

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

Conclusions of Law

I.

First, we adopt our actuaries' recommendations and order MVP to 1) revise the calculation of the rate increase, resulting in a -0.3% decrease to the rates; and 2) adjust the unit cost trend to reflect the approved FY2022 hospital budgets, resulting in a reduction to the 2022 first quarter rates by -0.6%. These recommended modifications either correct for omissions in the filing or incorporate more accurate information not available at the time of filing. Moreover, the recommendations were not contested by either party. *See* Findings, ¶¶ 26, 27.

II.

Second, we address MVP's request for an additional $1.45 PMPM in claim costs in 1Q22 for COVID-19 booster shots. MVP based the proposed cost on its flu vaccine uptake of approximately 29% and $56.00 unit cost experience. L&E recommends using a COVID-19 booster cost assumption of $0.70 PMPM, half of MVP's actual COVID-19 vaccination costs for utilizers of 2-dose vaccinations from December 2020 to May 2021. Adopting L&E's recommendation would decrease the 2022 first quarter rates by 0.2%. Findings, ¶ 16.

We adopt L&E's recommendation because we find that L&E's approach of using MVP's actual COVID-19 vaccination costs to be more reasonable than MVP's approach of using its flu vaccine experience, which was not adequately supported. Nevertheless, we acknowledge that there is uncertainty regarding how closely MVP's COVID-19 vaccine experience from December 2020 to May 2021 will reflect its 2022 costs for boosters. For example, it is unclear how long the federal government will continue paying for ingredient costs. While we think L&E's approach is more reasonable, this uncertainty factors into how we approach MVP's CTR proposal.

[4] Under Actuarial Standard of Practice No. 8, rates may be considered adequate if they provide for payment of claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins; rates may be considered excessive if they exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins; and rates may be considered unfairly discriminatory if they result in premium differences among insureds within similar risk categories that: (1) are not permissible under applicable law; or (2) in the absence of applicable law, do not reasonably correspond to differences in expected costs.

III.

Third, consistent with modifications we have required in other filings, we order MVP to reduce the proposed CTR from 2.0% to 1.5%. *See, e.g., In re: MVP Health Plan, Inc., 2022 Individual Market Rate Filing and 2022 Small Group Market Rate Filing,* GMCB-007-21rr and GMCB-008-21-rr, Decision and Order, 18 (reducing CTR from 1.5% to 1.0); *In re: MVP Health Plan, Inc., 2021 Large Group HMO Rate Filing,* GMCB-008-20rr, Decision and Order, 10-11 (reducing CTR from 2.0% to 1.0); *In re: MVP Health Plan, Inc., 2020 Individual and Small Group Market Rate Filing*, GMCB-005-19rr, Decision and Order, 13 (reducing CTR from 1.5% to 1.0%); *In re: MVP Health Plan, Inc., 2020 Large Group HMO Rate Filing,* GMCB-008-19rr*,* Decision and Order, 7-8 (reducing CTR from 2.0% to 1.0%). We expect this will lower the first quarter 2022 rate increase by 0.5%.

Reducing the CTR from 2.0% to 1.5% will make a substantial rate increase more affordable for Vermonters and will not threaten MVP's solvency. *See* Findings, ¶ 22. DFR found that MVP's Vermont business accounted for approximately seven (7) percent of total premiums written in 2020 and that MVP's Vermont operations pose little risk to its solvency. Findings, ¶ 22.

The HCA recommends that the Board reduce the CTR from 2.0% to 1.0% because the proposed 2.0% CTR is unaffordable and unnecessary to protect insurer solvency. Findings, ¶ 28. While, as noted above, we have reduced MVP's proposed CTR to 1.0% in prior filings, uncertainty around the extent of COVID booster costs in 2022 leads us to a take a more cautious approach in this filing.

IV.

Finally, consistent with our obligation to consider changes in health care delivery and changes in payment methods, we strongly encourage MVP to include its large group business in an accountable care organization (ACO) initiative and, as part of such an initiative, to offer truly fixed prospective payments to health care providers in its network. *See In re: MVP Health Plan, Inc., 2022 Individual Market Rate Filing and 2022 Small Group Market Rate Filing,* GMCB-007-21rr and GMCB-008-21-rr, Decision and Order, 19 (encouraging use of fixed prospective payments). By transferring accountability for the cost and quality of the care to health care providers, such initiatives can limit increases in claims costs (and therefore premium growth) while maintaining or improving the quality and health outcomes. Furthermore, even if fixed prospective payments have minimal impact on MVP's reserves and administrative costs, they provide stronger incentives than prospective payments reconciled to fee-for-service equivalents, as well as greater predictability, stability, and flexibility for providers. If the State is to achieve the goals of the Vermont All-Payer Accountable Care Organization Agreement, commercial insurers such as MVP must expand their value-based payment programs to impact more Vermonters.

Order

For the reasons discussed above, we order MVP to 1) revise the calculation of the rate increase; 2) adjust the unit cost trend to reflect the approved FY2022 hospital budgets; 3) reduce

its COVID-19 booster cost assumption from $1.45 PMPM to $0.70 PMPM; and 4) reduce the proposed CTR from 2.0% to 1.5%.

SO ORDERED.

Dated: November 4, 2021, at Montpelier, Vermont

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

Filed: November 4, 2021

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

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