STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2023 Individual Market Rate Filing	)	GMCB-005-22rr SERFF No. MVPH-133238186
In re: MVP Health Plan, Inc. 2023 Small Group Market Rate Filing	)	GMCB-006-22rr SERFF No.: MVPH-133238198

DECISION AND ORDER

Introduction

MVP Health Plan, Inc. (MVP), one of two carriers offering individual and small group health insurance coverage in Vermont, has proposed to increase its premiums in 2023 by an average of approximately 24.4% for its individual plans and an average of approximately 23.4% for its small group plans. Based on our review of the record, including the testimony and evidence presented at a hearing that was held on July 20, 2022, 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 be approximately 19.3% and the average annual premium increase for MVP's small group plans will be approximately 18.3%.

Procedural History

1. On May 6, 2022, MVP filed its 2023 individual and small group rate filings with the Board using the System for Electronic Rate and Form Filing (SERFF). The filings outline MVP's development of premiums for health benefit plans that MVP will offer to individuals and small employers for the 2023 benefit year. The plans covered by the filings include plans available through Vermont Health Connect (VHC), Vermont's health insurance exchange, as well as plans available directly from MVP. *See* Ex. 1, 2; Ex. 2, 2.

2. On May 13, 2022, 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. HCA 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 11, 2022, through June 22, 2022, the Board and its contracted actuaries at Lewis & Ellis (L&E) asked MVP to respond to a series of interrogatories, which included questions suggested by the HCA. *See* Exs. 3 – 7, 9 – 11, 17, 34 – 35, 43 – 44.

4. L&E reviewed the filings on behalf of the Board and issued an actuarial report with respect to each filing on July 5, 2022. In its reports, L&E summarized its review and analysis of

the filings and recommended adjustments to each filing. Exs. 12 – 13. Also on July 5, 2022, the Vermont Department of Financial Regulation (DFR) issued opinions regarding the impact of each filing on MVP's solvency. Exs. 14 – 15.

5. Vermont hospitals began submitting their proposed fiscal year 2023 (FY 2023) budgets to the Board on July 1, 2022. On July 12, 2022, L&E asked MVP to respond to an interrogatory regarding the hospital budgets. MVP responded to this interrogatory on July 14, 2022. Exs. 34 – 35.

6. The Board held a hearing on MVP's individual and small group rate filings on July 20, 2022. 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 Alice McDermott from the law firm of Primmer Piper Eggleston & Cramer PC. The HCA was represented by Jay Angoff from the law firm Mehri & Skalet, PLLC, as well as HCA staff attorneys Eric Schultheis and Charles Becker. At the hearing, the Board heard testimony from 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 & Principal Consulting Actuary at L&E. *See* Hearing Transcript (Tr.).

7. On July 20, 2022, L&E asked MVP to respond to a final interrogatory regarding new data and calculations that had been provided by MVP at the hearing. MVP 2023 SG Exchange Filing Objection Letter 10; MVP 2023 Ind. Exchange Filing Objection Letter 10. MVP responded to this interrogatory on July 21, 2022. MVP Response to 2023 SG Exchange Filing Objection Letter 10; MVP Response to 2023 Ind. Exchange Filing Objection Letter 10.

8. On July 21, 2022, the Board asked MVP a series of follow-up questions from the hearing. Post-Hearing Questions. MVP responded to the Board's questions on July 27, 2022. MVP Responses to Post-Hearing Questions.

9. On July 21, 2022, the Board held a public comment forum from 4:00 to 6:00 p.m. to hear from the public on the 2023 individual and small group rate filings of MVP and Blue Cross and Blue Shield of Vermont (BCBSVT). The forum was held via Microsoft Teams with a designated physical location at the Board's offices at 144 State Street in Montpelier, Vermont.

10. Just before midnight on July 21, 2022, the Board closed a special public comment period that it had opened on May 9, 2022, regarding the 2023 individual and small group rate filings. The Board received approximately 245 comments during the special comment period.

11. On July 22, 2022, L&E issued an addendum to its July 5, 2022, report, which it revised on July 26, 2022. Revised Addendum to L&E Reports.

12. On July 28, 2022, the HCA and MVP filed post-hearing memorandums or briefs pursuant to GMCB Rule 2.000, § 2.307(g).

13. On July 29, 2022, L&E provided additional information requested by the Board regarding the medical trends proposed by carriers nationally for individual and small group ACA filings. Letter re CCIIO Public Use Files. On August 1, 2022, MVP submitted a supplement to its brief in which it addressed this new information.

Findings of Fact

14. 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. 1, 2; Ex. 16, 1.

15. As of February 2022, there were 20,900 members enrolled in MVP's small group plans and 15,026 members enrolled in MVP's individual plans. Ex. 12, 1; Ex. 13, 1. While MVP has gained members in the individual and small group market in recent years, its membership declined in both markets between 2021 and 2022, as reflected in the following table:

Membership by Coverage Year

Coverage Year	Small Group Members	Small Group % Change	Individual Members	Individual % Change
2018	14,355		10,868	
2019	16,396	14.2%	14,491	33.3%
2020	20,843	27.1%	16,137	11.4%
2021	21,858	4.9%	15,371	-4.7%
2022	20,900	-4.4%	15,026	-2.2%

Ex 12, 1; Ex. 13, 1.

16. In its individual filing, MVP initially proposed an average annual premium or rate increase of 17.4%, or approximately $117 per member per month (PMPM), with plan-level increases ranging from 9.7% to 24.2%. Ex. 1, 4, 41. In its small group filing, MVP initially proposed an average annual rate increase of 16.6%, or approximately $96 PMPM, with plan-level increases ranging from 8.9% to 19.8%. Ex. 2, 4, 43.

17. After Vermont hospitals submitted their FY 2023 budget proposals to the Board in early July 2022, MVP increased its average request by approximately 7.0% in each filing. *See* Ex. 39; Testimony of Christopher Pontiff, Transcript (Tr.), 59:4. After adjusting the proposed rates downward slightly to account for new risk adjustment transfer data (discussed below), MVP now requests annual average premium increases of approximately 24.4% for its individual plans and 23.4% for its small group plans. Ex. 39; Testimony of Christopher Pontiff, Tr., 63:22 – 64:6.

18. The federal government provides a premium tax credit (PTC) to certain individuals who purchase a qualified health plan through a health insurance marketplace such as VHC. *See* 26

U.S.C. § 36B. The PTC is typically paid directly to the insurance carrier by the federal government to lower an eligible individual's monthly premium.[1]

19. Prior to the passage of the American Rescue Plan Act (ARPA) in 2021, 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).

20. The PTC covers the difference between the premium for the second-lowest cost Silver plan – referred to as the "benchmark plan" – and a specified percentage of an individual's household income. *See* 26 U.S.C. § 36B(b). For example, prior to APRA, an individual earning 150% FPL could have received a PTC equal to the difference between the benchmark plan's premium and 4.14% of his or her income. *See* 26 U.S.C. § 36B(b)(3)(A)(i). The individual could then apply this PTC to the cost of a plan at any metal level (e.g., a Bronze or Gold plan).

21. ARPA significantly expanded the PTC. First, for those who were already eligible, ARPA increased the amount of the PTC they could receive by reducing the share of income they had 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 expanded eligibility for the PTC to individuals and households above 400% FPL. *See id.*; *see also* 26 U.S.C. § 36B(c)(1)(E).

22. ARPA's enhancements to the PTC, while significant, were temporary; unless Congress acts to extend them, they will expire at the end of 2022. *See* 26 U.S.C. § 36B(b)(3)(iii). To take advantage of ARPA, Vermont unmerged the individual and small group markets for 2022, which had the effect of reducing premiums for small group plans and increasing premiums for individual plans compared to what they would have otherwise been. *See* Act 25 of 2021, § 34; *In re MVP Health Plan, Inc. 2022 Individual Market Rate Filing*, GMCB-007-021rr, *In re MVP Health Plan, Inc. 2022 Small Group Market Rate Filing*, GMCB-008-022rr, Decision and Order (Aug. 5, 2021) (noting that unmerging the markets had an impact of approximately +6.1% on the proposed individual rates and -4.8% on the small group rates). The individual and small group markets will continue to be separate for 2023. *See* Act 137 (2022), § 9.

23. If Congress does not extend ARPA's enhancements to the PTC, many individuals will see a reduction in premium assistance in 2023. In other words, if ARPA's enhancements to the PTC are allowed to expire, *net* premiums for many individuals receiving the PTC would increase even if gross premiums remained unchanged. *See, e.g.,* Ex. 20.

24. Individuals with household incomes over 400% and 700% (who will no longer be eligible for the premium tax credit at all if ARPA's PTC enhancements are not extended) will be most affected. For example, MVP calculated that if the Board approves the 2023 rates *initially* proposed by each carrier, the net monthly premium for an individual at 500% FPL currently

[1] Most taxpayers choose to have the credit estimated and paid to the carrier in advance to lower monthly premiums (referred to as an advanced premium tax credit or APTC). However, taxpayers can also pay the fully monthly premium and claim the credit when they file their tax returns.

receiving a PTC would rise by $464.80 for MVP's lowest cost Gold Plan, $396.75 for MVP's lowest cost Silver plan, and $383.81 for MVP's lowest cost Bronze plan. *See* Ex. 20, 2.

25. On July 27, 2022, it was reported that a "deal" had been reached between Senator Joe Manchin III and Democratic leaders on a spending bill (the Inflation Reduction Act of 2022) that would extend the ARPA subsidy enhancements for another three years. However, that bill has not yet been passed by Congress. *See, e.g.,* Tony Room, Jeff Stein, Rachel Roubein and Maxine Joselow, *Manchin says he has reached deal with Schumer on economy, climate bill*, Washington Post (July 27, 2022).

26. Individuals are not required to purchase their coverage through VHC; they may purchase a plan directly from a carrier instead. However, individuals enrolled in such plans ("direct enrollees") are not eligible for the PTC. MVP has used a variety of approaches to inform its direct enrollees of the subsidies they may be eligible for if they purchase a plan through VHC, including targeted letters and emails, resources on its website, and renewal notification inserts. Ex. 17, 3 – 4. As of May 2022, MVP had 1,509 direct enrollees, a decrease of approximately 810 from May 2021, when the number was 2,319. Ex. 17, 3.

27. L&E reviewed MVP's filings to assist the Board in determining whether to approve, modify, or disapprove the proposed rates. Ex. 12, 1; Ex. 13, 1. L&E's review focused on the concepts of "excessive, inadequate, and unfairly discriminatory," specifically from an actuarial perspective. Ex. 21, 4. These terms have definitions that are included in Actuarial Standard of Practice (ASOP) No. 8. L&E bases its evaluation of a filing on these actuarial standards and recommends that the Board adjust the filing if necessary to meet the standards. *See* Ex. 21, 4.

28. MVP developed its proposed rates based on historical claims data for its individual and small group membership. Specifically, MVP used claims incurred between January 1 and December 31, 2021, and trended these claims costs forward to 2023. *See* Ex. 1, 10; Ex. 2, 10.

29. A significant driver of MVP's proposed 2023 rate increases is a large variance between MVP's actual 2021 claims experience and the projected 2021 claims experience embedded in the 2022 rates. *See* Ex. 1, 10; Ex. 2, 10; Ex. 12, 4; Ex. 13, 4. MVP's actual 2021 claims experience was approximately 13.6% higher in the individual market and 13.5% higher in the small group market than was projected in the 2022 filings. L&E determined that this component of the proposed rate increases appears to be reasonable and appropriate since it is based on actual claims experience. *See* Ex. 12, 4; Ex. 13, 4.

30. Another driver of MVP's proposed 2023 rate increases is trend. In its individual filing, MVP initially proposed a total allowed trend for 2022 to 2023 of approximately 6.1%, comprised of a total allowed medical trend of 5.5% and a total allowed pharmacy trend of 10.9%. In its small group filing, MVP initially proposed a total allowed trend from 2022 to 2023 of approximately 6.2%, comprised of a total allowed medical trend of 5.5% and a total allowed pharmacy trend of 11.1%. Ex. 12, 4 – 5; Ex. 13, 4 – 5.

31. MVP's proposed pharmacy (Rx) trends are largely driven by a projected increase in specialty pharmaceutical costs, as reflected in the following table, which shows MVP's annualized allowed Rx trend projections for different categories of pharmaceuticals.

Annualized Allowed Rx Trends

Tier	Unit Cost (Ind.)	Utilization (Ind.)	Total Trend (Ind.)	Unit Cost (Small Grp.)	Utilization (Small Grp.)	Total Trend (Small Grp.)
Generic	-2.5%	2.6%	0.1%	-2.5%	2.6%	0.1%
Brand	5.2%	2.1%	7.4%	5.2%	2.1%	7.4%
Specialty	5.0%	10.8%	16.3%	5.0%	10.8%	16.3%
Total			***10.9%***			***11.1%***

See Ex. 12, 6; Ex. 13, 6.

32. After reviewing MVP's approach to developing its Rx trends, as well as MVP's actual and projected trends from 2016 through 2021, L&E concluded that the Rx trends in the filings are reasonable. *See* Ex. 12, 6 – 7; Ex. 13, 6 – 7.

33. In each filing, MVP's total allowed medical trend of 5.5% consists of a medical utilization trend of 1.0% and a medical unit cost trend of 4.5%. Ex. 12, 5; Ex. 13, 5.

34. Regarding medical utilization trend, MVP ran simulations that produced a wide range of forecasted trends, with a 10th percentile of -3.5%, a mean trend of 3.4%, and a 90th percentile of 10.3%. Since the simulations produced a volatile and wide range, MVP selected an annualized utilization trend of 1.0%, which is consistent with the approved 2021 and 2022 filings. Ex. 12, 5 – 6; Ex. 13, 5 – 6. L&E performed a series of independent calculations using MVP's data. L&E's analyses also resulted in a wide range of forecasted utilization trends, ranging from -4.6% to 12.5%. L&E's opinion is that while MVP's membership has been more stable in recent years than in the past, the instability of market utilization due to the COVID-10 pandemic over 2020 and 2021 has created an unreliable dataset for forecasting future utilization trend. L&E concludes that an annual utilization trend of 1.0% appears reasonable. Ex. 12, 6; Ex. 13, 6.

35. The University of Vermont Health Network (UVMHN) was the victim of a cyberattack in October 2020. *See* Testimony of Christopher Pontiff, Tr., 121:14; *see also* State of Vermont, Executive Order No. 05-20 (Emergency Guard Call-Out for Hospital Systems Restoration) (Nov. 8, 2020). Following the hearing, MVP was asked to review its claims data for UVMHN providers and explain whether an adjustment to experience period claims was warranted to account for the impact of the cyberattack. MVP responded by providing a graph of allowed claims PMPM for UVMHN providers over the past four years. The graph shows that claims were suppressed at the end of 2020, around the time of the cyberattack, and then increased in early 2021. The graph also reveals that there were much larger increases in September and November of 2021. MVP asserts that the claims fluctuations are "normal" and that the increases observed in early 2021 are "within range," but does not explain what either of those terms denote or how that conclusion was reached. *See* MVP Responses to Post-Hearing Questions, 2.

36. Regarding medical unit cost trends, MVP distinguishes between facilities and providers impacted by the Board's hospital budget process and other facilities and providers. *See* Ex. 12, 5; Ex. 13, 5; *see also* Exs. 4 – 5. In developing its medical unit cost trends for facilities and providers impacted by the Board's hospital budget process, MVP's initial filings assumed the Board would approve commercial charge (rate) increases for Vermont hospitals in 2022 that are equal to the increases the Board approved in 2021. *See* Ex. 12, 5; Ex. 13, 5; Revised Addendum to L&E Reports, 1. This assumption resulted in medical unit cost trends for these facilities of 5.1% in the individual filing and 5.0% in the small group filing. Ex. 12, 5; Ex. 13, 5.

37. In its July 5 report, L&E recommended that once FY 2023 hospital budgets are submitted, this new information be considered in evaluating MVP's unit cost assumptions. Ex. 12, 16; Ex. 13, 16. The FY 2023 budgets submitted by hospitals reflected larger rate increases than MVP had included in its filings. *See* Exs. 34 – 35. MVP has assumed that the Board will approve the FY 2023 hospital budgets as submitted and, as a result, increased its proposed rates by approximately 7.0% in each filing. *See* Revised Addendum to L&E Reports, 1; Exs. 34 – 35; Testimony of Christopher Pontiff, Tr., 59:1-19.

38. As part of the hospital budget process, the Board establishes a ceiling or cap on the amount each hospital's rates can increase. *See, e.g., In re Central Vermont Medical Center Fiscal Year 2022*, 21-002-H, FY2022 Hospital Budget Decision and Order (Oct. 1, 2022), 12 (approving Central Vermont Medical Center's charge increase "at *not more than* 6.0% over current approved levels.") (emphasis added); *see also* Confidential Tr. of Executive Session, 14.

39. Over the past decade, approximately 30% of hospitals' charge or rate requests have been reduced by the Board. The gap between filed and approved increases has not been constant over time. Through 2016, the difference between filed and approved increases was minimal. However, beginning in 2017, more substantial reductions by the Board have been commonplace and the reductions have tended to be larger for larger requests. *See* Revised Addendum to L&E Reports, 2 – 3.

40. The rate increases requested by hospitals for FY 2023 are substantially higher than rates requested in recent years. *See* Revised Addendum to L&E Reports. The weighted average increase for all hospitals was 16.3%. Revised Addendum to L&E Reports, 2. Many of the FY 2023 hospital budget proposals also reflect growth in net patient revenue and fixed prospective payments that exceeds the two-year 8.6% guidance established by the Board. *See* Green Mountain Care Board, Preliminary Review of FY2023 Hospital Budget Submissions (July 27, 2022), 12 – 14, https://gmcboard.vermont.gov/sites/gmcb/files/documents/Preliminary%20Review%20FY2023%20Hospital%20Budgets%20%281%29.pdf; Green Mountain Care Board, FY 2023 Hospital Budget Guidance and Reporting Requirements (effective March 31, 2022), 5, https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY23%20Hospital%20Budget%20Guidance-%20FINAL.pdf.

41. The Board is scheduled to hold hearings on Vermont hospitals' FY 2023 budgets between August 15 and August 23, 2022. The Board must establish hospitals' FY 2023 budgets by September 15, 2022, and issue written decisions by October 1, 2022. 18 V.S.A. § 9456(d)(1).

42. In New York, MVP's total trends for 2023 are similar to what they have been in prior years – in the range of 6 or 7 percent – and MVP's rates do not reflect the same jump in expected facility costs that MVP is expecting in Vermont. *See* Testimony of Christopher Pontiff, Tr., 146:5 – 16.

43. [redacted] MVP Responses to Post-Hearing Board Questions, 4. [redacted] *See* Testimony of Christopher Pontiff, Tr. of Executive Session, 14 – 16.

44. L&E's second recommendation relates to an adjustment MVP made in each filing to account for increased costs it expects to bear for COVID-19 vaccinations in 2023. MVP assumes its members will receive the COVID-19 vaccine at a rate of 52% in 2023, receiving 1.4 vaccines per utilizing member at a cost of $104 per shot. These assumptions are based on projections that the Centers for Medicare and Medicaid Services (CMS) included in calendar year 2023 Medicare Advantage capitation rates. Ex. 1, 12; Ex. 2, 12; Ex. 12, 8 – 9; Ex. 13, 8; Ex. 16, 17.

45. MVP's COVID-19 vaccination assumptions result in a projected PMPM cost of $6.31 in each filing, more than double what MVP's COVID-19 vaccination costs were in 2021. MVP's COVID-19 vaccination costs in 2021 were $2.65 PMPM in the individual market (based on a utilization rate of 37%, 1.7 vaccines per utilizing member, and a cost of $39.31 per shot) and $2.63 PMPM in the small group market (based on a utilization rate of 39%, 1.8 vaccines per utilizing member, and a cost of $38.48 per shot). Ex. 12, 9; Ex. 13, 8.

46. MVP selected the utilization rates in the 2023 Medicare Advantage announcement because it believes that its own experience period data is highly suppressed due to the mass vaccinations sites that were available to its members in 2021. *See* Testimony of Christopher Pontiff, Tr., 38:17 – 39:13; *see also* Revised Addendum to L&E Report, 7. L&E believes a reasonable range for a COVID-19 vaccination rate in 2023 is between 52% (Vermont's flu vaccination rate) and 76% (Vermont's 95% first dose COVID-19 vaccination rate multiplied by 0.8 vaccines per utilizing member). *See* Revised Addendum to L&E Reports, 7. MVP's utilization assumptions produce an effective rate of 73%,[2] which is at the upper end of L&E's range.

47. MVP believes that it will be responsible for the ingredient cost of COVID-19 vaccines in 2023 rather than just the cost of administering the vaccine, which was approximately $40 per shot in the experience period. MVP also believes that the ingredient cost will be $64 per shot. *See* Revised Addendum to L&E Report, 7; Testimony of Christopher Pontiff, Tr., 43:14 – 18; Ex. 12, 9; Ex. 13, 9. At the hearing, MVP expressed a belief that federal funds used to pay for

[2] 0.52*1.4 = 0.73

the ingredient cost "are running short," but did not cite any sources that informed this belief. *See* Testimony of Christopher Pontiff, Tr., 43:19 – 44:8.

48. L&E is not aware of any announcement by the federal government indicating when vaccine purchases will cease and notes that the U.S. Dept. of Defense announced in June 2022 that the administration purchased more than 100 million doses of the vaccine for the fall. Revised Addendum to L&E Reports, 7. L&E believes a reasonable range for the unit cost of the COVID-19 vaccine is between $43.96 (the administrative cost in the experience period trended to the rating period) and $63.96 (the administrative cost in the experience period plus an ingredient cost of $20 based on the CDC vaccine price list for the private sector for the flu shot). Revised Addendum to L&E Reports, 7.

49. Based on the utilization and unit cost ranges that it developed, L&E calculates that a reasonable range for COVID-19 vaccination costs in 2023 is between $1.90 PMPM[3] and $4.02 PMPM.[4] L&E's opinion is that MVP's experience period COVID-19 vaccination costs, trended to the rating period, are reasonable projections of its 2023 costs without any upward adjustment. This recommendation produces a result (approximately $3.00 PMPM based on the trend rates as filed) that is well within the range that L&E calculated. MVP's proposed adjustment is not within the range. *See* Revised Addendum to L&E Reports, 8.

50. L&E recommended that MVP's COVID-19 vaccine cost adjustment be removed from the filings. Ex. 12, 9; Ex. 13, 8 – 9; Revised Addendum to L&E Reports, 8.

51. L&E's third recommendation is to include a paid-to-allowed normalization factor in the "AV and Cost Sharing Design" line item of worksheet 2 of the URRT, in accordance with the URRT instructions, rather than the "other factor" on worksheet 1 of the URRT. This would have no impact on the proposed rates. Ex. 12, 16; Ex. 13, 16. MVP agrees with this recommendation. Ex. 19, 1.

52. L&E's fourth recommendation relates to a risk adjustment transfer projection. Under the Affordable Care Act (ACA), premiums are transferred between carriers in the small group and individual markets based on the age, sex, and health status of enrolled members. MVP has consistently paid funds under this "risk adjustment" system to Blue Cross and Blue Shield of Vermont, the other carrier offering individual and small group plans in Vermont. This payout requires MVP to collect additional premium from its members. MVP projected the expected 2021 risk adjustment transfer payments in the individual and small group markets based on the most recent data available, which, at the time of the filing, was an interim risk adjustment report published by CMS in March 2022. Ex. 12, 12; Ex. 13, 11 – 12.

53. Actual 2021 risk adjustment transfer values were published by CMS on June 30, 2022 (based on the merged market that existed in Vermont in 2021). L&E gathered confidential data from both carriers and provided the carriers with estimated risk adjustment transfer amounts for an unmerged market. Ex. 12, 12; Ex. 13, 12. L&E recommends that MVP's projected risk

[3] (0.52*$43.96) / 12
[4] (0.76*$63.96) / 12

adjustment figures be changed to reflect the final market-wide figure announced by CMS and the market-specific risk transfers estimated by L&E. MVP agrees with this recommendation. Ex. 12, 12, 16; Ex. 13, 12, 16; Ex. 19, 2. MVP's revised rate requests incorporate this recommendation. *See*, *supra*, Findings of Fact (Findings), ¶ 17.

54. L&E's final recommendation relates to "large" claims (i.e., claims greater than $200,000). Historically, MVP removed these claims[5] from the experience (base) period and replaced them with a pooling charge based on a reinsurance contract. MVP will not be purchasing this reinsurance coverage in 2023. This produces an increase of 0.8% to the individual rates and 0.3% to the small group rates. *See* Ex. 12, 8; Ex. 13, 8.

55. Since MVP is no longer replacing large claims in the experience period with a pooling charge, these claims remain in the experience period and are trended forward to the rating period. MVP observed a high level of large claims in 2020 and 2021 compared to 2018 and 2019. L&E recommends adjusting the base period claims to account for this. *See* Ex. 12, 8; Ex. 13, 8.

56. It is a common actuarial practice to adjust the base period to account for fluctuations over time that the actuary thinks may not happen in the future. *See* Testimony of Jackie Lee, Tr., 173:7 – 10. L&E initially recommended replacing the large claims in the experience period (after adjusting for recoveries from the National High-Cost Reinsurance Pool) with a three-year average of aggregate large claims, which would have reduced the individual rates by 0.7% and the small group rates by 0.9%. *See* Ex. 12, 11; Ex. 13, 11; Revised Addendum to L&E Reports, 9.

57. At hearing, MVP asserted that it would be more appropriate to use a 3-year PMPM large claims average to account for fluctuations in member months from year to year. MVP also asserted that the historical PMPMs should be based on claim amounts that are trended to 2021 levels so that all dollar amounts are represented on a consistent basis for calculating the adjustment. *See* Testimony of Christopher Pontiff, Tr., 52:9 – 53:13; Revised Addendum to L&E Reports, 9. L&E agrees that these modifications are appropriate and revised its recommendation accordingly. Revised Addendum to L&E Reports, 9.

58. MVP does not agree with L&E's revised recommendation because it maintains that 2021 is not an outlier that needs to be adjusted for, but rather a "new norm". *See* Testimony of Christopher Pontiff, Tr., 49:24 – 51:4.

59. L&E notes that concerns have been raised regarding the impact of deferred care on 2021 experience resulting from the COVID-19 "lockdown" and a cyberattack that affected UVMHN providers in October 2020. L&E suggests that the Board consider MVP's response to post-hearing questions about the cyberattack on deferred care. Revised Addendums to L&E Reports, 8.

60. MVP's proposed 2023 individual premiums include an administrative expense load of $51.46 PMPM, an increase over the $47.10 PMPM approved in the 2022 premiums. The proposed 2023 PMPM administrative expense represents 6.5% of premium, while the approved

[5] In fact, MVP replaced all claims in excess of $100,000 with a pooling charge, not just claims in excess of $200,000. *See* Ex. 12, 8; Ex. 13, 8.

2022 PMPM administrative expense represent 7.1% of premium. Therefore, while administrative expenses are increasing on a PMPM basis, the overall rate impact to individual plans is -0.6%. Ex. 12, 13.

61. MVP's proposed 2023 small group premiums include an administrative expense load of $43.53 PMPM, an increase over the $38.75 PMPM approved in the 2022 premiums. MVP's proposed 2023 PMPM administrative expense represents 6.5% of premium, while the approved 2022 PMPM administrative expense represents 6.7% of premium. Therefore, while administrative expenses are increasing on a PMPM basis, the overall rate impact to small group plans is -0.3%. Ex. 13, 13.

62. MVP's actual 2021 administrative expenses, projected 2022 administrative expenses, and proposed 2023 administrative expenses are reflected in the tables below on a per member per month basis, by expense category and by filing.

Individual Admin Expenses PMPM

Expense Category	2021 Actual Admin PMPM	2022 Projected Admin PMPM	2023 Proposed Admin PMPM
Personnel Expenses	$30.30	$26.17	$29.01
Software	$4.10	$3.60	$4.39
Consulting/Project Expenses	$6.53	$4.90	$5.15
All Other Admin	$10.78	$12.42	$12.91
Total	***$51.71***	***$47.10***	***$51.46***

Small Group Admin Expenses PMPM

Expense Category	2021 Actual Admin PMPM	2022 Projected Admin PMPM	2023 Proposed Admin PMPM
Personnel Expenses	$27.47	$23.56	$26.85
Software	$3.68	$3.23	$3.83
Consulting/Project Expenses	$6.44	$4.86	$5.04
All Other Admin	$6.90	$7.10	$7.84
Total	***$44.49***	***$38.75***	***$43.56***

Ex. 12, 13; Ex. 13, 13.

63. MVP's assumed administrative costs for 2023 are higher than its recent administrative costs as reported in the 2019 to 2021 Supplemental Health Care Exhibits (SHCEs). In the individual market, the assumed 2023 administrative costs ($51.46 PMPM) are $8.74 PMPM higher than the three-year average ($42.72 PMPM). In the small group market, the assumed 2023 administrative costs ($43.56 PMPM) are $4.57 PMPM higher than the three-year average ($38.99). Ex. 12, 13; Ex. 13, 13; *see also* MVP Response to Post-Hearing Board Questions (July 27, 2022).

64. When asked to explain why its individual market administrative costs materially increased in 2021 compared to prior years, MVP cited a significant amount of activity (and expense) resulting from its partnership with UVMHN to co-create a doctor-influenced plan that was launched in 2022. Ex. 6, 4; *see also* MVP Responses to Post-Hearing Questions, 4.

65. MVP also took over billing and payment processing functions from the State in 2022, which added an estimated $6.61 to the administrative expenses for individual plans and $0.93 PMPM to the administrative expenses for small group plans. When these additional expenses are added to the three-year averages, L&E concludes that the resulting amount is consistent with the 2023 proposed administrative costs PMPM. L&E considers the assumed 2023 administrative costs to be reasonable and appropriate. Ex. 12, 13; Ex. 13, 13.

66. The filings do not reflect several hundred thousand dollars in savings that MVP expects to achieve in 2023 from coding and implant pricing initiatives. Ex. 17, 3. Had these savings been reflected in the filings, it would have reduced the initially filed rates by approximately 0.2%, although MVP notes that this impact may vary slightly based on the hospital budget assumptions approved by the Board. MVP Responses to Post-Hearing Questions, 4.

67. "Benefit buy-down" occurs when a policyholder selects a "leaner" plan with a lower actuarial value (AV) to mitigate premium increases. MVP did not attempt to adjust its utilization assumptions to account for expected benefit buy-down or care avoidance that may result from its proposed premium increases or from inflationary pressures affecting individuals and small businesses. *See* Testimony of Christopher Pontiff, Tr., 126:8 – 12. However, both MVP and L&E witnesses agreed that this is a valid concern. Testimony of Jackie Lee, Tr., 174:24 ("some of the board members have made comments that I think are very valid about potentially having the high rate increases impacting utilization . . ."); *see also* Testimony of Christopher Pontiff, Tr., 126:8 – 127:2 (agreeing that buydown is "certainly possible" or "likely").

68. In response to post-hearing questions, MVP noted that lower risk members are more likely to buy down in benefits, resulting in a lower impact on utilization. *See* MVP Responses to Post-Hearing Questions, 3. However, while lower risk members may be *more* likely to buy down, it is not clear that the phenomenon will be limited lower risk members.

69. Last year, the Board ordered MVP to reduce its proposed individual rates by 0.2% to account for improved population morbidity resulting from ARPA. *In re MVP Health Plan, Inc. 2022 Individual and Small Group Market Rate Filings*, GMCB-007-21rr & GMCB-008-21rr, Decision and Order (Aug. 5, 2021), 18. MVP did not make a similar adjustment to this year's filing because, at the time of the filing, ARPA's PTC enhancements were set to expire at the end of 2022. This decision – not making an adjustment – resulted in a 0.2% increase to the individual rates this year. L&E concluded that it was reasonable for MVP to not make an adjustment for improved morbidity. Ex. 12, 8. However, as noted above, it was recently reported that the ARPA subsidy enhancements may be extended to 2023 as part of the Inflation Reduction Act of 2022. *See*, *supra*, Findings, ¶ 25.

70. During the COVID-19 public health emergency, states have been required to maintain continuous health care benefits for Medicaid enrollees in order to receive enhanced federal Medicaid funding. *See* Families First Coronavirus Response Act, Pub.L. 116-127, Sec. 6008(b) (Mar. 18, 2020). Vermont has ensured this "continuous coverage" by extending Medicaid coverage periods (i.e., not processing redeterminations or annual reviews that could result in a loss of coverage) and suspending Medicaid terminations (i.e., not terminating a member's coverage

unless the member requests it or moves out of state). *See* Agency of Human Services, Department of Vermont Health Access, COVID-19, Eligibility and Enrollment (last updated Jan. 31, 2022);[6] *see also* Testimony of Christopher Pontiff, Tr., 114:15 – 18 (describing MVP's experience in New York with Medicaid membership); Ex. 6, 3. It is reasonable to expect that when Vermont begins to unwind these continuous coverage policies, enrollment in qualified health plans will increase.

71. MVP and OneCare Vermont, a statewide accountable care organization, are actively ramping up discussions for their 2023 contract and are exploring a shared risk model as well as primary care capitation for provider groups. MVP is also exploring fixed prospective payment opportunities with providers and hospitals, with an anticipated 2024 glide path based on ongoing discussions (dependent on provider and health system interest and operational and financial readiness and capabilities). Ex. 16, 17 – 18.

72. MVP is working to implement policies to ensure that the "intensity" of services provided to its members, particularly emergency room utilization, is warranted and appropriate. *See* Testimony of Christopher Pontiff, Tr., 119:8 – 120:25.

73. MVP's proposed premiums include a risk margin or contribution to reserve of 1.5%, which is consistent with the risk margin MVP proposed in last year's filings but greater than the 1.0% risk margin approved by the Board. *See* Ex. 12, 14; Ex. 13, 14; *In re MVP Health Plan, Inc. 2022 Individual and Small Group Market Rate Filings*, GMCB-007-21rr & GMCB-008-21rr, Decision and Order (Aug. 5, 2021), 20.

74. Risk based capital is a metric used to evaluate insurer solvency. *See* Testimony of Jesse Lussier, Tr., 71:4 – 5. MVP's RBC ratio fell from 429% to 354% from 2020 to 2021.

75. MVP lost approximately $30 million on its individual and small group plans in 2021. *See* Testimony of Christopher Pontiff, Tr., 72:5 – 7; Ex. 17. This loss contributed to the 75-point decline in MVP's RBC ratio between 2020 and 2021, although other factors contributed as well. *See* Testimony of Christopher Pontiff, Tr. 114:4 – 21. MVP's actual and approved (ordered) risk margins for the most recent three years are reflected in the following table.

Historical Risk Margins

Year	Actual Individual	Approved Individual	Actual Small Group	Approved Small Group
2019	-1.0%	1.5%	-1.0%	1.5%
2020	4.4%	1.0%	9.2%	1.0%
2021	-11.1%	0.5%	-8.5%	0.5%
Total	-7.7%	3.0%	-0.3%	3.0%

See Ex. 12, 14; Ex. 13, 14.

76. Based on a review of public use files published by the Center for Consumer Information & Insurance Oversight (CCIIO), 442 carriers submitted individual or small group ACA filings nationally in 2022. The filed CTR varied from -17% to 9%, but most often fell

[6] https://dvha.vermont.gov/covid-19

between 0% and 5%. The mode is between 2% and 3%, and the premium-weighted average CTR for all carriers was filed as 2.4%. MVP's filed CTR of 1.5% would place it at around the 27th percentile for all QHP carriers. Ex. 12, 14; Ex. 13, 14. These carriers include both for-profit and not-for-profits. Testimony of Jackie Lee, Tr., 205:13 – 14.

77. In 2021, Vermont business accounted for approximately 5% - 7.5% of MVP's overall business. *See* Ex. 12, 15; Ex. 13, 15; Ex. 14, 2; Ex. 15, 2; Testimony of Christopher Pontiff, Tr., 71:23 – 25. MVP's Vermont business is not a major factor in determining MVP's RBC ratio. Ex. 12, 15; Ex. 13, 15.

78. L&E's opinion is that a CTR between 0.5% and 3.0% would be reasonable in each filing and that MVP's CTR assumptions are reasonable and appropriate as filed. L&E also recommends that any solvency analysis performed by DFR be considered. Ex. 12, 15; Ex. 13, 15.

79. 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 7.5% of its total premiums written. 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, 2; Ex. 19, 2.

80. The public comments received by the Board this year reflected dismay and alarm regarding the affordability of health insurance and the accessibility of health care due to member cost sharing requirements. For example, one commenter wrote: "It has come to the point this year that, while I am insured, I pay so much for a premium out of pocket monthly that, even with the subsidy, the high deductible hanging over my insurance has made it so that I am no longer receiving regular care." This year, many Vermonters also expressed their concerns in the context of high inflation. For example, one commenter wrote: "At a time when everything is going up in cost (food, fuel, gas, etc.) an increase in cost for health insurance would be cost prohibitive for many families, including mine." Another commenter wrote: "Now, with purchasing power eroding fast amid inflation, a leap in insurance costs this high would be an absolute gut punch. Costs need to be falling, not rising, as all of us scramble to do more with hard-earned money that is losing its value."

81. The Health Care Advocate testified about the decisions Vermonters will have to make regarding health insurance and health care in the context of the overall inflationary challenges and the stagnation of real wages. Testimony of Mike Fisher, Tr., 215:22 – 219:10. He also testified that under the initially proposed rates, a family of four at slightly over 400% FPL would pay over 25% of their income for premiums. Testimony of Mike Fisher, Tr., 217:14 - 19.

82. The Change in the Consumer Price Index for All Urban Consumer (CPI-U) for the Northeast Region increased 7.6% for the 12-month period ending June 2022. Ex. 33, 1; *see also* Ex. 6, 4.

83. The Vermont Household Health Insurance Survey (VHHIS) is a survey that has been completed periodically since the early 2000s and is used to monitor the health insurance coverage status of Vermont residents. Ex. A, 4. According to the 2021 VHHIS, the results of which were published in March 2022, of the estimated 19,400 Vermonters without health insurance, cost is the primary barrier to coverage – more than half identified cost as the only reason they do not have health insurance. Ex. A, 19, 35. Uninsured Vermonters are significantly less likely to have visited a doctor or health care provider in the past 12 months. Ex. A, 51. Furthermore, 44% of privately insured residents surveyed were "underinsured" based on a formula developed by the Commonwealth Fund that compares current and potential future medical expenses to household income. Ex. A, 43 – 44. Underinsured Vermonters aged 18 to 64 were more likely to delay medical care due to cost than those who were not underinsured. Ex. A, 59.

84. MVP submitted proposed findings of fact and conclusions of law on July 28, 2022. MVP cautions that any modifications to the rates based on hospital budgets should be consistent with approved hospital budgets. MVP urges the Board to reject L&E's recommendation regarding the COVID-19 vaccination adjustment, arguing, among other things, that L&E's position on unit cost is not supported. MVP urges the Board to reject L&E's recommendation regarding large claims, asserting that MVP's experience does not evidence any impact on high-cost claims for deferred care and that L&E's recommendation is contrary to the trend in observed large claims costs. MVP asserts that its proposed CTR is adequate, reasonable, and necessary to maintain its solvency in Vermont. Finally, MVP argues that it is lowering costs, promoting quality care, access, and affordability and the Board should not reduce the proposed rate increase on any of these bases.

85. The HCA submitted a post-hearing brief on July 28, 2022. The HCA argues that MVP's rates fail to meet the statutory criteria and are excessive; unjust, unfair, inequitable, and misleading; fail to promote access; and are unaffordable. The HCA urges the Board to pare the rates back to the lowest practicable rate that is within a zone of reasonableness between excessive and inadequate. The HCA argues that public comments prove that the proposed rate increases are unaffordable. The HCA asserts that MVP's rate increases for individual and small group plans have far outpaced both real GDP and real wage growth for the period between 2014 and 2021 and that the proposed rates only accelerate that trend. The HCA provides calculations that it believes demonstrate that MVP's Standard Silver plan is unaffordable to large numbers of Vermonters not income-eligible for Medicaid, even after accounting for premium subsidies and cost-sharing benefits. The HCA states that this lack of affordability is compounded by the fact that recovery from the worst days of the pandemic has been slow in sectors that lower- and middle-income Vermonters depend on for work. The HCA argues that the proposed rates fail to promote access, asserting that MVP's actuary agreed it was likely that MVP's rate increases would force some members to buy down into lower metal levels. The HCA also argues that, days before the hearing, MVP sought to increase its already unprecedently high rate increases by significant amounts and that "eleventh hour" increases of such magnitude are unjust, unfair, inequitable, and misleading.

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 is on the insurer proposing a rate change to justify the requested rate. GMCB Rule 2.000 § 2.104(c).

In addition to our longstanding statutory criteria, the Board has received temporary supplemental authority. Effective through March 31, 2023, the Board may waive or permit variances from State laws, guidance, and standards with respect to health insurance rate review, among other regulatory activities, as necessary to prioritize and maximize direct patient care, safeguard health care provider stability, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic. Act 85, § 5(a)(3) (2022).

Conclusions of Law

As noted above, in reviewing a rate filing, we must consider 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 Vermont, and is not excessive, inadequate, or unfairly discriminatory. As we have recognized in prior decisions, these factors are interrelated and often in tension with one another. *See, e.g., In re MVP Health Plan, Inc. 2022 Individual and Small Group Market Rate Filings*, GMCB-007-21rr & GMCB-008-21rr, Decision and Order (Aug. 5, 2021), 16. Neither our statue nor our rule specifies how much weight we should give to any one factor, and we seek to find the most appropriate balance we can amongst them based on the facts and circumstances before us.

Balancing the various rate review factors is difficult even in a "normal" year. This year is anything but normal, as evidenced by the flexibilities given to the Board and other agencies in Act 85 of 2022. The rates that MVP initially requested in its filings were historically high. *See* Findings, ¶ 17; HCA Brief, 4. During our review of the filings, Vermont hospitals submitted their FY 2023 budget proposals to the Board. Findings, ¶ 5. These budget proposals are historically high as well, due in part to the inflationary and workforce pressures hospitals are facing as they emerge from what we hope is the worst of the COVID-19 pandemic. *See* Findings, ¶ 40. In response to the hospital budget submissions, MVP raised its proposed rates even further. *See* Findings, ¶ 37. Individuals and small businesses who will be purchasing health benefit plans in 2023 are also dealing with high inflation and increased costs. *See* Findings, ¶ 82. Moreover, ARPA's enhancements to the PTC are set to expire at the end of 2022, which would have drastic impacts

on certain segments of the individual market. *See* Findings, ¶¶ 22 – 24. It now appears that Congress may extend these PTC enhancements through the Inflation Reduction Act of 2022, but the passage of this bill is still uncertain at this time. *See* Findings, ¶ 25. Affordability and access are therefore top of mind for us this year. At the same time, while MVP's Vermont business poses little risk to the company's overall solvency, adequacy of rates and contribution to surplus are necessary for health insurers to maintain strength of capital to keep pace with claims trends. *See* Findings, ¶¶ 77, 79.

Ultimately, the size of the proposed rate increases, the potential loss or reduction in federal assistance, the impact of inflation, and concerns that people may forego purchasing insurance or fail to seek necessary care compel us to maximize affordability and access this year to the extent that we are able in light of the other factors we must consider. For the reasons below, we accept our actuaries' recommendations and require MVP to further reduce the rates by 2.0% to promote affordability and access.

I

First, we require MVP to implement L&E's recommendations to 1) include the paid-to-allowed normalization factor in the "AV and Cost Sharing Design" line item of worksheet 2 of the URRT rather than the "other factor" on worksheet 1 of the URRT, and 2) change the projected risk adjustment figures to reflect the final market-wide figure announced by CMS and the market-specific risk transfers estimated by L&E. MVP agrees with these changes. Findings of Fact (Findings), ¶¶ 51, 53.

II

Second, we require MVP to remove its COVID-19 vaccine adjustment.

MVP has not proven that the adjustment is warranted. The adjustment is based on MVP's assumption that its members will utilize the COVID-19 vaccine at a rate of 52% in 2023, receiving 1.4 vaccines per utilizing member at a cost of $104 per shot. Findings, ¶ 43. These assumptions would result in MVP's COVID-19 vaccination costs more than doubling from 2021 to 2023. *See* Findings, ¶ 44. The only support MVP provided for these assumptions is that the assumptions were used to develop the 2023 Medicare Advantage capitation rates. *See* Findings, ¶¶ 43, 47.

MVP's assumption that the vaccine will cost $104 cost per shot is by far the most impactful of the three. To date, MVP has only been responsible for the cost of administering the vaccine, approximately $40. Findings, ¶ 47. MVP assumes that it will also be responsible for an ingredient cost of $64 per shot in 2023. *Id*. Yet, as L&E notes, there has been no announcement from the federal government specifying when it will stop covering the ingredient costs of the vaccine. *See* Findings, ¶ 48. Furthermore, even if the government stops covering the vaccine's ingredient cost in 2023, we cannot conclude from the Medicare Advantage announcement that the charge to commercial carriers such as MVP will be $64 per shot.

We find that L&E's recommendation – to allow MVP's base period COVID-19 vaccination costs to be trended to the rating period – is a more reasonable approach. It allows for an increase over MVP's experience period costs and, unlike MVP's approach, produces a result

(approximately $3.00 PMPM based on the trend rates as filed[7]) that falls well within the range of reasonable results calculated by L&E. *See* Findings, ¶ 49.

III

Third, consistent with L&E's revised recommendation, we require MVP to replace experience period claims over $200,000 with a 3-year PMPM average of claims over $200,000, trended to 2021 levels. *See* Findings, ¶ 57.

It is a common actuarial practice to adjust the base period to account for fluctuations over time that may not happen in the future. *See* Findings, ¶ 56. MVP observed a significant increase in large claims in 2020 and 2021. *See* Findings, ¶ 55. We are not convinced that this is a "new norm," as MVP claims, or a clear trend. If there is some factor driving these increases that will continue into 2023, MVP has not identified it. We are also concerned that deferred care resulting from the COVID-19 "lockdown" and the UVMHN cyberattack in 2020 could be impacting these values. *See* Findings, ¶¶ 35, 59. MVP has not convinced us that this concern is misplaced. It's analysis with respect to the cyberattack revealed that, even looking only at UVMHN providers, there was suppressed utilization at the end of 2020, smaller increases in the beginning of 2021, and larger increases towards the end of 2021. It is not clear to us that 2021 claims were not impacted or were minimally impacted by the attack, either in aggregate or for UVMHN providers specifically. *See* Findings, ¶ 35. Furthermore, no analysis was done regarding the impact of COVID-19. We think it is appropriate to employ the smoothing technique recommended by L&E, which accounts for the observed increases without giving too much weight to recent experience that may not be indicative of what will occur in 2023. *See* Findings, ¶¶ 55 – 57.

IV

Fourth, we require MVP to assume that the Board will reduce the rates requested by Vermont hospitals in their FY 2023 budget proposals by 17%.

The timelines for the Board's review of individual and small group rate filings and hospital budgets present a challenge every year. We would prefer to complete our review of the individual and small group rate filings after having established hospital budgets for the upcoming year. Unfortunately, we have not found a reasonable way to make this work. *See* GMCB Regulatory Alignment White Paper, Part 2: Options for Regulatory Timeline and Logistics (July 2021).[8]

While we cannot know what we will do with hospitals budgets later this year,[9] we must ensure that the assumptions in the filings are reasonable. MVP's assumption that the Board will approve the rates proposed by the hospitals without modification is not reasonable; it is not consistent with what the Board has done in the recent past. *See* Findings, ¶ 39.

[7] Because the medical unit cost trend we are approve in the filing is higher than what MVP originally filed, the amount will be higher than $3.00 PMPM.

[8] https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCBRegulatoryAlignment_Part2_20210730.pdf

[9] The Board is scheduled to hold hearings on hospital budgets between August 15 and August 26, 2022 and will begin deliberating on August 31, 2022.

A reasonable approach this year is to assume the Board will reduce hospitals' proposed rates by the average *percentage* rate reduction that the Board has imposed over the past five years, which is approximately 17%. We think this is a reasonable approach because reductions in recent years have tended to be larger for larger budget requests and this year's requests are historically high. *See* Findings, ¶¶ 39 – 40. Furthermore, this year's historically high requests reflect budgeted revenue growth for many hospitals that exceeds the two-year revenue guidance set by the Board. Findings, ¶ 40.

V

Fifth, we require MVP to reduce its proposed rates by 2.0% in each filing to provide greater affordability and access for Vermonters.

We received 245 comments during the public comment period. Many of the comments were compelling and personal, and nearly all underscored a common theme – the cost of health insurance and health care is unaffordable for many individuals, families, and businesses in Vermont who are trying to cope with rising inflation and higher costs for other goods and services. *See* Finding ¶ 80. These comments are supported by the record. *See* Findings, ¶¶ 81 – 83.

MVP is requesting an average annual premium increase of 24.4% for its individual plans and 23.4% for its small group plans, which would increase the overall average gross premium by approximately $164 PMPM for individual plans[10] and $135 for small group plans.[11] *See* Finding ¶¶ 16 – 17. Increasing premiums by this much is likely to cause significant hardship for many individuals and small business. For example, increases of this magnitude may cause people to seek leaner (lower AV) plans and avoid seeking care. *See* Findings, ¶ 67. In the individual market, the increase could be mitigated if ARPA's enhancements to the PTC are extended to 2023. *See* Findings, ¶ 21. Conversely, the increase could be compounded if ARPA's enhancements to the PTC are allowed to expire, particularly for individuals just over 400% FPL. *See* Findings, ¶¶ 19, 21, 24. Affordability and access are of paramount concern this year and, in light of these concerns, we conclude that a 2.0% reduction to the rates is warranted.

We note that there is a range of actuarially sound rates and evidence in the record demonstrates that the adjustments we require in sections I – IV do not set the lowest actuarially sound rate. For example, the filings do not reflect several hundred thousand dollars in savings that MVP expects to achieve in 2023 from coding and implant pricing initiatives. Findings, ¶ 66. It was also just recently reported that ARPA's enhancements to the premium tax credit may be extended to 2023. Findings, ¶ 25. Should this happen, for reasons we explained last year, the morbidity of the individual market will likely be slightly better in 2023 than it was in 2021. *See* Findings, ¶ 69; *In re MVP Health Plan, Inc. 2022 Individual and Small Group Market Rate Filings*, GMCB-007-21rr & GMCB-008-21rr, Decision and Order (Aug. 5, 2021), 18. While L&E concluded that MVP's CTR request of 1.5% is reasonable, it also concluded that a 0.5% CTR could be considered reasonable as well. Findings, ¶ 78. Consumer behavior in response to high premium increases and high inflation may dampen costs as consumers buy down in benefits or avoid seeking care. *See*

[10] ($673.33*1.245) - $673.33 = $164.29
[11] ($577.60*1.234) - $577.60 = $135.16

Findings, ¶¶ 67 - 68, 82 – 83. Finally, when the COVID-19 public health emergency expires and the State begins redetermining Medicaid eligibility, people will likely move from Medicaid to private insurance, and it is reasonable to expect MVP's membership will grow, lowering its PMPM administrative costs. Findings, ¶ 70.

MVP can also take actions to constrain costs and manage a 2.0% reduction. First and foremost, MVP can more actively negotiate with Vermont providers. [redacted] Findings, ¶ 43. MVP's proposed rates in New York do not reflect the same jump in expected facility costs that MVP is expecting in Vermont. Findings, ¶ 42. As MVP has increased its market share in Vermont in recent years, it is reasonable to expect that it can leverage its increased bargaining power to negotiate more favorable reimbursement rates with providers. *See* Findings, ¶ 15. The rate *restrictions* or *limitations* we place on hospitals through our hospital budget orders should not stand in the way of these negotiations. *See* Findings, ¶ 38.

MVP can also make greater efforts to lower its administrative costs. MVP is proposing to increase its charge for administrative expenses by $4.36 PMPM in the individual market (an increase of approximately 9.3%) and $4.78 in the small group market (in increase of approximately 12.3%). *See* Findings, ¶¶ 60 – 62. We expect MVP to actively and critically review its operations and find efficiencies to lower growth in administrative expenses. Relatedly, we are not convinced that it is appropriate for MVP to allocate administrative charges connected to its partnership with UVMHN to its individual and small group blocks of business; the benefits of this partnership to individual and small group members are not clear, at least not on this record. *See* Findings, ¶ 64.

Finally, MVP can carry through on its plans to evolve its value-based payment arrangement with OneCare Vermont from a shared savings to a shared risk arrangement and implement fixed prospective payments. A shared risk arrangement would provide a stronger financial incentive to providers to reduce cost growth than the prior shared savings arrangement because it would transfer some level of risk for higher-than-expected claims from MVP to OneCare. *See* Findings, ¶ 71. Fixed prospective payments would advance the arrangement further, providing more flexibility and more immediate financial incentives to providers.

In sum, we do not believe a 2.0% reduction to the rates places an undue burden on MVP because the record shows that there are factors that could justify a lower rate and there is time for MVP to implement changes that could positively impact the company's bottom line.

Based on the above, we believe a 2.0% reduction results in rates that strike the best balance available amongst the factors that we must consider. Our approach is also supported by the discretion provided in Act 85 to take necessary actions to prioritize and maximize direct patient care in response to evolving need related to the COVID-19 pandemic. Act 85 (2022), § 5(a)(3).

VI

Finally, while it does not impact rates, we feel compelled to express our opinion that MVP can and should do more to encourage its direct enrollees to purchase a plan through VHC so that

they can take advantage of federal and state subsidies that may be available to them. *See* Findings, ¶ 26. Particularly in this difficult year, carriers need to do everything they can to help consumers make wise choices and enhance affordability. MVP must include in next year's individual rate filing detailed information on the efforts it has taken to encourage enrollment through VHC and the effectiveness of these efforts.

Order

For the reasons discussed above, we modify and then approve MVP's 2023 Individual and Small Group Rate Filings. Specifically, for each filing, we order MVP to: (1) include the paid-to-allowed normalization factor in the "AV and Cost Sharing Design" line item of worksheet 2 of the URRT rather than the "other factor" on worksheet 1 of the URRT; (2) change the projected risk adjustment figures to reflect the final market-wide figure announced by CMS and the market-specific risk transfer estimated by L&E; (3) remove the COVID-19 vaccine adjustment; (4) replace experience period claims over $200,000 with a 3-year PMPM average of claims over $200,000, trended to 2021 levels; (5) assume that the Board will reduce the rates requested by Vermont hospitals in their FY 2023 budget proposals by 17%; and (6) reduce the resulting rate increase, after items (1) – (5) are implemented, by 2.0 percentage points.

With the modifications required by this order, we expect that the overall average rate increase for individual plans will be reduced from approximately 24.4% ($164 PMPM) to approximately 19.3% ($130 PMPM) and the overall average rate increase for small group plans will be reduced from approximately 23.4% ($135 PMPM) to approximately 18.3% ($106 PMPM).

Pursuant to 8 V.S.A. § 4062(b)(3)(A), we also require MVP to submit a report to the Board following the conclusion of its negotiations with Vermont hospitals that describes the actual reimbursement increases negotiated with each hospital.

SO ORDERED.

Dated: August 4, 2022, at Montpelier, Vermont

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

Walsh, concurring in part.

I concur with the Board's decision to reduce the requested rates by 2.0% to provide greater affordability and access. I believe this reduction appropriately goes further than prior reductions made by the Board explicitly for affordability.[12] Nevertheless, I write separately to express my opinion that the decision and the process do not adequately consider the affordability of the rate request, which is paramount to our charge under Act 48.

In our review of insurance premium rates, the Board must determine if the rate is "affordable, promotes quality of care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law."

Actuarial calculations help to measure concepts such as adequacy and excessiveness, financial calculations help to measure insurer solvency, and legal analysis ensures that the rates are not misleading or contrary to existing law. The evidence presented during our recent hearings assures that those standards are met. However, affordability, justness, fairness, and equity are concepts that are more challenging to measure and have not been included in the calculations.

There are measurements that speak to the concept of affordability. Under the Affordable Care Act, for example, employer-sponsored coverage is considered "affordable" if the portion of the premiums required to be paid by the employee costs less than 9.12% of household income. *See* 26 CFR § 1.36B-2(c)(3)(v)(A); IRS Rev. Proc. 2022-34. Similarly, according to a Commonwealth Fund definition, someone is "underinsured" if they have insurance coverage but incur annual out-of-pocket expenses equaling 10% or more of their income if their income is at or above 200% FPL or 5% or more of their income if their income is below 200% FPL, or if they have a deductible equal to or greater than 5% of household income. *See* Ex. A, 43. During the recent hearing, the Health Care Advocate testified that even before the rate increases approved in this order go into effect, a Vermont family of four earning just over 400% FPL would pay over 20% of their income on premiums alone to purchase a standard Silver plan. Findings, ¶ 81. This amount does not include out-of-pocket expenses like deductibles and copayments.

Concepts of equity and fairness could also be better reflected in our process. For example, increased costs may disproportionately impact single-parent households, many of which are headed by women, BIPOC communities, and other historically marginalized groups, and could therefore exacerbate existing disparities in access to care.

For these reasons, I believe we should work with our governmental partners and other stakeholders to develop a framework that includes better measures of affordability, justice, fairness, and equity.

Developing better measures of affordability is crucial because people who cannot afford adequate insurance still get sick, have accidents, and need care. Therefore, the potential for creating

[12] *See In re Blue Cross Blue Shield of Vermont 2019 Individual and Small Group Rate Filing*, GMCB-009-18rr, Decision and Order (Aug. 14, 2018), 17 – 19 (reducing overall rate by 1.0% to provider greater affordability); *In re MVP Health Plan, Inc. 2019 Individual and Small Group Rate Filing*, GMCB-008-18rr, Decision and Order (Aug. 14, 2018), 14 – 16 (reducing overall rate by 1.0% to provide greater affordability and access).

more uncompensated care should concern regulators, insurance carriers, and healthcare provider systems because an unaffordable system is not sustainable.

Filed: August 4, 2022

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.