STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Plan, Inc.	)	GMCB-008-20rr
	2021 Large Group HMO Rate Filing	)	SERFF No. MVPH-132497714
		)	

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 2021 large group HMO rate filing submitted by MVP Health Plan, Inc. (GMCB-008-20rr).

Procedural History

On August 14, 2020, the Board received a rate filing via the System for Electronic Rate and Form Filing (SERFF) from MVP Health Plan, Inc. (MVPHP) for its 2021 large group HMO products, including point of service riders offered in connection with the large group products.[1] On August 24, 2020, 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 6, 2020, 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 19, 2020, 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] 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/node/727.

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. (MVP), 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.

2. This filing demonstrates the premium rate development of MVP's large group HMO product portfolio and includes proposed rates for all four quarters of 2021. This product portfolio is comprised of base major medical high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and benefit riders. Additional riders were previously available on the MVP Health Insurance Company (MVPHIC) license; however, as of April 2019, the entire product portfolio has migrated to MVP Health Plan. L&E Actuarial Memorandum (L&E Memo), 1. The rates are composed of a manual rate change, an age/gender factor change, and a change in retention (i.e. administrative costs). *See* L&E Memo, 1.

3. As of February 2020, there were approximately 2,100 members enrolled in MVP large group plans in Vermont. Approximately 80% have renewal dates during 1st quarter of 2021 (1Q21). L&E Memo, 1; MVP Actuarial Memorandum (MVP Memo), 1.

4. MVP proposes a -1.2% annual rate change for members renewing in 1Q21. L&E Memo, 1.[2] The total premium changes for quarters 2, 3 and 4 vary slightly from the -1.2% due to quarterly trend changes and COVID-19 adjustments. L&E Memo, 1-2; MVP Memo, 1-2.

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 35% and the manual rate at approximately 65%. Therefore, some groups will experience decreased premiums, and some may experience premium increases. If a group experiences a higher rate increase, it is because their claims experience deteriorated relative to the other large groups in this block (i.e. that group's employees used more health care services and therefore cost more than other large groups in this block). All groups will experience the effect of changes in retention (i.e. administrative costs), 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, 1-2.

6. The federal loss ratio for MVP in 2019 is 76.9%, and the rolling three-year average (2017-2019) is 91.8%. L&E Memo, 8; *see also* Response to Objection Letter #1 (Sep. 9, 2020), 9 (MVP experienced federal loss ratios of 93.9% and 104.7% for 2017 and 2018, respectively).

7. MVP utilized large group claims data (constituting HDHP and non-HDHP products) for the period from March 2019 through February 2020 and paid through April 2020 (with incurred estimates updated through June 2020) as the base period experience. The base period data is 100% credible. MVP elected not to include 2020 incurral months after February as these months were impacted by COVID-19 and had lower claims than MVP's expected claim costs in 2021. The base period experience used in this filing has two months of claims run-out and therefore, needed to be

[2] Notably lower than MVP's 2020 Large Group HMO approved average annual rate increase for 1Q20 of approximately 15.0%.

adjusted for claims incurred but not reported (IBNR). The IBNR adjustment appears to be actuarially sound and is consistent with MVP's other filings. L&E Memo, 2-3.

8. Claims exceeding $100,000 made up 8.2% of the base period experience. The claims above the pooling limit of $100,000 for the prior 5 years has ranged from 4.5% to 24.9%, with an average of 13.1%. This volatility demonstrates the importance of pooling claims in setting the rates each year. The Vermont-only data is not fully credible due to the small membership in Vermont and the use of New York data to set the pooling charge assumption results in more stable premiums. L&E found this pooling practice to be reasonable and appropriate. L&E Memo, 2-3.

9. The adjusted claims were projected forward to the midpoint of the 1Q21 rating period using an annual paid medical trend assumption of 7.4%. MVP's paid medical trend is derived from its proposed allowed cost trend and the impact of cost share leveraging. The prescription claims were projected forward to the midpoint of the 1Q21 rating period using an annual paid Rx trend of 8.6%. The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q21. These adjustments included projected cost of capitation, non-FFS claim expenses, Rx rebates, and the COVID-19 pandemic. Reflecting these adjustments, the quarterly manual rate change suggested by the data was -7.8% for 1Q21. MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims and reducing the COVID-19 pent-up demand impact. This results in quarterly manual rate increases of between 1.8% and 2.1% in each quarter of 2021. That is, groups renewing in April will be charged premiums based on manual rates approximately 1.8%-2.1% higher than groups renewing in January. As noted above, approximately 80% of groups have 1Q21 renewal dates. L&E Memo, 3; *see supra* Findings of Fact (Findings), ¶ 3.

10. MVP is requesting a utilization trend of 1.0% and a unit cost trend of 6.6% for 2021. This represents a total allowed trend of 7.7% for 2021. 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 7.4% 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, twenty-two months of trend were used to trend the experience period claims forward to 1Q21. L&E Memo, 3-4.

11. MVP analyzed its combined MVPHIC and MVPHP 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 the utilization trend used in the 2021 QHP filing. L&E found the utilization trend of 1.0% to be reasonable and appropriate. L&E Memo, 4.

12. The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. Since the filing was submitted, the Green Mountain Care Board has made final decisions regarding 2021 hospital budgets. The budgeted unit cost increases approved by the GMCB are lower than MVP anticipated at the time of the filing. L&E Memo, 4.

L&E recommended revising the trends to reflect the final orders regarding FY2021 hospital budgets, which would decrease the 1Q21 rates by -0.8%. L&E Memo, 9.

13. To develop its annual allowed pharmacy trend assumption of 7.9%, which is composed of a utilization trend of 2.4% and a unit cost trend of 5.3%, 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), reflecting MVP's business in the state of Vermont. L&E Memo, 5.

14. MVP is using 2021 drug rebate forecasts provided by the PBM. These forecasts assume that drug rebates will equal $24.42 PMPM for 1Q21 renewals and increasing with pharmacy trend for later quarters. L&E Memo, 5.

15. L&E concluded that MVP's assumptions regarding Rx trend and Rx rebates appear to be reasonable and appropriate. L&E Memo, 6.

16. COVID-19 is a potentially life-threatening disease caused by a recently discovered coronavirus (SARS-CoV-2). On March 7, 2020 and March 11, 2020, the first two cases of COVID-19 were detected in Vermont. On March 11, 2020, the World Health Organization characterized COVID-19 as a pandemic. On March 13, 2020, Vermont's Governor declared a state of emergency to help ensure Vermont has the necessary resources to respond to this evolving threat. Executive Order 01-20. Over the weeks and months following the arrival of COVID-19 in Vermont, a number of measures were taken to prevent the spread of the virus, including the closure of schools and childcare centers, the closure of bars and restaurants, and restrictions on the size of non-essential gatherings. Office of Governor Phil Scott, Novel Coronavirus (COVID-19): Vermont State Response & Resources (updated July 15, 2020). To conserve personal protective equipment and other critical resources and to limit exposure of hospital patients and staff to COVID-19, on March 20, 2020, Vermont's Governor ordered the postponement of all non-essential adult elective surgery and medical and surgical procedures. Addendum 3 to Executive Order 01-20. On May 4, 2020, Vermont's Governor ordered that limited elective medical procedures could resume. Amendment to Addendum 3 to Executive Order 01-20.

17. Actions were taken with respect to health insurance, as well. For example, because knowledge of whether an individual is infected with COVID-19 is critical to limiting that person's exposure to others—and thus the spread of the disease—DFR directed health insurers to cover any medically necessary COVID-19 testing with no co-payment, coinsurance, or deductible requirements for members. *See* Reg. H-2020-03-E (Apr. 14, 2020). DFR required health insurers to provide coverage for clinically appropriate health care services delivered remotely or through telehealth or audio-only telephone visits on the same basis as in-person consultations. Reg. H-2020-02-E (Mar. 30, 2020). DFR also encouraged insurers to provide policyholders with a reasonable grace period to pay insurance premiums to avoid cancellation for non-payment and directed insurers to suspend all routine provider audits. Insurance Bulletin #211 (Mar. 18, 2020). DFR has since ordered the resumption of routine audits effective August 3, 2020. Insurance Bulletin #215 (July 7, 2020). On October 23, 2020, a number of the above COVID-19-related DFR regulations were rescinded so the provisions could be encompassed by emergency rule. *See* Reg. H-2020-06-E (Oct. 23, 2020), which rescinds and supersedes the provisions of Rules H-2020-02-E, H-2020-03-E, and H-2020-04-E, and Insurance Bulletins #209 and #214.

18. The federal and state governments have acted to help individuals, businesses, state and local governments, and health care organizations deal with the economic effects of the pandemic and the pandemic response. For example, the $2 trillion CARES Act that the federal government enacted on March 27, 2020 authorized one-time direct cash payments to qualified individuals and married couples, increased unemployment insurance benefits and expanded unemployment insurance eligibility, provided grants and low-interest loans to businesses, provided payments to hospitals and other health care providers, and created a Coronavirus Relief Fund to provide $150 billion in direct assistance to state and local governments. Pub. L. 116-36. Vermont's allocation of the $150 billion Coronavirus Relief Fund is $1.25 billion. In Act 136, the Vermont Legislature appropriated $275 million of this $1.25 billion to the Agency of Human Services (AHS) to distribute needs-based grants to health care providers. Act. No. 136 (2020), Sec. 7. AHS accepted grant applications through August 15, 2020 from providers that experienced revenue losses or increased expenses due to COVID-19. Vermont Agency of Human Services, Health Care Provider Stabilization Grant Program Frequently Asked Questions (July 31, 2020).[3] AHS accepted a second round of applications for health care and human service providers seeking grant funding for both COVID-19-related lost revenue and COVID-19-specific incurred expenses for March 1 – September 15, 2020. The application period was open from October 19, 2020 through November 6, 2020.[4]

19. MVP's filing included a COVID-19 impact of an additional $6.50 PMPM in claim costs in 1Q21, which includes $1.50 for pent-up demand and $5.00 PMPM for immunization costs. As a result of the COVID-19 pandemic, elective surgeries and associated services were postponed for two months in 2020 (mid-March through mid-May 2020). Based on a Society of Actuaries research paper, "Potential Impact of Pandemic Influenza on the U.S. Health Insurance Industry", MVP assumed that 20% of these deferred services will not be ultimately fulfilled. Based on information from the MVP's medical management team, providers of elective services were already working at near full capacity prior to the pandemic. MVP believes that providers will be financially incentivized to recoup lost revenue during the pandemic. Therefore, to fulfill the remaining 80% of deferred services, MVP assumed that providers would operate at 110% capacity beginning in August 2020 through April 2021. In 2019, elective services cost $45.09 PMPM. An increase of 10% would result in $4.51 PMPM of additional costs. This increase produces an annualized 2021 increase of $1.50 PMPM. This development assumes that there will not be a second wave of stay-at-home orders in 2020 or 2021. L&E Memo, 6.

20. The Board's actuaries did not find the assumption that providers will run at 110% capacity to be adequately supported based on the following: (1) providers have had an opportunity to receive financial assistance from the government to alleviate financial hardship, which reduces the financial incentive to run at greater than 100% capacity in the future, (2) there is an immense uncertainty regarding how long social distancing, cleaning, and other safety guidelines will continue into 2021, which limits hospital capacity, (3) Vermont had a quicker than average turnaround from shelter-in-place to reopening, which potentially sets the stage for all deferred care to be recouped in 2020 while not exceeding 100% capacity, and (4) Vermont is unlikely to see a second wave due to its older, more compliant residents and rural environment. Additionally, L&E

[3] https://dvha.vermont.gov/sites/dvha/files/documents/News/Frequently%20Asked%20Questions.pdf
[4] https://dvha.vermont.gov/health-care-provider-stabilization-grant-program

requested more information on which providers MVP has spoken to regarding running at 110% capacity in 2021, and MVP stated that "MVP has had conversations with providers in New York regarding this, who provided us with information that was used to derive our assumption." Response to Objection Letter 3 (Oct. 12, 2020). L&E recommends that the additional PMPM claims costs for COVID-19 pent-up demand be removed. L&E Memo, 6.

21. MVP's filing assumed that a vaccine will be available beginning in January 2021, based on the Federal Government announcement of Operation Warp Speed and initiated Phase II/II clinical trials for testing as of July. MVP assumed that the vaccine cost will be $75, which is based on the cost of Tamiflu. MVP assumed that 80% of the covered population will receive the vaccination in 2021. This assumption was based on published research by Wakely Consulting Group. While MVP acknowledged that flu vaccination rates are lower, at approximately 55%, MVP asserted that the vaccination rate for COVID-19 will be higher than the vaccination rate for the flu. This was assumed because of the unique nature of the removal of social distancing requirements being contingent on individuals receiving the vaccine. These COVID-19 vaccination assumptions produce a projected 2021 PMPM cost of $5.00 ($75 * 80% / 12). L&E Memo, 7.

22. L&E did not find the assumed vaccination rate of 80% to be adequately supported based on the following: (1) L&E considers the 80% vaccination rate used in the Wakely report to be an example scenario, not the expected scenario, (2) the filing does not consider that there could be constraints in supply of a vaccine, once available, which would restrict access to the most vulnerable population initially, (3) the most vulnerable population being covered more widely under Medicare and Medicaid, rather than commercial coverage, (4) the filing does not consider potential cost coverage by the federal government, and (5) the filing does not consider people may be wary of the COVID-19 vaccine initially given the increased speed at which it was developed and therefore potential unknown effectiveness and side effects. L&E asserted that a more reasonable assumption for the 2021 COVID-19 vaccination rate is consistent with flu vaccination rates and recommended a vaccination rate assumption of 55%. L&E Memo, 7, 9.

23. The rates for this product 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 the prior filing, the demographics of this block have been observed to deviate from past expectations. The enrolled population was slightly younger than the prior experience period, resulting in decreased revenue available to cover claims. The demographic factors were re-normalized to reflect the updated experience and increased by 1.2% to maintain the necessary premium level. L&E determined that MVP's age/gender normalization methodology appears to be reasonable and appropriate. L&E Memo, 3.

24. As in the prior approved filing, retention charges (i.e. administrative costs) are added to the blended pure premium in deriving the group required premium. The 14.3% total retention load is composed of the following: (a) a 8.6% general expenses, (b) a 2.6% broker load, (c) a 0.5% VT Vaccine Pilot expense, (d) 0.3% load for bad debt, (e) 0.3% expense for billback, and (f) a 2.0% contribution to reserves (CTR). MVP notes that the projected administrative expenses of 8.6% of premium is less than the actual calendar year 2019 expenses of 9.3% but does not provide an expected PMPM for administrative expenses in 2021 for comparison with 2019. L&E Memo, 8.

25. L&E concluded that the administrative expense load appears to be reasonable and appropriate. L&E Memo, 8.

26. The federal loss ratio for MVP in 2019 is 76.9%, and the rolling three-year average (2017-2019) is 91.8%. L&E Memo, 8.

27. The proposed 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, 8.

28. 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 2019, all of MVP Holding Company's operations in Vermont accounted for approximately 5.7 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 Analyses for MVP's 2021 Large Group HMO Rate Filing.

29. L&E reviewed the filing and first recommended that the Board adjust the unit cost trends to reflect the FY2021 hospital budgets established by the Board while the filings were pending, which would decrease the 1Q21 rates by -0.8%. Second, L&E recommended that the COVID-19 pent-up demand adjustment be removed, and the COVID-19 vaccination adjustment be reduced using a 55% vaccination rate. These two modifications would decrease the 1Q21 by -0.6%. L&E Memo, 9.

30. 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, 9-10.

31. In its memorandum in lieu of hearing, MVP stated that it "accepts L&E's recommendation of a downward adjustment of 0.8% due to revising the trends to reflect the final orders on FY2021 hospital budgets. This adjustment brings the quarterly manual rate decrease to -8.6% and translates to an annual decrease of -4.1%. MVP disagrees with L&E's second recommendation to remove its COVID-19 pent-up demand adjustment and alter its COVID-19 vaccination adjustment." MVP Brief, 1. In support of its COVID-19 pent-up demand adjustment, MVP asserted that "[g]overnment assistance has not enabled providers to significantly recoup lost revenue, and providers for MVP are generally struggling and will work at 110% capacity," but cited no evidence to support its assertion. *See* MVP Brief, 3. In support of its COVID-19 vaccination adjustment, MVP asserted that "Vermonters are more frightened about spreading, contracting and dying from COVID-19 than the flu, and will seek out and take the COVID-19 vaccine at much higher rates than the flu vaccine." *Id*. Lastly, MVP noted the Board may consider

the steps MVP outlined in its 2021 QHP filing to contain costs and address affordability, access, and quality of care. *Id* at 3-4.

32. The HCA contended in its memorandum in lieu of hearing that MVP has failed to demonstrate that the proposed rates are affordable; promote access to care; promote quality care; are not unfair, unjust, inequitable or misleading; and are not excessive, inadequate or unfairly discriminatory. The HCA asserted that Vermonters are in an affordability crisis and that "[d]ue to the sacrifices Vermonters and Vermont businesses are making to control the Covid-19 pandemic, they currently face economic straits that have not been seen for decades, if ever in their lifetimes: spiking unemployment, dramatic workforce contractions, loss of income, and rising basic necessity prices. In July and August 2020, 8.2% and 4.8%, respectively, of Vermonters in the labor force were unemployed. This rate is approximately twice as high as it was at the same time last year and equates to over 15,000 unemployed Vermonters." *See* HCA Brief, 3. The HCA concluded that MVP's filing includes several points that are excessive and that MVP is in a strong solvency position. In light of all of these factors, the HCA requested that the Board reduce MVP's CTR to 0.5%, reduce the proposed premium price to account for final hospital budget orders, remove from the rate the 110% utilization and 80% vaccination assumptions, and reduce the administrative load. HCA Brief, 7.

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,[5] 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).

[5] 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.

Conclusions of Law

I.

First, we adopt our actuaries' recommendation to adjust the unit cost trend to reflect the approved FY2021 hospital budgets. This recommendation modifies the filing to incorporate information that was not available at the time of the initial filing and both parties agree this modification is appropriate. Findings, ¶¶ 29, 31-32. This modification reduces the average annual rate for 1Q20 by approximately -0.8%. *See* Findings, ¶ 29.

II.

Second, we address the carrier's request for an additional $6.50 PMPM claim costs in 1Q21 due to COVID-19 impacts, which includes $1.50 for pent-up demand and $5.00 PMPM for immunization costs. MVP's filing assumes: (1) that a vaccine for COVID-19 will be widely available beginning early 2021, and (2) that providers will perform 110% of their prior elective service volume from August 2020 until April 2021. Findings, ¶¶ 19, 21, 32. In its October 19, 2020 report, L&E recommended that the COVID-19 pent-up demand adjustment be removed. This recommendation was based on the carrier's filing failing to consider variables specific to Vermont providers and on L&E's analysis of different utilization scenarios for deferred elective services. *See* Findings, ¶ 20. With regard to increased 2021 utilization, we agree with our actuaries that there is a good chance that MVP will not see an increase in utilization in 2021 to make up for the deferred 2020 elective services. We believe it is equally, if not more, likely that providers will not exceed 100% utilization, as deferred services from Spring 2020 may be made up in 2020 given Vermont's successful COVID-19 suppression or because providers may not have the ability to run at 110% due to enhanced safety protocols for testing, distancing, and more frequent cleaning requirements. *See* Findings, ¶ 20. Further, we find MVP's reasoning that providers will either have financial incentive to perform services at 110% is overly speculative, particularly given that MVP has not spoken with any Vermont providers about their ability, expectation, or desire to perform services at more than 100% capacity in 2021. *See* Findings, ¶¶ 20, 31.

With regard to vaccine costs, we do not find there is enough evidence to support this assumption. First, we agree with our actuaries and the HCA that a vaccination rate of 80% of MVP's membership during 2021 is unlikely. L&E recommended a vaccination rate assumption of 55%, similar to flu vaccination rates, and noted that an 80% vaccination rate does not take into account constraints in supply of a vaccine, once available, which could restrict access to only the most vulnerable populations initially. Findings, ¶ 22. As noted by L&E, there is likely to be a priority system to ensure that the people who are in the greatest need and the highest risk categories receive the vaccine first,[6] with the young and healthy individuals getting it last, and that Wakely's estimate of an 80% vaccination rate is an example, not a prediction. *Id*.

[6] In October 2020, Vermont submitted responses to a series of questions from the Centers for Disease Control and Prevention (CDC), laying out the framework for Vermont's vaccine distribution and Vermont's preparedness. *See* Vermont COVID-19 Vaccination Plan (Oct. 16, 2020), Section 3: Phased Approach to COVID-19 Vaccination. *Available at:* https://www.healthvermont.gov/sites/default/files/documents/pdf/Vermont%20Jurisdictional%20COVID-19%20Vaccination%20Plan_Interim%20Draft.10.21.2020.pdf

Second, we note that L&E's review and recommendations are based on the carrier's assumptions that a vaccine will be approved and widely available in early 2021 and that the cost of the vaccine will be borne by the carrier and consumers. However, we do not find that the carrier has provided sufficient evidence to support the timing of a vaccine in early 2021 or that the carrier will experience the assumed costs of a vaccine. The timing of a vaccination being widely available and the cost per vaccine are at this point, again, only speculation. We must take into account the unknown factors that will affect the timing of the vaccine and ultimate cost to the company—the vaccine approval process may not be as fast as people hope; people may be wary of a COVID-19 vaccine given the speed at which it was developed compared to customary vaccine timelines (with development over multiple years); the effectiveness and side effects of a future vaccine are unknown and will affect how many people choose to be vaccinated; if the most effective vaccine is developed by another nation we do not know how long it will be before our country is able to get a sufficient supply of the vaccine; and there is the possibility that the federal government will set aside money to cover most or all of vaccine costs. These are only some of the variables and no doubt there are other unknown variables.

In summary, we do not find the carrier has provided enough support to overcome the possible supply constraints noted by our actuaries and the many variables we note above that will significantly affect the carrier's base assumptions as to timing and cost. There is no doubt for us that many Vermonters and Vermont businesses are experiencing an extreme level of financial difficulty during this pandemic. Findings, ¶¶ 16-18, 32. We are faced with the difficult decision of how to account for the unknown timing and use of a potential COVID-19 vaccine in 2021; depending on how the many variables play out, there might be costs to the carrier in 2021 or there may not be.

Upon review of the record, we find the carrier's assumptions for the impacts of COVID-19 to be too speculative and that MVP has failed to sufficiently justify this component of its requested rate. Given these considerations, we reduce the company's requested overall rate to remove the COVID-19 assumptions (a reduction of approximately -1.3%). Recognizing that we are putting the risk of potential vaccine costs and additional utilization costs (either as pent-up demand or the possibility of a "second wave" of COVID-19 cases affecting MVP's membership) on the carrier, we will not reduce the company's requested CTR to 0.5% as requested by the HCA, as discussed further below.

III.

Lastly, consistent with modifications we have required in past filings, we order the carrier to reduce the proposed CTR from 2.0% to 1.0%. *See, e.g., 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., 2019 Large Group HMO Rate Filing*, GMCB-010-18rr, Decision and Order, 6 (reducing CTR from 2.0% to 1.5%); *In re: MVP Health Plan, Inc., Third Quarter 2018 and Fourth Quarter 2018 Large Group HMO Rate Filing*, GMCB-007-18rr, 5 (reducing CTR from 2.0% to 1.0%). We find a reduction of the CTR from 2.0% to 1.0% poses no threat to the solvency of the carrier, given its small book of business in Vermont. *See* Findings, ¶ 28. At the same time, such a reduction will enhance the affordability of premiums during a difficult financial time for many Vermonters.

The HCA has recommended that the Board approve a 0.5% contribution to reserve this year in light of the financial situation of Vermonters, the economic impacts of the pandemic, and the rising cost of health care. Findings, ¶ 32. While we have determined that affordability requires a significant reduction to CTR when the company is not facing solvency concerns, we will not reduce the company's overall rate or its CTR to 0.5% given a number of uncertainties related to the COVID-19 pandemic. As noted above, we are requiring MVP to assume the risk of increased utilization in 2021 for deferred elective services in 2020, the potential costs of a COVID-19 vaccine in 2021, and the possibility of a second wave of COVID-19 cases in Vermont that result in costs to the carrier.[7] While we did not find the carrier has sufficiently supported its COVID-19 assumptions such that we approve those requested increases, we cannot ignore that actuarial science is not precise and there is a chance these costs will have to be borne. This requires the carrier to have reserves to cover unexpected costs.

In light of the above considerations, we reduce the carrier's proposed CTR from 2.0% to 1.0%, which we conclude will not materially impact or pose a threat to the carrier's solvency. *See* Findings, ¶ 28. The above 1.0% reduction in CTR reduces the proposed rate by approximately -1.0%.

We conclude that these rates, as modified, are not excessive, inadequate, or unfairly discriminatory, and strike the most appropriate balance between maintaining insurer solvency and promoting affordability.

Order

For the reasons discussed above, we order the carrier to 1) adjust the unit cost trend to reflect the approved FY2021 hospital budgets; 2) remove the additional $6.50 PMPM claim costs due to COVID-19 impacts; and 3) reduce the proposed CTR from 2.0% to 1.0%. We thereafter approve the filing, resulting in an average annual rate change of approximately -4.3%.

SO ORDERED.

Dated: November 12, 2020 at Montpelier, Vermont

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

[7] We note that there has been a recent uptick in COVID-19 cases such that Vermont's Governor issued an advisory on November 6, 2020, for private social gatherings, strongly recommending they be limited to 10 or fewer people, in response to an increasing number of cases as a result of socializing and in anticipation of the holiday season. https://governor.vermont.gov/press-release/governor-phil-scott-and-health-commissioner-mark-levine-issue-advisory-social. However, it is unknown whether cases will continue to increase at this faster pace or whether individuals requiring treatment for COVID-19 will fall within MVP's large group membership.

)
s/ Maureen Usifer)

Filed: November 12, 2020

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.