STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.	)	
2023 Small Group and Individual Group	)	DOCKET NOS. GMCB-005-22rr
Vermont Health Connect Rate Filing	)	GMCB-006-22rr
	)	
SERFF Nos. MVPH-133238186	)	
MVPH-133238198	)	

MVP'S POST-HEARING PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

MVP Health Plan, Inc., ("MVP") by and through Primmer Piper Eggleston & Cramer PC, submits this Post-Hearing Memorandum to the Green Mountain Care Board (the "Board"), pursuant to Board Rule 2.307(g), in support of its 2023 Vermont Exchange Rate Filings (the "Rate Filings"), requesting an average rate increase of 24.54% for the Individual Market ("IM") and 23.44% for the Small Group Market ("SG").

Findings of Fact

On May 9th, MVP initially proposed a 17.4% rate increase for IM and a 16.6% rate increase for SG. *MVP's May 9, 2022 Rate Filings ("Rate Filings"), at Ex. 1, p. 2; Ex. 2, p. 2; Christopher Pontiff Testimony ("Pontiff"), pp. 30-31.* The Board's actuary Lewis & Ellis ("L&E")'s July 5, 2022 Actuarial Reports (collectively "L&E Report") provided five recommendations to the Board ("L&E Recommendations"). *Ex. 12, p. 16 and Ex. 13, p. 16.* MVP agrees with L&E Recommendation Nos. 1, 3 and 4.[1] *Pontiff, pp. 31-34.* MVP and L&E disagree on L&E Recommendation No. 2 (remove the COVID-19 vaccination adjustment (-0.6% both markets));

[1] L&E Recommendation No. 1: rates should incorporate as-approved hospital budget information; L&E Recommendation No. 3: move a normalization factor to Worksheet 2 on the Unified Rate Review Template (no change to proposed rate increase); and, L&E Recommendation No. 4: that the rates should reflect updated risk transfer information (-0.1% reduction to IM; -0.3% reduction to SG). *Pontiff, pp. 31-34.*

and, L&E Recommendation No. 5: (large claim adjustment (-0.7% to IM; -0.9% to SG)). *Pontiff, pp. 31-34; Ex 12, p. 16; Ex. 13 p. 16; Ex. 18.*

On July 13, 2022 the Board released a summary of change in charges for Fiscal Year 2023 hospital budget review ("Hospital Budgets"). On July 15, 2022, MVP calculated the combined resulting impact due to the updated risk transfer and the Hospital Budget information resulting in a 24.45% increase for IM and a 23.44% increase for SG, the increases MVP now seeks.[2] *Pontiff, p. 64;* Exs. *34, 35*. On July 20, 2022, the Board held a hearing on the Rate Filings. On July 22, 2022, L&E filed an Addendum to its Actuarial Report. On July 26, 2022 L&E filed a corrected Addendum ("L&E Addendum"). L&E reiterated that MVP's rate increases must align with Hospital Budgets, but did not make quantitative recommendations. *L&E Addendum, pp. 1-5.*

L&E and MVP continue to disagree on the impact of vaccination unit cost. L&E and MVP continue to disagree on whether 2021 large claims were an outlier or the new norm. *L&E Addendum, pp. 6-9*. Taking MVP's original rate requests (17.4% increase for IM and 16.6% increase for SG), and subtracting out agreed adjustments for updated risk transfer information (L&E Recommendation No. 4 (-0.1% reduction to IM; -0.3% reduction to SG)) results in a net requested increase of 17.3% for IM and 16.3% increase for SG before adjustments for Hospital Budgets. After all adjustments based on L&E Recommendations, except for adjustments for Hospital Budgets, L&E calculates the 2023 rate increases as 15.8% for IM, and 14.8% for SG. *L&E Addendum, p. 9.* The difference between MVP's net requested increases and L&E's calculation of the impact of L&E's recommendations is 1.5%—the remaining disagreement between MVP and L&E on each proposed rate increase.

[2] The impact of the Hospital Budgets resulted in an additional 7.2% increase for SG and 7.0% increase for IM. *Pontiff, p. 32; Exs. 34, 35*.

1. <u>Any Modification To MVP's Proposed Rate Increases Based On Hospital Budgets Should Be *Consistent* With Approved Hospital Budgets</u>. MVP's rate increases should align with actual Hospital Budgets. *Pontiff, pp. 31-2; Lee, p. 211; Ex. 12, pp. 5-6; Ex. 13, p. 5.* The HCA agrees with the simple notion that this insurance should cover the additional costs for services the Board approves for hospitals. *Fisher, p. 219.* "[I]f you approve fully UVMC, we would want that reflected. If you give them nothing . . . we would want that reflected." *Pontiff, pp. 141-2.* Ms. Lee testified that she agreed that MVP's proposed rates as amended to account for Hospital Budgets would not be inadequate. *Lee, p. 179; 198.* L&E generally recommends "to the Board to be very thoughtful that whatever . . . you're going to do in September or October time frame for the hospital budget, that it be consistent with what decision you make here. Because as you noted, the [Hospital Budgets] were significantly high and absolutely exceed the CTR presented by either carrier, which means that more solvency issues could occur if there is a disconnect between the two." *Lee, p. 211.* The Board should be consistent in setting any Hospital Budget figure in this rate review and the Hospital Budgets hearings (including any mid-year adjustments to Hospital Budgets) otherwise the Board risks abusing its discretion.[3]

Last year, the Board reduced MVP's proposed rates by 1.0% based on L&E's analysis of the Board's historical modifications to the Hospital Budgets. *Ex. 42*; *2022 Vermont Health Connect Rate Filing Decision, SERFF Nos. MVPH-*132824950; *MVPH-132824927, p. 17.* However, the Board's reduction last year was in fact in excess of the 0.7% weighted average of

[3] *In re MVP Health Ins. Co.*, 2016 VT 111, ¶ 1 (2016) (The Vermont Supreme Court may intervene and reverse on a showing of abuse of Board discretion resulting in prejudice to a party); *Petition of Cent. Vermont Pub. Serv. Corp.*, 143 Vt. 120, 122, 463 A.2d 525, 526 (1983) (reversing Public Service Board, "in establishing just and reasonable rates the Board must exercise its discretion affirmatively in determining the extent to which the increased costs should be awarded as recoupment.").

the Board's actual reductions to Hospital Budgets illustrated in L&E's analysis. *Pontiff, pp. 62-63; Ex. 42.* L&E cautions that, "this year represents a unique situation, and it may not be appropriate for the Board to make drastic cuts to the filed hospital budgets." *L&E Addendum, p. 3.* L&E notes that since 2017, more substantial reductions to proposed hospital budgets have become more commonplace. *L&E Addendum, p. 4.* Ms. Lee agreed that an assumption of a 4% reduction to Hospital Budgets would not be supported by L&E's 2021 historical analysis. *Lee, 182-83; Ex.* 42.

If the Board reduces MVP's rates based on anticipated cuts to Hospital Budgets, but does not reduce Hospital Budgets in the same amount, then MVP's rate may not ultimately be adequate or support solvency. *Pontiff, pp. 141-42; Lee p. 211; Lussier, pp. 160-61.* The Board should approve MVP's proposed rate increases based on the evidence before it—the proposed Hospital Budgets. "(T)he hospital budget and insurance rate processes should not be siloed, and the information before us at this time, prior to approving insurance rate increases, should be used to maximize **consistency**." *2018 Vermont Health Connect Rate Filing Decision, SERFF No.* MVPH-131034103, pp. 8-9 (emphasis added). L&E agreed with MVP's calculation at the Hearing accounting for the proposed Hospital Budgets, and provides no reason why MVP's calculation should not be adopted in the L&E Addendum. *Lee, pp. 178-79; L&E Addendum, pp. 1-5.* The Board can avoid abusing its discretion by simply ensuring that any cut the hospitals receive at the Hospital Budget hearings is not less than any Hospital Budget cut the Board adopts here.[4]

2. <u>L&E's 0.6% Reduction To MVP's COVID-19 Vaccination Adjustment Based On Ingredient Costs Should Be Disregarded</u>. The basis for L&E Recommendation No. 2, to remove

[4] For example, even if the Board cuts MVP's proposed rate by 1% to reflect a consistent 1% reduction in the Hospital Budgets, then that would reflect a modified rate of 23.86% for IM and 22.86% for SG after adjustment for updated risk transfer information. *Ex. 39.*

MVP's COVID-19 adjustment, was a disagreement with MVP's assumption on vaccine utilization. *Ex. 12, p. 9; Ex. 13, p. 9.* L&E now concedes that MVP's 52% assumption on vaccine utilization "appears to be a lower bound.". *L&E Addendum, p.* 7. However, L&E continues to recommend a 0.6% reduction based on new unit cost information cited in the L&E Addendum. *L&E Addendum, pp. 6-8.*

L&E, for the first time, addresses MVP's unit cost assumption. *Ex. 12, p. 9; Ex. 13, p. 9; L&E Addendum, p. 6*. MVP disagrees with L&E's new assumptions that MVP will have no ingredient costs, or up to $20 per dose based on flu vaccination costs. *L&E Addendum, p. 6.* L&E offers no insight into why flu vaccination costs are an appropriate assumption in this case. *Id*. MVP will pay more for each vaccine administered in 2023 than in prior years because MVP will pay ingredient costs. *Pontiff, pp. 43-44*. MVP's cost assumption relies on credible CMS and Medicare data. *Id*. Additionally, without explanation, L&E now assumes one vaccine per utilizing member. *L&E Addendum, p. 8*. By contrast, MVP assumes 1.4 based on CMS data. *Pontiff, p. 105; Ex. 1, p. 45; Ex. 2, p. 26; Ex 4. P. 8; Ex. 5, p. 8*. L&E's new assumption is not supported and should be disregarded. L&E agrees that MVP's assumed utilization rate is likely a lower bound. L&E's argument on unit cost is not supported. The Board should disregard L&E Recommendation No. 2.

3. <u>Year Over Year Trend Shows That Increased Large Claims Costs Is The New Norm</u>. MVP disagreed with L&E Recommendation No. 5 on quantitative grounds[5] and on one substantive ground: 2021 was not an outlier for large claims, but the new norm. *Pontiff, pp. 50-51; Exs. 9, 10.* L&E now agrees with MVP's quantitative points and revised its calculations, resulting

[5]1) Three-year arithmetic averaging is not appropriate because MVP membership fluctuates; 2) L&E did not trend its adjustments; 3) the presentation of membership failed take into account membership fluctuations due to volatility in the IM or SG; and, 4) in L&E's calculation table, the column labelled PMPM should be labelled Per Member Per Year. *Pontiff, pp. 51-55.*

in a revised recommended 0.6% reduction for each market—down 0.1% from L&E's original recommended 0.7% reduction for IM and down 0.3% from L&E's original recommended 0.9% reduction for SG. *L&E Addendum, p. 9.* L&E still does not agree with MVP that current large claims data is the new normal. *Pontiff, pp. 50-51; Exs. 9, 10; L&E Addendum, p. 9*. However, the evidence supports that large claims have trended upwards every year. *Pontiff, pp. 50-51; Lee, pp. 190-91; Exs. 9, 10; Ex. 12, p. 11; Ex. 13, p. 11*. L&E now argues that 2021 was an outlier and the result of deferred care resulting from 2020 COVID-19 "lockdown" and from the University of Vermont Health Network cyberattack in October 2020. *L&E Addendum, p. 9*. Deferred care typically relates to delaying procedures like elective knee replacements which do not generally impact high cost claims. MVP's 2022 and 2021 experience to date does not evidence any impact on high cost claims for deferred care due to 2020 COVID-19 "lockdown". L&E's concern regarding the UVMHN cyberattack is similarly not supported by MVP's data. *MVP's July 27, 2022 Response to the Board's Post-Hearing Questions, p. 2.*

Notwithstanding L&E's mathematical concessions, the Board should still disregard L&E Recommendation No. 5 as producing a result contrary to trend.

4. <u>MVP's Proposed Contribution To Reserves ("CTR") Is Adequate, Reasonable, And Necessary to Maintain Its Solvency in Vermont</u>. DFR and L&E both agree with MVP's 2023 proposed 1.5% CTR[6], and that MVP's proposed CTR still supports MVP solvency. *Lussier, pp. 74-75.* MVP's 2023 proposed 1.5% CTR would not result in an inadequate rate after amendment to the proposed rate increases based on the Hospital Budgets. *Pontiff, p. 66; Lee, pp. 192-93; Ex. 1, p. 15; Ex. 2, p. 14; Ex. 12, pp. 14-15; Ex. 13, pp. 14-15.* L&E agreed that "a higher CTR could be justified". *Lee, p. 196; Ex. 12, p. 15; Ex. 13, p. 15*.

[6] MVP's proposed CTR does not include a bad debt component. *Pontiff, p. 69; Lee, p. 192*.

As a "reasonableness check," L&E reviewed rate filings nationwide and the 442 Qualified Health Plan (combined individual and small group) filings submitted in 2022. *Ex. 12, p. 14; Ex. 13, p. 14*. MVP's proposed CTR approximately places it in the 27th percentile for all 2022 QHP filings and is lower than the national average. *Lee, p. 194; Ex. 12, p. 14; Ex. 13, p. 14*. The 2023 projected federal loss ratio for MVP using this CTR is 91.9%, significantly higher than the 80% statutory minimum, meaning that 91.9 cents on every premium dollar will go back to paying claims. *Pontiff, p. 67; Lee, pp. 193-94; Ex. 12, p. 14; Ex. 13, p. 14*. MVP runs lean as a company and is not overcharging Vermonters—MVP charges costs needed to continue to run the business. *Pontiff, p. 67.*

The evidence is clear that the Vermont percentage of MVP's overall business can significantly impact MVP's overall solvency. *Pontiff, pp. 75-76; Lussier, p. 157; Lee, p. 196.* 2021 should serve as a cautionary tale. MVP lost approximately $32 million and $30 million of that loss came from Vermont. *Pontiff, pp. 71-73.* A continued 11.1% spread between actual and expected risk margin losses over the next years are not sustainable. *Pontiff, pp. 70-73;; Lussier, p.* 157; *Ex. 12, p. 15; Ex. 13, p. 15*. Every year, MVP sets CTR at a level that will protect insurer solvency for that year without being excessive or inadequate. *Pontiff, pp. 65; 80-81.* MVP does not attempt to "catch-up" based on losses in a previous year. *Pontiff, pp.* 73-74. Nevertheless, when premium and claim costs do not align, the continued resulting losses exacerbated by cuts to CTR year over year threaten carrier solvency and the Board should not cut CTR for 2023. *Pontiff, pp. 70-73; Lee, pp. 195-96; Lussier, pp. 157.*

6. <u>MVP Is Lowering Costs, Promoting Quality Care, Access, And Affordability In This Rate Filing, And The Board Should Not Reduce The Proposed Rate Increase On Any Of These Bases</u>. MVP has taken significant steps to contain costs and address affordability,

access, and quality of care. MVP's broad suite of initiatives and programs include, access to a nationwide network of providers, promotion of primary care, member guidance towards high quality and lower cost options as well as available subsidies, and telehealth and telemedicine support. *Exs. 1, 2; 4-7; 9-13; 16, 17, 20; 34-37; 43, 44; Pontiff, pp. 22-83; 118-147; Pontiff (Confidential Hearing Transcript), pp. 4-19; MVP's July 21, 2022 Responses to L&E Objection Letter # 10; MVP's July 27, 2022 Responses Post-Hearing Board Questions.*

Conclusions of Law

1. Health insurance rates in Vermont must be approved before they are implemented. 8 V.S.A. § 4062(a) and § 5104(a). The Board is empowered to approve, modify, or disapprove requests for health insurance rates. 18 V.S.A. § 9375(b)(6); 8 V.S.A. § 4062(a). MVP bears the burden of demonstrating that its rates satisfy the statutory criteria. *Board Rule 2.104(c)*. The Board must consider changes in health care delivery, changes in payment methods and amounts, DFR's solvency analysis, and other issues at the discretion of the Board. *Board Rule 2.401*. The Board shall modify or disapprove a rate request only if it is unjust, unfair, inequitable, misleading, or contrary to law, or if the rates are excessive, inadequate or unfairly discriminatory, fail to protect the insurer's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access. 8 V.S.A. §§ 5104(a) and 4062(a)(2)-(3); *Board Rule 2.000*. Each piece of evidence in the record could apply to one, multiple, or all of these statutory criteria. All of the statutory criteria are interrelated.

2. MVP's proposed rate increases are adequate and not excessive because they provide for and do not exceed the rates needed to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital for the benefit year. *Pontiff, p. 80.* MVP's proposed rate increase is not unfairly

discriminatory because it does not result in premium differences among the insured within similar risk categories that are not permissible under applicable law, or do not reasonably correspond to differences in expected costs. *Pontiff, pp. 79-81*. The proposed premiums are reasonable relative to the benefits that are included in the Rate Filings, and will maintain minimum solvency requirements in 2023. *Pontiff, pp. 79-81; Lussier, pp. 157-160; Ex. 14, p. 2; Ex. 15, p. 2.* Based on the Rate Filings and all the other evidence submitted at the Hearing, including testimony, the rates are not unjust, inequitable, misleading, nor contrary to Vermont law because they are actuarially sound and fairly charge a premium for services covered, and are reasonable based on the data that MVP and L&E analyzed. *Pontiff, pp. 79-81*.

3. The Board must consider affordability, promotion of quality care and access to care in a "fair, predictable, transparent, [and] sustainable" manner. *In re MVP Health Ins. Co.*, 203 Vt. 274, 284 (2016); *2021 Vermont Health Connect Rate Filing Decision, SERFF No. MVPH-*132371260, p. 15 ("[r]elated to the affordability criterion in the Board's rate review process is the expectation that MVP provide benefits and services at minimum cost under efficient and economical management. *See 8 V.S.A. §§ 4513(c), 4584(c), 5104(b)*."). MVP's rates are affordable "because they align the healthcare costs and the benefits provide at the minimum costs we've been able to achieve." *Pontiff, p.* 79. The HCA argues that affordability means "do people reasonably have enough money to buy the product[.]". *Fisher, p. 217*. That definition, while certainly reasonable, is not a legal definition found anywhere in the statute, the Board's rules, prior Board decisions, or Vermont Supreme Court decisions. MVP has established that a rate increase of 24.45% for IM and an increase of 23.44% for SG are actuarially sound. If the Board modifies the proposed rates, that decision must be based on evidence in the record, satisfy *all* statutory criteria, and result in a balanced rate. *In re MVP Health Ins. Co.*, 203 VT at 286. A reduction on non-

actuarial grounds may result in an inadequate, unsustainable rate.

4. The Board should consider the analysis and opinion of DFR in making its solvency determination. 8 V.S.A. §4062(a)(3). This year DFR concurred that MVP's proposed rate increases as amended are adequate to protect MVP's solvency. *Pontiff, pp. 79-81; Lussier, pp. 157-160; Ex. 14, p. 2; Ex. 15, p. 2.* L&E agreed that the rates as amended were not inadequate or excessive in light of the proposed Hospital Budgets. *Lee, pp. 174-75; 197-98.*

5. Based on all of the evidence, which was substantial, the Board should reject L&E Recommendation Nos. 2 and 5, accept L&E Recommendations 1, and 3-4, and find that MVP has met its burden of proving that the Rate Filings, with a 24.45% increase for IM and a 23.44% increase for SG, meet all of the statutory criteria. 8 V.S.A. §§ 4062(a); 5104(a); and, 18 V.S.A. § 9375(b); *Exs. 1-44; Pontiff, pp. 22-154; Pontiff (Confidential Hearing Transcript), pp. 4-19; Lussier, pp. 155-163; Lee, pp. 163-215.*

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