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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

OFFICE OF THE HEALTH CARE ADVOCATE
POST-HEARING MEMORANDUM

The Office of the Health Care Advocate (HCA) offers the following memorandum to assist the Green Mountain Care Board (Board) in its deliberations regarding MVP Health Plan, Inc.'s (MVP) 2023 Individual and Small Group rate filings.

MVP has asked the Board to approve rate increases of 24.5% in the individual market and 23.4% in the small group market. Such rate increases are truly extraordinary and could potentially ignite the smoldering crisis in Vermont's health care system. MVP attributes much of this steep rise in rates to medical trend, including the high cost of pharmaceuticals, especially specialty medications, and, uniquely this year, to the staggeringly high budget submissions from the state's hospitals. Vermonters are not blind to these realities. However, they do expect MVP to make reasonable rate assumptions to lower premiums and to act as stewards with the money they pay them. They know too well that drug prices continue to rise, as does the cost of receiving care. Vermonters also know that they cannot possibly absorb rate increases approaching 25% in a single year, while also keeping roofs over their heads, food on their tables, and gas in their cars.

In this memo, we will discuss how MVP's rates fail to meet the statutory criteria: how they are excessive; how they are unjust, unfair, inequitable, and misleading; how they fail to promote access; and most significantly, how they are simply unaffordable. The HCA urges the

Board to find that MVP has failed to justify rate increases of 24.5% and 23.4% and to pare the rates back to the lowest practicable rate that is within the zone of reasonableness between excessive and inadequate.

I. STATUTORY BACKGROUND

MVP bears the burden of demonstrating that its proposed rates meet the multi-faceted test governing the lawfulness of rate increases in Vermont: that the proposed rates are affordable; promote quality care; promote access to health care; protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to law; and are not excessive, inadequate, or unfairly discriminatory.[1] The Board may approve, modify, or disapprove proposals for health insurance rates.

In deciding how to act on proposed rates, the Board must consider the above factors as well as changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the Board.[2] The Board must accept comments from the public and from the HCA on all topics relevant to the proposed rates, and from the Department of Financial Regulation (DFR) on the limited subject of the impact of the filings on the insurer's solvency and reserves.[3] The Board is not bound by the views of DFR, the public, the HCA, or Lewis & Ellis (L&E), but must consider them.

II. MVP'S PROPOSED RATES ARE UNAFFORDABLE

MVP is required to prove that their proposed premiums are affordable. MVP's actuary, Christopher Pontiff, states and certifies that the proposed premiums comply with state law.[4]

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[1] 8 V.S.A. § 4062; 18 V.S.A. § 9375(b)(6).
[2] 18 V.S.A. § 9375(b)(6).
[3] 8 V.S.A § 4062(a)(2)(B); 8 V.S.A § 4062(c); 8 V.S.A § 4062(e)(1)(B).
[4] E.g., GMCB-005-22rr & GMCB-006-22rr, Hr'g Tr. at 78, lines 6-11 [hereinafter Hr'g Tr.].

However, he also admits that MVP did not engage in an analysis of whether the proposed premiums are affordable to Vermonters.[5] Rather, MVP conflates production costs with affordability.[6] In doing so, MVP is essentially conceptualizing affordability as being synonymous with "not excessive." However, actuarial justifications and production costs do not reflect whether Vermonters have enough money to buy insurance, let alone use it.[7] In fact, a vast amount of qualitative and quantitative evidence suggests, unfortunately, that Vermonters cannot afford their health insurance now, let alone after MVP's proposed increases.

Public comments from more than 245 Vermonters expressing the current affordability crisis, the high rate at which premiums and cost sharing are outpacing Vermonters' ability to pay, and the high percentage of Vermonters' incomes being taken up by premiums and deductibles prove that the proposed rate increases are unaffordable for Vermonters.[8]

If MVP's 2023 24.5% individual rate increase and 23.4% small group rate increase are approved, MVP's rates will have cumulatively increased 106% and 83% since 2014, respectively.[9] As we show in Chart 1 on the following page, MVP's rate increases for these books of business have far outpaced both Vermont real GDP and Vermont real wage growth for the period between 2014 and 2021. The proposed rates, indicated by the dashed line, only accelerate that trend.

[5] See, GMCB-005-22rr & GMCB-006-22rr, Ex. 16 at 6–25.
[6] See, e.g., id. at 79, lines 12–11.
[7] E.g., GMCB-005-22rr & GMCB-006-22rr, Hr'g Tr. at 359, lines 17–24.
[8] GMCB-005-22rr & GMCB-006-22rr, Pub. Comment 1–245.
[9] GMCB-005-22rr & GMCB-006-22rr, Ex. 39; GMCB-007-21rr; GMCB-008-21rr, Decision; GMCB-006-20rr; Decision; GMCB-005-19rr, Decision; GMCB-008-18rr, Decision; GMCB-007-17rr, Decision; GMCB-007-16rr, Decision; GMCB-007-15rr, Decision; GMCB-017-14rr, Decision [collectively, hereinafter referred to as 2014–2021 GMCB MVP Rate Decisions].

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Chart 1. MVP VHC premium price growth compared to Vermont real GDP growth and Vermont real wage growth. [10]

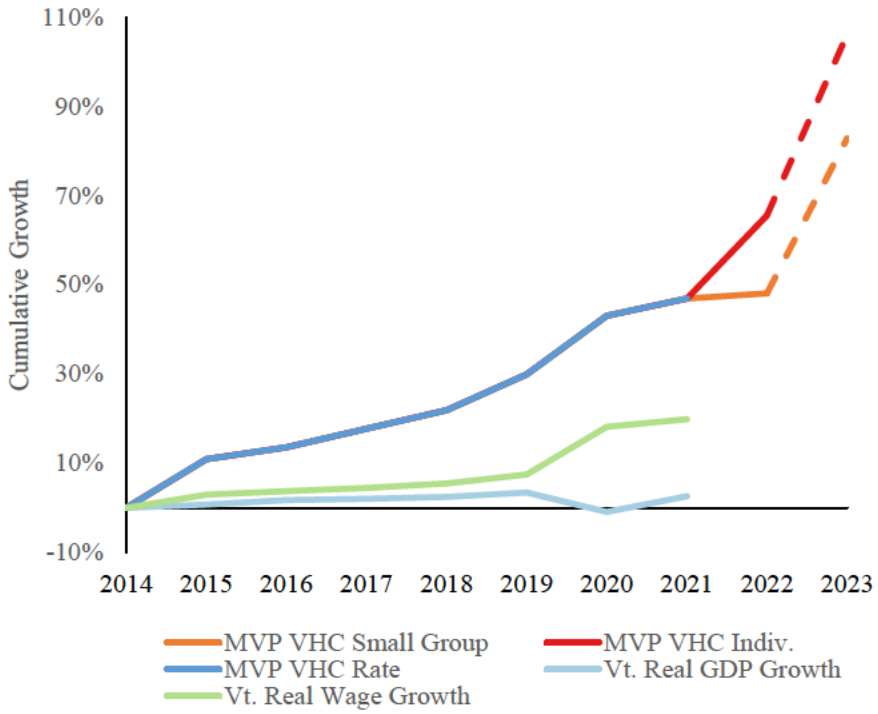

Table 1. 2023 MVP premium as a percent of income for households earning 401% of the Federal Poverty Limit

	Annual Premium	Annual Premium as Percent of Income
Standard Silver -Reflective (Non-HDHP)		
Individual	$9,864	18.10%
Couple	$19,728	26.87%
Family	$27,718	24.91%
Gold		
Individual	$11,914	21.86%
Couple	$23,828	32.45%
Family	$33,478	30.09%
Platinum		
Individual	$14,429	26.48%
Couple	$28,858	39.30%
Family	$40,546	36.44%

[10] GMCB-005-22rr & GMCB-006-22rr, Ex. 27, 28, 29, 39; 2014-2021 GMCB MVP Rate Decisions.

Moving to the micro-level, we show in Table 1 on the previous page the percent of income individuals, couples, and families of four who earn on a pre-tax basis $54,496, $73,423, and $111,000, respectively,[11] would need to pay for various MVP standard plans on the individual market under the proposed rates.[12] When reading Table 1, it is important to remember two facts. First, the percent of income spent on premium is not based on the percent of income that is actually available to households (i.e., it is pre-tax). [13] Second, measuring affordability by just looking at premium costs essentially assumes a Vermonter does not ever use their plan (i.e., it assumes $0 in deductibles and co-pay spend).

Given the issues related to measuring affordability by looking at premium costs alone, how does one quantify affordability as it relates to health insurance overall? To answer that question, we offer a metric that captures the dual burden of premiums and deductibles on Vermonters. The metric combines (1) the ACA maximum percentage of the required consumer share for premiums for the applicable year up to a reasonable FPL, and (2) the Vermont Household Health Insurance Survey's underinsurance standard.[14] An insurance plan is affordable if a household (1) does not pay more than 9.78% of its income for premiums if its income is equal to or under 600% FPL and 15% if the household's income is above 600% of FPL, and (2)

[11] The incomes are 401% of the 2022 Federal Poverty Limit.
[12] As MVP has not provided plan-level premiums that account for the substantially increased amended rates, we apply the premium as filed increased by the difference between the average individual plan percent increase and the newly amended rate.
[13] GMCB-005-22rr & GMCB-006-22rr, Ex. 31. Assuming an effective federal tax rate of 8.8% and an effective Vermont tax rate of 6.5%, the family would spend roughly 28% of their after-tax household income to pay for MVP's Standard Silver – Reflective (non-HDHP) premium.
[14] GMCB-005-22rr & GMCB-006-22rr, Ex. A. The thresholds used for the income spent on premium reflect the income needed so that a household is not faced with the choice between purchasing health insurance or other basic necessities. We assume that households earning over 600% of FPL can pay 15% of income for premium results rather than the ACA 9.78% threshold. If the metric is biased, it is likely biased in favor of MVP.

the plan has a combined deductible equal to or less than 5% of its pre-tax income, regardless of income.[15]

Using this metric, the 2022 MVP Standard Silver plan[16] is unaffordable to large numbers of Vermonters not income-eligible for Medicaid.[17] Specifically, after accounting for premium subsidies, cost-sharing benefits, and Dr. Dynasaur eligibility, the plan is unaffordable to individuals whose income is between $19,325 and $77,285. It is unaffordable to couples whose income is between $26,134 and $111,149. And it is unaffordable for families whose income is between $39,751 and $152,151.[18] The proposed rate increases will mean that the 2023 MVP Standard Silver plan is unaffordable to even more Vermonters.

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. For instance, the Accommodation and Food Services sector is still down 21% from 2019 levels, a period that covers both before and after the worst days of the pandemic.[19] The Professional and Business Services Supersector, in contrast, grew 2.7% between 2019 and 2021. The growth in this higher-wage sector compared to that of the lower-wage service sector is one example of how the recovery from COVID has been different for different Vermonters.

[15] We assume that households not eligible for premium tax credit (PTC) purchase a reflective silver plan and that households that are income-eligible for PTC receive PTC and purchase an on-Exchange silver plan.
[16] This analysis cannot be done on the proposed 2023 rates as MVP Health Care has not released plan-level premiums that take account of the recent amendment to the filed rates increasing the medical unit costs. As such, the 2023 benchmark plan cannot be determined.
[17] We assume that ARPA-enhanced subsidies did not apply in 2022 but rather pre-ARPA subsidies, to not give a false sense of greater affordability.
[18] The assumed family composition is two adults and two dependent children under 19.
[19] GMCB-005-22rr & GMCB-006-22rr, Ex. 30.

In summary, MVP failed to show any evidence that the rates are affordable. Numerous comments from Vermonters show that the rates are not affordable. In addition, quantitative data from Vermont and federal agencies show that the rates are not affordable.

III. MVP'S PROPOSED RATES FAIL TO PROMOTE ACCESS TO CARE

MVP's proposed rates fail to promote access to care. On cross-examination by the Board, Christopher Pontiff agreed that it was "likely" that MVP's requested rate increases would force some MVP members to "buy down" into lower metal levels and thereby "get lower benefits to keep their same premium level."[20] Mr. Pontiff further agreed that consumers who "buy down" may access less care than they need:

> "But for the – the people who . . . don't have high incomes or are just low income in general, it puts that pressure on them where you feel like you can't go [to the doctor] because you can't [or] don't want to pay for the care you need because you can't afford it."[21]

Rates that force a significant number of people to self-ration care—people who "don't have high incomes or are just low income"—do not promote access to care.

IV. *MVP'S PROPOSED RATES ARE UNJUST, UNFAIR, INEQUITABLE, AND MISLEADING*

The Board must consider whether MVP has proven that the proposed rates are not unjust, unfair, inequitable, or misleading. The rates being proposed by MVP fail this test in at least two significant ways.

Most significantly, days before hearing, MVP further increased its already unprecedently high filed rate increase by an additional 7.1 points to 24.5% in the individual market, and an additional 6.8 points to 23.4% in the small group market. Eleventh hour increases of such scale are the very definition of unjust, unfair, inequitable, and misleading. Vermonters who purchase

[20] Hr'g Tr. at 126, lines 8–12.
[21] Hr'g Tr. at 126, lines 20–25.

their health insurance on the exchange know to tune-in each May to learn how much their insurance costs might increase in the next plan year. Although, as the GMCB website states, the filed rates are subject to change throughout the approval process, Vermonters have come to expect that the approved rate will nearly always be moderately lower than the original, filed rate. This year, Vermonters may be very surprised to see an approved rate that is significantly higher than the filed rate. We ask the Board to disregard the last-minute rate increase and to only consider the rates as originally filed.

Additionally, upon questioning from the Board in executive session, MVP's actuary, Christopher Pontiff, acknowledged [redacted] [22] This description, provided behind closed doors, stands in contrast to Mr. Pontiff's publicly available pre-filed testimony, which touts MVP's ability "to manage costs and contracts to improve affordability . . . . through contract negotiations with doctors, hospitals, and pharmacies."[23] Such contradictory testimony shows that the requested rates are unfair, unjust, inequitable, and misleading.

In summary, MVP has failed to prove that its proposed rates are not unjust, unfair, inequitable, or misleading. As discussed, the rates are unjust, unfair, inequitable, and misleading in the following ways: the rates seek to bake in unprecedentedly high hospital budget increases before a full hearing on those budget requests and Board action; and MVP acknowledges it [redacted]

[22] Exec. Sess. Tr. at 14, lines 21–25, and at 15, lines 1–7.
[23] GMCB-005-22rr & GMCB-006-22rr, Ex. 16 at 11, lines 1–7.

[redacted] despite its public pre-filed testimony to the contrary.

V. MVP'S PROPOSED RATES ARE EXCESSIVE

The Board must consider whether MVP has proven that the proposed rates are not excessive. MVP has failed to meet this burden.

In describing how he prepared the rate filings, MVP's actuary, Christopher Pontiff agreed that actuaries determine a reasonable range of rates and not a single precise rate.[24] Upon further questioning, Mr. Pontiff also agreed that in developing the rate none of the assumptions he made were the only reasonable assumptions an actuary could make.[25] The Board also heard testimony from its own actuary, Jaqueline Lee, about the reasonable range of possible rate assumptions.[26]

What is an actuarially sound rate given the wide range of possibly reasonable rates? Further, how do actuaries pick a rate? The answer to the first question is easy. An actuarially sound rate is a rate that falls within the reasonable range. There is no specific algorithm to determine the range. Rather, actuaries must exercise their professional discretion looking at data in determining what the range is. The second question appears thornier at first glance given the actuarial skill and math needed to arrive at an actuarily reasonable range. However, it is simple. Good actuaries, pick a rate within the reasonable range. They consider the totality of circumstances and make a guess.

The range of reasonable rates is something that actuaries are uniquely qualified to determine. The precise value selected within the reasonable range is, however, something that any person with subject-area expertise can do. The Board's determination of a rate or rate

[24] Hr'g Tr. at 99, lines 21–23.
[25] Hr'g Tr. at 100, lines 21-25.
[26] Hr'g Tr. at 199, lines 6-9.

component within the actuarially reasonable range is just as sound as MVP's guess. In fact, the Board's selection will likely be better than MVP's as it has a full grasp of the totality of circumstances including a clearer understanding of the affordability and access crisis facing Vermont due to cost and the perspective gained by regulating a large percentage of the health care system.

VI. CONCLUSION

MVP has not justified rate increases of 24.5% in the individual market and 23.4% in the small group market. Under Vermont's rate review standards, MVP must prove that the rates are affordable, and they have not done so. The rates also undermine access, are excessive, and are unjust, unfair, inequitable, and misleading, but affordability is the fundamental problem.

MVP essentially asserts that the rates are not excessive and therefore that they are affordable. But vast numbers of Vermonters cannot afford even the 2022 rates. Approving increases of 24.5% and 23.4% will make health insurance even more unaffordable.

It will be difficult, but the Board must significantly trim back these rates. We urge the Board to carefully consider the testimony that there is a range of reasonable rates. With the pressures facing Vermonters, the possibility of triggering a crisis in the market by forcing consumers out of the market due to cost, and the wide latitude given to the Board by the tremendous uncertainty of this year's requested rates: the Board should approve rate changes for MVP that produce the lowest practicable aggregate rates that are within the reasonable range.

Dated at Montpelier, Vermont this 28th Day of July, 2022.

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CERTIFICATE OF SERVICE

I, Eric Schultheis, hereby certify that I have served the above OFFICE OF THE HEALTH CARE ADVOCATE POST-HEARING MEMORANDUM on Michael Barber, Green Mountain Care Board General Counsel; Laura Beliveau, Green Mountain Care Board Staff Attorney; and Gary Karnedy, Ryan Long and Alice McDermott, Primer Piper Eggleston & Cramer PC, representatives of MVP, by electronic mail, return receipt requested, this 28th day of July, 2022.

s/ Eric Schultheis
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