STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.	)	GMCB-007-16rr
2017 Vermont Health Connect Rate Filing	)	
	)	
SERFF No. MVPH-130558905	)	
	)	

DECISION & ORDER

Introduction

In this filing, MVP Health Plan Inc. (MVP) initially proposed an 8.8% average annual rate increase, which it subsequently reduced to 6.3%, for health plans offered on Vermont Health Connect (VHC) with coverage beginning January 1, 2017. Based on our review of the record and the testimony and evidence provided at hearing, we modify the rates as explained below, and then approve the filing.

Background

1. The Patient Protection and Affordable Care Act of 2010 (ACA) requires that individuals and families have qualifying health insurance coverage or pay a penalty on their personal income tax returns. Qualifying coverage includes insurance provided by or through an employer, insurance purchased through the health benefit exchange, or government-sponsored coverage that meets federally mandated minimum levels of coverage.

2. Vermont Health Connect offers qualified health plans (QHPs) on Vermont's health benefit exchange (exchange) to individuals, families and small employers with rates based on a single risk pool that includes the individual and small group markets. 33 V.S.A. §§ 1803, 1811. For plan years 2014 and 2015, a "small employer" was defined as employing up to 50 employees. Beginning in 2016, Vermont law expanded the definition to include employers with 51-100 employees. 33 V.S.A. §1811(a)(3) (defines small employer to include up to 100 employees as of January 1, 2016).

3. Plans are offered to consumers in four "metal levels": bronze, silver, gold, and platinum. In addition to the metal level plans, catastrophic coverage is available primarily to persons under thirty years of age.[1]

4. To make health insurance plans offered on the exchange more affordable for individuals without employer-sponsored insurance, individuals enrolling for coverage through VHC may be eligible for federal premium assistance depending on their household income. *See* 26 U.S.C. § 36B ("Refundable credit for coverage under a qualified health plan"). In addition, Vermont caps the percentage of household income that eligible individuals and families pay for health insurance premiums and offers subsidies for lower deductibles and copayments.

5. The ACA includes three risk spreading programs with mechanisms intended to stabilize costs and provide incentives for insurers to participate in the exchanges. The transitional reinsurance program, funded through fees levied on health insurance plans, ends with the 2016 plan year, as does the risk corridor program.

6. The third risk spreading program is permanent, and applies to ACA-compliant plans in both the individual and small group markets. Under the risk adjustment program, insurers with an enrolled population with lower than average actuarial risk will provide payments to insurers that have an enrolled population with higher than average actuarial risk. The program is intended to reduce incentives for insurers to structure plan offerings to make them most attractive to a healthy, low risk population, while unattractive to a less healthy population more in need of insurance services.[2]

Procedural History

7. On May 11, 2016, MVP filed its 2017 Vermont Health Connect Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The SERFF filing outlines the development of proposed exchange rates for coverage commencing January 1, 2017. *See* Exhibit 1.[3]

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[1] Catastrophic coverage is characterized by low premiums and high deductibles. Individuals enrolled in catastrophic plans do not qualify for income-based subsidies.

[2] Additional information is available about the three risk spreading programs at https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8544-explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors1.pdf.

[3] The exhibits referred to in this decision were stipulated to by the parties. All exhibits, documents, hearing transcript and public comments referenced in this Decision and Order are available at http://ratereview.vermont.gov/MVPH-130558905.

8. On May 20, 2016, the Office of Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of consumers of Vermont health care, entered a Notice of Appearance as an interested party to our review of this filing.

9. On July 8, 2016, the Vermont Department of Financial Regulation (DFR) issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency. Noting that MVP's Vermont operations accounted for only 3.7% of its total written premiums, DFR opined that the rates as proposed would not materially impact the company's solvency. Exhibit 8 at 2. DFR stated that its opinion assumed and was contingent upon the Board's actuary finding that the proposed rates were not inadequate. *Id*.

10. The Board's actuary, Lewis & Ellis (L&E), conducted an actuarial review of the filing and on July 11, 2016 issued a memorandum summarizing its analysis and recommendations for modification. Exhibit 9.

11. On July 13, 2016, MVP submitted a letter amending its proposed average annual rate increase by lowering it from 8.8% to 6.3%. Exhibit 11.

12. The Board held a public administrative hearing on July 21, 2016. Noel Hudson, Esq. served as hearing officer by designation of Board chair Al Gobeille. Gary F. Karnedy, Esq. of Primmer Piper Eggleston & Cramer PC represented MVP and presented testimony from MVP's Associate Director of Actuarial Services, Matthew Lombardo. Kaili Kuiper, Esq. appeared for the HCA. Ryan Chieffo, Esq., DFR Assistant Director of Rates and Forms, testified regarding DFR's solvency analysis and opinion. Judith Henkin, Esq. General Counsel, represented the Board and conducted the examination of L&E actuary Jacqueline Lee.

13. The Board accepted public comments on the proposed rates from May 11, 2016 through July 26, 2016.[4] The Board received 133 written comments referencing both MVP's and Blue Cross Blue Shield of Vermont's (BCBSVT)'s filings for health plans offered on VHC, five specifically addressed MVP's proposed increase. Two individuals offered spoken comments at the public hearing. The comments overwhelmingly address the issue of affordability for Vermonters and oppose any increase in premium rates.

[4] Although the deadline for accepting comment expired on July 26, 2016, additional comments were received and reviewed by the Board subsequent to that date.

Findings of Fact

Nature of the Filing

1. MVP Health Plan, Inc. is a non-profit health insurer domiciled in New York State and licensed as a health maintenance organization (HMO) in New York and Vermont. The company is a subsidiary of MVP Health Care, Inc., a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries. The company offers HMO products to individuals and employers in the small and large group markets in Vermont. Exhibit 1 at 19.

2. The rates in this filing will be used for MVP's plan offerings through Vermont Health Connect with coverage beginning January 1, 2017. *Id*.

3. There are 2,987 policyholders, 4,354 subscribers, and 6,614 covered lives affected by this filing. *Id*.

Summary of the Data, Analysis, and Testimony Presented at Hearing

4. To form a credible experience base for projecting its 2017 VHC rates, MVP used 2015 combined experience claims data from its non-ACA compliant and its ACA-compliant individual and small group books of business, and groups with 51-100 members. MVP adjusted the claims data to reflect cost-sharing reductions, incurred but not reported paid claims (IBNR), and pharmacy rebates, and replaced high cost claims with a pooling charge. Exhibit 1 at 20-21.

5. MVP also adjusted the claims data to account for average policy duration and the claims-suppressing effect of deductibles, differing benefits in non-ACA compliant and ACA compliant plans, and Vermont's prescription drug out-of-pocket (OOP) maximum.[5] *Id*. at 21-23.

6. MVP projected the experience period claims forward to the rating period using an average annual allowed medical trend factor[6] of 2.5% and an annual allowed pharmacy trend of 11.6%. *Id*. at 23-24.

7. MVP projected no growth in administrative expenses for this block of business and proposes an administrative expense figure of $36.60 per member per month (PMPM), unchanged from 2016. The company also proposed a 1.0% contribution to reserves (CTR). *Id*. at 26-27.

[5] Section 4089i(c) of Title 8 limits the amount an insured will pay out-of-pocket for prescription drugs, including specialty drugs.

[6] In basic terms, trend refers to the change in the cost of health care and consists of utilization (frequency of use of the product or service) and unit cost.

8. In the actuarial memorandum submitted with its filing, MVP assumed a payment into the federal risk adjustment program of $29.42 per member per month (PMPM). MVP stated that it did not expect a material change in the enrollment in its ACA-compliant plans or a change in its exchange plan risk scores. Additionally, MVP noted that 2014 risk adjustment data was heavily skewed by the state's extension of the open-enrollment period into May of 2014. In light of these circumstances, MVP estimated that its risk adjustment payment would be approximately two-thirds of its 2014 payment of $44.58 PMPM. *Id*. at 25.

9. On review, L&E recommends two modifications to the filing. L&E first recommends that MVP correct an inadvertent error in its rate calculation, which would reduce the proposed rate by approximately 0.5%. Exhibit. 9. MVP does not contest this modification. Exhibit 11 at 1.

10. Second, L&E recommends reducing the projected risk adjustment payment from $29.42 to $9.75, resulting in an approximate 4.2% decrease in the proposed rate change. In formulating its recommendation, L&E relied on final 2015 risk adjustment data released on June 30, 2016, by the Centers for Medicare & Medicaid Services (CMS), and which was unavailable to MVP when it developed its rates. In addition, because L&E had access to confidential data relative to both Vermont insurers offering plans on the exchange, L&E's calculation included plan-level detail that was not available to MVP. Exhibit 9 at 7-8; TR at 80-90, 94-107.

11. After first declining to revise its risk adjustment projection based on the final CMS report, TR at 82, MVP revised its calculation and proposed a 1.8% reduction in the proposed rate. Exhibit 11 at 2. With a small market share and volatile risk scores, MVP assigned twice the credibility to its 2015 data than to its 2014 data (two-thirds and one-third, respectively). *Id*.

12. At hearing, the Board heard extensive testimony concerning the methodologies used to calculate the projected risk adjustment payment. Matthew Lombardo, MVP's actuary, acknowledged that MVP had declined to use 2014 data for its 2016 filing because, among other reasons, the 2014 data did not represent full year claims data, did not incorporate small group expansion, and the small percentage of MVP members enrolled in plans subject to the risk adjustment program would skew the results, TR at 45-46. Lombardo noted several times in his testimony that MVP's revised 2017 rate proposal was sound because it relied on two data points, 2014 and 2015, rather than giving full credibility to 2015 data. TR at 49, 56.

13. L&E's actuary, Jacqueline Lee, testified that L&E's risk adjustment calculation incorporated MVP's 2015 data, in addition to its actual and projected data for 2016 and 2017, and confidential plan-level data relating to BCBSVT'S risk adjustment calculation. MVP did not have access to BCBSVT's data, and instead made assumptions concerning its risk scores. Lee testified that L&E's calculation omitted the 2014 data because it was not reliable, had not been used in L&E's calculation of MVP's 2016 risk adjustment payment, and that L&E would not use the 2014 data to calculate the risk adjustment going forward. Lee testified that L&E's methodology employed more current MVP data and confidential data not accessible to MVP, and therefore resulted in a more precise risk adjustment projection. TR at 80-90; 94-107.

14. In its post-hearing memorandum, MVP contends that L&E's recommendation cannot be relied on by the Board because it was informed by confidential data to which MVP did not have access, and which was not entered into evidence.

15. The HCA submitted a post-hearing memorandum arguing that the Board should adopt L&E's recommendation because it is actuarially sound and makes health insurance rates more affordable for Vermonters.

Standard of Review

1. Vermont law provides that the Board shall review health insurance rate filings to ensure that rates are affordable, that they are not "excessive, inadequate or unfairly discriminatory," that they promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. §§ 4512(b); 4062(a)(2), (3); GMCB Rule 2.000, *Rate Review*, §§ 2.301(b), 2.401. In addition, the Board 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).

2. As part of its review, the Board will consider the Department's analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2), (3). The Board shall also consider any public comments received on a rate filing. Rule 2.000, § 2.201.

3. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id*. § 2.104(c).

Conclusions of Law

As an initial matter, MVP agrees that its rate development contained an error in calculation, as discussed in Findings of Fact (Findings) ¶ 11. Once modified as recommended by L&E, the change will produce an approximate 0.5% decrease in the rate.

Turning to the only contested issue, we conclude that MVP has not met its burden to prove that its risk adjustment calculation is either accurate or supported by the credible evidence. Although MVP argues that L&E utilizes less of the available credible data than does MVP in its calculation, the testimony clearly shows the opposite. Witness Lee testified that L&E incorporated 2015 data, actual and projected 2016 and 2017 data, and confidential plan-level BCBSVT data in its calculation. Findings ¶ ¶ 12, 15. In contrast, MVP incorporated only 2014 data which it previously characterized as unreliable, a view shared by L&E, and the same 2015 data used in L&E's calculation. Finding ¶ 14. Moreover, the 2014 data was not used in the prior year's calculation due to its unreliability, and L&E does not believe it should be used going forward, given its consistent absence in prior years. Findings ¶¶ 14, 15.The evidence shows that L&E's calculation was not based on less data and in fact was based on more reliable, current data that accurately reflects the increased stability in the marketplace.

MVP further contends that because L&E incorporated confidential information in its risk assessment calculations that was neither entered into evidence nor provided to MVP, there is no foundation for Ms. Lee's testimony that L&E's calculation was more precise. *See* MVP *Post-Hearing Memorandum* at 8-9. We find this argument without merit. Actuary Lee testified about her education, professional credentials and experience as an actuary, her experience working on rate filings for this Board and on Exchange filings in other venues, her knowledge of the risk adjustment program and how L&E was able to incorporate reliable information unavailable to MVP into its risk adjustment calculation, and to the extent of data used to determine an estimate of the risk adjustment transfer payment. Finding ¶ 12; TR 80-90. Use of BCBSVT's confidential, detailed information allowed L&E to more accurately calculate the risk adjustment payment, and effectively test the assumptions used by MVP's actuary. Accordingly, we conclude that there is ample foundational support for L&E's calculation, and that the calculation is more precise than the one produced by MVP.

MVP further contends that BCBSVT's confidential information cannot be used to support L&E's calculation unless it is entered into evidence or examined for its reliability. As a

threshold matter, MVP did not request to view the data *in camera*, obtain a protective order, or question the data's reliability prior to or during the hearing, remedies it now suggests should have been provided. *See* MVP Post-Hearing Memorandum at 9. By failing to timely raise any objection to the data's reliability, the Board had no opportunity to rule on whether a remedy was appropriate. MVP has therefore waived the objection.

In addition, the Board is required to keep information deemed confidential outside of the public record. *See* GMCB Rule 2.000, § 2.403(b) ("The public record shall exclude any information that is determined by the Board to be confidential or is otherwise subject to protection from disclosure by law."); 1 V.S.A. § 317(c)(9) (Board must keep "confidential . . . [certain] business records or information"). Keeping an insurance carrier's confidential and important formulae and records from inspection and review by its competitors strikes to the heart of the Public Records Act's exemption for materials that constitute "trade secrets." *See* 1 V.S.A. § 317(c). In addition to violating Vermont law and the Board's rule, entering such information into evidence defeats the point of confidentiality. Indeed, MVP also requested confidentiality—a request the Board honored—for its own plan-level risk score information during this review.

Even if the risk score information was not confidential, MVP did not timely object to the witness's testimony at the time of the hearing. Objections to a witness's testimony or other evidence must be timely. 3 V.S.A. § 810(1) ("The Rules of Evidence as applied in civil cases in the Superior Courts of this State shall be followed."); *see also* V.R.E. 103(a)(1) (objections to evidence must be "timely"). MVP's failure to offer timely, specific objections to the testimony waived its right to offer objections.

We also conclude that MVP's argument regarding market competition fails on its own terms. MVP argues that because of its role in a competitive Vermont marketplace, the Board should not reduce MVP's rate while raising rates for BCBSVT. *See* MVP *Post-Hearing Memorandum* at 9-10. The Board's role is not to maintain equal rates, or equivalent rate changes, as a matter of principle regardless of their adherence to statutory requirements. We further disagree with MVP's contention that the rates are "unfairly discriminatory"; the phrase is a term of art which refers to disparate treatment of insureds based on status (for example, gender or income).

Last, we note that MVP's comment that the Board should "infer that [the HCA's actuary's] 'empty chair,' meant that she could not support L&E's recommendation on the 2017

risk adjustment," is entirely speculative and without merit. The risk adjustment is fully supported by credible evidence in the record, and the inference is neither appropriate nor warranted by the record.

Order

Based on the reasons discussed above, the Board modifies MVP's 2016 Vermont Health Connect Rate Filing, and then approves the filing. Specifically, we order that MVP adopt the calculation of the weighted average of its AV normalization and induced utilization factors, and reduce its projected risk adjustment payment from $29.42 PMPM to $9.75 PMPM, as calculated by L&E.

As modified, the average annual rate increase is reduced from the proposed 8.8% to approximately 3.7%.

SO ORDERED.

Dated: August 9, 2016
Montpelier, Vermont

s/ Alfred Gobeille)
)
s/ Cornelius Hogan) GREEN MOUNTAIN
) CARE BOARD
s/ Jessica Holmes) OF VERMONT
)
s/ Betty Rambur)

s/ Allan Ramsay)

Filed: August 9, 2016
Attest: s/ Janet Richard
Green Mountain Care Board
Administrative Services Coordinator

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: Janet.Richard@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.