

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.)	GMCB-004-23rr
2024 Individual Market Rate Filing)	
)	SERFF No. MVPH-133660955
)	
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In re: MVP Health Plan, Inc.)	GMCB-005-23rr
2024 Small Group Market Rate Filing)	
)	SERFF No.: MVPH-133660956

DECISION AND ORDER

Introduction

MVP Health Plan, Inc. (MVP), one of two carriers offering individual and small group health insurance coverage in Vermont, seeks to increase its premiums in 2024 by an average of 15.0% for its individual plans and an average of 15.4% for its small group plans.¹ Based on our review of the record, including the testimony and evidence presented at a hearing on July 17, 2023, we modify the proposed rates and then approve the filings. As modified, we expect premiums to increase, on average, approximately 11.4% for individual plans and 11.5% for small group plans.

Procedural History

1. On May 9, 2023, MVP filed its 2024 individual and small group rate filings with the Board using the System for Electronic Rate and Form Filing (SERFF). *See* Exhibit (Ex.) 1, 1; Ex. 2, 1.
2. On May 12, 2023, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care and health insurance, appeared as an interested party to the proceedings. *See* HCA Notices of Appearance; 8 V.S.A. §§ 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule 2.000, §§ 2.105(b), 2.303.
3. From May 16 through June 29, 2023, MVP responded to a series of interrogatories issued by the Board and its contracted actuaries at Lewis & Ellis, Inc. (L&E). *See* Exs. 3 – 16. The interrogatories included questions suggested by the HCA. *See* Ex. 12.
4. L&E reviewed the filings on behalf of the Board and issued actuarial reports on July 5, 2023, in which it summarized its review and recommended adjustments to the filings. Exs. 21 – 22. That same day, L&E provided the Board with information it had requested regarding historical premium changes for certain plans offered by MVP. Ex. 20. Also on July 5, 2023, the

¹ At the time of the initial filings, the average proposed rate increases were 12.8% for individual plans and 12.5% for small group plans. Ex. 21, 2; Ex. 22, 2.

Vermont Department of Financial Regulation (DFR) issued opinions regarding the impact of the filings on MVP's solvency. Exs. 18 – 19.

5. Vermont hospitals submitted their proposed fiscal year 2024 (FY 2024) budgets to the Board in early July 2023. On July 13, 2023, MVP responded to interrogatories from L&E regarding the impact of the hospital budget submissions on the proposed rates. Exs. 47 – 48.

6. The Board held a hearing on the filings on July 17, 2023. The hearing was held remotely. Members of the public were able to attend the hearing using Microsoft Teams® or their phone. The Board's General Counsel, Michael Barber, served as hearing officer by designation of Board Chair Owen Foster. MVP was represented by Gary Karnedy and Ryan Long from the law firm of Primmer Piper Eggleston & Cramer PC. The HCA was represented by HCA staff attorneys Eric Schultheis and Charles Becker. At the hearing, the Board heard testimony from Christopher Pontiff, Senior Director, Commercial Pricing, Network and Trend Actuary at MVP; Michael Fisher, Chief Health Care Advocate and Director of the Vermont Office of the Health Care Advocate; Jesse Lussier, Administrative Insurance Examiner at DFR; and Jacqueline (Jackie) Lee, Vice President & Principal Consulting Actuary at L&E. *See* Hearing Transcript (Tr.).

7. On July 24, 2023, MVP responded to an interrogatory regarding one of L&E's recommended modifications to the individual filing. MVP Response to 2024 Ind. Exchange Objection Letter #10. The Board also held a public comment forum that day to hear from the public on the 2024 individual and small group rate filings of MVP and Blue Cross and Blue Shield of Vermont (BCBSVT). *See* Public Comment Forum Tr.

8. Just before midnight on July 24, 2023, the Board closed a special comment period that it had opened on May 10, 2023, regarding the 2024 individual and small group rate filings. The Board received approximately 147 comments during the public comment period. *See* Compilation of 2024 Vermont Individual and Small Group Rate Filing Comments.

9. On July 27, 2023, MVP responded to interrogatories from L&E regarding the impact of hospital budget submissions. MVP Response to 2024 Ind. Exchange Objection Letter #11; MVP Response to 2024 SG Exchange Objection Letter #11. MVP also responded to post-hearing questions from the Board. MVP Responses to Post-Hearing Board Questions.

10. On July 28, 2023, the HCA and MVP filed post-hearing memorandums pursuant to GVCB Rule 2.000, § 2.307(g). HCA Post-Hearing Memorandum; MVP Post-Hearing Memorandum.

Findings of Fact

11. MVP is a non-profit health insurer domiciled in New York State. MVP is licensed as a health maintenance organization (HMO) in Vermont and New York and is a subsidiary of MVP Health Care, Inc., a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries. *See* Ex. 1, 2; Ex. 2, 2; Ex. 25, 49.

12. MVP's filings outline the development of premiums or "rates" for health benefit plans that MVP will offer to individuals and small employers for calendar year 2024 coverage.

The plans will be available either through Vermont Health Connect (VHC or the “Exchange”) or directly from MVP. *See* Ex. 1, 11; Ex. 2, 11.

13. Premiums for MVP’s individual and small group plans increased significantly last year. While the Board ordered MVP to reduce its proposed 2023 premiums by approximately 5.1% in each filing, the final approved rates were, on average, 19.3% higher in the individual market and 18.3% higher in the small group market than 2022 premiums. Ex. 21, 2; Ex. 22, 2; *In re MVP Health Plan, Inc. 2023 Individual and Small Group Market Rate Filings*, GMCB-005-22rr & GMCB-006-22rr, Decision and Order (Aug. 4, 2022), 1.

14. As of February 2023, there were 11,602 members enrolled in MVP’s individual plans and 16,262 members enrolled in MVP’s small group plans. MVP’s membership in these markets declined from 2022 to 2023; MVP’s individual membership fell 22.8%, from 15,026 to 11,602, and MVP’s small group membership fell 22.2%, from 20,900 to 16,262. Ex. 21, 1; Ex. 22, 1. High premium increases were likely a significant driver of these membership declines. *See* Testimony of Christopher Pontiff, Hearing Tr. 172:24 – 25.

15. Plans in Vermont’s individual and small group markets are offered in bronze, silver, gold, and platinum metal levels. “Catastrophic” coverage is also available to certain individuals.² Each metal level corresponds to an “actuarial value” (AV), which reflects the percentage of claims for essential health benefits that an insurer expects to cover, on average. Bronze plans have the lowest AV and the least generous coverage, while platinum plans, with the highest AV, have the most generous coverage. *See* 42 U.S.C. § 18022(d) – (e); Ex. 1, 75; Ex. 2, 73.

16. In its individual filing, MVP initially sought approval of premiums that were 12.8% or \$101.39 per member per month (PMPM) higher than 2023 premiums. Ex. 22, 2. In its small group filing, MVP initially sought approval of premiums that were 12.5% or \$84.82 PMPM higher than 2023 premiums. Ex. 21, 2. These figures represent averages across multiple plans. Proposed rate increases for specific plans ranged from 7.7% to 15.5% in the individual filing and from 8.4% to 15.2% in the small group filing. Ex. 1, 5; Ex. 2, 5.

17. During the Board’s review of the filings, MVP sought to increase the proposed premiums in response to Vermont hospitals’ 2024 budget requests, as well as certain recommendations made by L&E in its July 5, 2023, reports. As a result, MVP is now asking the Board to approve 2024 rate increases that average 15.0% or \$118.98 PMPM in the individual market and 15.4% or \$104.42 PMPM in the small group market.³ Ex. 49; Testimony of Christopher Pontiff, Hearing Tr., 79:8 – 12; Ex. 21, 1; Ex. 22, 2.

² Catastrophic coverage is characterized by low premiums and high deductibles. *See* 42 U.S.C. § 18022(e).

³ MVP provides two sets of numbers; it says it is requesting average increases of 13.81% for individual plans and 14.29% for small group plans “if the Board orders the same 17% reduction on hospital budget as it ordered in the August 4, 2022 Vermont Exchange Rate Filing Decision and Order” and it also says that “[i]f the Board does not reduce Hospital Budgets this year, then MVP’s average requested rate increase is 14.98% for IM and 15.39% for SG.” MVP Post-Hearing Memorandum, 1, 9; *see also* Testimony of Christopher Pontiff, Hearing Tr. 79:13 – 17 (same). The Board’s decisions on hospital budgets, like many factors impacting the filing, cannot be known at this time. MVP cannot condition its request on how this assumption, or any assumption, ultimately turns out. While the parties cite the lower set of numbers, we use the higher numbers in this decision.

18. Each plan has its own cost sharing rules (e.g., deductibles, copays, and coinsurance). Within certain limits, these rules require members to pay out of their own pockets for costs covered by the plan. In general, cost sharing increases every year. This year is no exception. *See* Ex. 1, 146; Ex. 2, 144.

19. If MVP's filings are approved without modification, its rates will have cumulatively increased 125% in the individual market and 100% in the small group market since 2014. Rate increases for these plans far outpaced real GDP and real wage growth in Vermont from 2014 – 2022. The proposed rates would only accelerate this trend. *See* HCA Post-Hearing Memorandum, 5; Exs. 27 – 30, 39, 49; *In re MVP Health Plan, Inc. 2023 Individual and Small Group Market Rate Filings*, GMCB-005-22rr & GMCB-006-22rr, Decision and Order; *In re MVP Health Plan, Inc. 2022 Individual and Small Group Market Rate Filings*, GMCB-007-21rr & GMCB-008-21rr, Decision and Order; *In re MVP Health Plan, Inc. 2021 Individual and Small Group Market Rate Filing*, GMCB-006-20rr; Decision and Order; *In re MVP Health Plan, Inc. 2020 Individual and Small Group Market Rate Filing*, GMCB-005-19rr, Decision and Order; *In re MVP Health Plan, Inc. 2019 Individual and Small Group Market Rate Filing*, GMCB-008-18rr, Decision and Order; *In re MVP Health Plan, Inc. 2018 Vermont Health Connect Rate Filing*, GMCB-007-17rr, Decision and Order; GMCB-007-16rr, Decision and Order; *In re MVP Health Plan, Inc. 2017 Vermont Health Connect Rate Filing*, GMCB-007-15rr, Decision and Order; *In re MVP Health Plan, Inc. 2016 Vermont Health Connect Rate Filing*, GMCB-007-15-rr; *In re MVP Health Plan, Inc. 2015 Vermont Health Connect Rate Filing*, GMCB-017-14rr, Decision and Order.

20. The Consumer Price Index for All Urban Consumers (CPI-U): All Items in Northeast, grew by approximately 7.0% between January 2021 and January 2022. *See* Ex. 30.

21. Those who purchase one of MVP's individual plans through VHC may be eligible for subsidies that help lower premiums, cost sharing, or both. Premium subsidies take the form of federally funded premium tax credits (PTC), as well as supplemental state funded premium assistance. *See* 26 U.S.C. § 36B; 33 V.S.A. § 1812(a). Cost sharing subsidies take the form of federally mandated but “unfunded” cost sharing reductions, as well as supplemental state funded cost-sharing assistance. *See* 42 U.S.C. § 18071; 33 V.S.A. § 1812(b). Subsidies are not available for most employees of small employers, or for people who enroll in an individual plan directly with MVP, instead of through VHC. *See* Testimony of Christopher Pontiff, Hearing Tr. 100:14 – 20; 26 C.F.R. § 1.36B-2(a)(1). As of February 2023, approximately 3.6% of MVP's members in the individual market – just over 400 people – were directly enrolled with MVP. *See* Ex. 21, 2.

22. The PTC is typically paid directly by the federal government to an insurer to lower an eligible individual's monthly premium.⁴ The PTC covers the difference between the premium for the second lowest cost silver plan in the market – referred to as the “benchmark plan” – and a specified percentage of an individual's household income (the “required contribution”). The required contribution varies with income such that individuals with lower incomes are eligible for

⁴ When paid in this way, the credit is referred to as an advanced premium tax credit (APTC). Eligible taxpayers can also pay the full monthly premium and claim the PTC when they file their tax returns.

a larger credit than individuals with higher incomes. While the PTC is calculated by reference to the second lowest cost silver plan in the market, it can be used to purchase a plan at any metal level. *See generally*, Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Subsidies* (Oct. 27, 2022).⁵

23. In 2021, the American Rescue Plan Act (ARPA) made significant enhancements to the PTC. *See* 26 U.S.C. § 36B(c)(1)(A). For individuals already eligible for the PTC, ARPA increased the size of the credit they could receive by reducing their required contribution. ARPA also expanded eligibility for the PTC to individuals with household incomes above 400% of the federal poverty level (FPL). 26 U.S.C. § 36B(c)(1)(E). ARPA’s enhancements to the PTC were extended through 2025 by the Inflation Reduction Act of 2022. *See* Pub.L. 117-169, Sec. 12001. Unless these enhancements are extended again or made permanent, the “cliff” that existed at 400% FPL prior to ARPA will return in 2026. *See* Testimony of Christopher Pontiff, Hearing Tr. 101:3.

24. Federal law requires carriers to offer cost sharing assistance to members with household incomes between 100% and 250% FPL. *See* 45 C.F.R. §§ 155.305(g)(2)(i) – (iii). These cost-sharing reductions (CSRs) take the form of different plan designs at the silver metal level (CSR variants) – plan designs that have lower member cost-sharing and higher AVs than a base silver plan.⁶ *See* 45 C.F.R. § 156.420; Ex. 1, 75; Ex. 2, 73. The federal government used to reimburse carriers directly for the cost of providing CSRs. In October 2017, however, the Trump Administration announced that it would stop making these payments, notwithstanding carriers’ continued obligation to provide CSRs to eligible individuals. Carriers responded by building the cost of CSRs (CSR loads) into their premiums. In most states, including Vermont, CSR loads were applied to on-Exchange silver plans only, a practice known as “silver loading.” *See* 33 V.S.A. § 1813; Ex. 1, 77; Ex. 2, 75. Because the PTC is calculated using the second lowest cost silver plan in the market, silver loading had the effect of increasing PTC for eligible individuals. In connection with silver loading, carriers also began to offer “reflective silver” plans directly to individuals (i.e., “off-Exchange”). These plans are almost identical to “on-Exchange” silver plans, except their premiums are lower because they do not include the additional cost of the CSR benefit. *See* 33 V.S.A. § 1813(a)(1); Ex. 1, 77 – 78; Ex. 2, 75 – 76.

25. Earlier this year, after consulting with L&E, MVP, BCBSVT, and the HCA, the Board adopted guidance on an aspect of carriers’ CSR load calculations. The Board’s policy was intended to ensure compliance with rating rules and to prevent insurers from calculating CSR loads based on the characteristics of individuals expected to enroll in CSR plans. *See* Green Mountain Care Board Guidance on Silver Loading (eff. March 15, 2023).⁷ The anticipated impact of the guidance, however, was a larger increase in the premiums of silver plans in relation to other plans, and an increase in PTC. *See* L&E Presentation to the Green Mountain Care Board, *Cost Sharing Reductions and Silver Loads* (Mar. 8, 2023), 9. While the guidance only addressed one aspect of

⁵<https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/>

⁶ CSR variants have AVs of around 94%, 87%, 77% (Vermont specific), and 73%. In contrast, a base silver plan has an AV of around 70%.

⁷ <https://ratereview.vermont.gov/sites/dfr/files/documents/Guidance%20on%20Silver%20Loading.pdf>.

CSR load calculations, the Board anticipated reviewing other aspects through the rate review process. *See* Recording of Mar. 15, 2023, Green Mountain Care Board Meeting, 3:57 – 5:05.⁸

26. L&E reviewed MVP’s 2024 individual and small group filings to assist the Board in determining whether to approve, modify, or disapprove the proposed rates. *See* Ex. 21, 1; Ex. 22, 1. L&E’s review focused on whether the proposed rates are “excessive, inadequate, and unfairly discriminatory,” specifically from an actuarial perspective. Ex. 24, 4. These terms have definitions that are included in Actuarial Standard of Practice (ASOP) No. 8. L&E bases its evaluation of a filing on these actuarial standards and, if necessary, recommends that the Board adjust the filing to meet the standards. *See* Ex. 24, 4. L&E does not review a filing to determine whether the proposed rates are affordable or promote access or quality. *See* Testimony of Jackie Lee, Hearing Tr. 220:24 – 221:2.

27. One of the major drivers of MVP’s proposed rate increases is a projected increase in claims costs (referred to as “trend”) from 2023 to 2024. MVP initially proposed a 2024/2023 total allowed trend of 6.1% in each filing. In the individual filing, the total allowed trend was comprised of an allowed medical trend of 5.7% and an allowed pharmacy trend of 8.7%. In the small group filing, the total allowed trend was comprised of an allowed medical trend of 5.8% and an allowed pharmacy trend of 8.7%. *See* Ex. 21, 4 - 5; Ex. 22, 4 - 5.

28. The allowed medical and pharmacy trends reflect projected changes in the utilization (utilization trends) and price (unit cost trends) of medical services and pharmaceuticals. *See* Ex. 21, 5; Ex. 22, 5.

29. In developing its medical utilization trends, MVP ran simulations that produced a wide range of forecasted trends, with a 10th percentile of -1.2%, a mean of 1.2%, and a 90th percentile of 3.5%. Because the simulations produced a wide range of trends, MVP assumed a medical utilization trend of 1.0% in each filing, which is consistent with the last several approved rate filings. L&E reviewed MVP’s monthly normalized allowed medical claims cost PMPM data and concluded that an annual medical utilization trend of 1.0% is reasonable. Ex. 21, 6; Ex. 22, 6.

30. MVP’s medical unit cost trend was 4.6% in the individual filing and 4.7% in the small group filing. These trends were significantly impacted by assumptions about the outcome of the Board’s hospital budget review process, which does not conclude until the beginning of October. 18 V.S.A. § 9456(d)(1). The facilities and providers impacted by the Board’s hospital budget review process account for more than half of the allowed medical costs in each filing. Facilities and providers not regulated by the Board also contribute to the medical unit cost trends in these filings. *See* Ex. 21, 5; Ex. 22, 5; Testimony of Jackie Lee, Hearing Tr. 274:25 – 275:10.

31. As part of the hospital budget review process, the Board has authority to limit the amount that Vermont hospitals can raise their charges or rates. In its filings, MVP initially assumed that the hospital rate increases the Board will allow for FY 2024⁹ will be comparable to the hospital

⁸ <https://www.orcamedia.net/show/march-15-2023-gmcb>.

⁹ Hospital fiscal years run from October through September. Thus, the Board’s FY 2024 budget approvals will only impact the first 9 months of calendar year 2024 and MVP implicitly assumed that FY 2025 budget approvals will mirror FY 2024 approvals.

rate increases the Board allowed for FY 2022. This assumption produced a medical unit cost trend for Board-regulated facilities and providers of 5.1% in the individual filing and 5.2% in the small group filing. MVP's medical unit cost trend for other facilities and providers was 3.8% in the individual filing and 4.0% in the small group filing. L&E concluded that MVP's unit cost trend for Board-regulated facilities and providers was reasonable but recommended that once Vermont hospitals submit their 2024 budgets, this new information be considered. *See* Ex. 21, 6; Ex. 22, 6.

32. In last year's individual and small group filings, the Board ordered MVP to assume a 17% reduction in hospitals' proposed FY 2023 rates. This was the average percentage reduction mandated by the Board over the past five years, which the Board calculated based on an analysis performed by L&E. *In re MVP Health Plan, Inc. 2023 Individual and Small Group Market Rate Filings*, GMCB-005-22rr & GMCB-006-22rr, Decision and Order (Aug. 4, 2022), 18 - 19.

33. Vermont hospitals submitted their FY 2024 budgets to the Board in early July 2023. MVP calculated that replacing its initial assumption regarding rate increases for Board-regulated facilities and providers with this new assumption would result in an increase of 3.4% to the individual premiums and an increase of 3.2% to the small group premiums. Ex. 47, 1; Ex. 48, 1. However, MVP was not confident in these calculations. For the FY 2024 budget cycle, the Board changed the forms that hospitals are required to complete. As a result, MVP had difficulty understanding hospitals' rate assumptions. *See* Ex. 47, 1; Ex. 48, 1; Testimony of Christopher Pontiff, Hearing Tr. 79:18 – 80:7.

34. On July 26, 2023, L&E provided MVP with a table that reflected the Board staff's understanding of hospitals' FY 2024 rate requests. MVP calculated that using these numbers would result in rate increases in each filing that are approximately 0.4% lower than MVP initially projected based on its own analysis of hospital budget submissions. *See* MVP Response to 2024 Ind. VT Exchange Objection #11; MVP Response to 2024 SG VT Exchange Objection #11.

35. The rate increases proposed by Vermont hospitals for FY 2024 significantly exceed the increases MVP expects for facilities and providers not regulated by the Board. For example, using the hospital budgets as filed, MVP's 2024/2023 inpatient unit cost trend for Board-regulated hospitals would be 11.0% in the individual filing and 11.2% in the small group filing. The same trend for hospitals not regulated by the Board is projected to be 6.8% in the individual filing and 6.7% in the small group filing. Similarly, MVP's 2024/2023 outpatient unit cost trend for Board-regulated hospitals would be 10.2% in the individual filing and 10.7% in the small group filing using the hospital budgets as filed. The same trend for hospitals not regulated by the Board is projected to be 5.4% in the individual filing and 5.7% in the small group filing. *See* REDACTED Support for 2024 INDV Objection #11; REDACTED Support for 2024 SG Objection #11. A similar dynamic exists with respect to MVP's unit cost trends for physician services. *See* CONFIDENTIAL Support for 2024 INDV Objection #11; CONFIDENTIAL Support for 2024 SG Objection #11.

36. Board-regulated hospitals received significantly higher increases from MVP last year than hospitals not regulated by the Board. MVP's 2023/2022 inpatient unit cost trend for Board-regulated hospitals was 15.6% in the individual filing and 15.4% in the small group filing.

The same trend for hospitals not regulated by the Board was 6.7% in the individual filing and 6.8% in the small group filing. Similarly, MVP's 2023/2022 outpatient unit cost trend for Board-regulated hospitals was 14.3% in the individual filing and 14.4% in the small group filing. The same trend for hospitals not regulated by the Board was approximately 5.4% in each filing. *See* REDACTED Support for 2024 INDV Objection #11; REDACTED Support for 2024 SG Objection #11. Again, a similar dynamic exists with respect to MVP's unit cost trends for physician services. *See* CONFIDENTIAL Support for 2024 INDV Objection #11; CONFIDENTIAL Support for 2024 SG Objection #11.

37. The Board's approach to hospital budget review will be different this year than it has been in prior years. Earlier this spring, the Board chose to maintain a two-year growth target for net patient revenue and fixed prospective payments (NPR/FPP). The target was set at 8.6% over hospitals' actual FY 2022 NPR/FPP and, because of the size of budget approvals last year, many hospitals' FY 2024 budgets do not meet this target. The Board will be scrutinizing these hospitals' budgets based on a variety of new factors and external benchmarks, many of which were recommended to the Board by economists who frequently work with the State of Vermont. *See* Economic and Policy Resources, Inc. and Kavet, Rockler & Associates, LLC, Initial Economic Analysis and Summary Consensus Recommendations Associated with Green Mountain Care Board Budgetary Review Process (Aug. 22, 2022).¹⁰ For example, growth in salary and benefits, a significant component of hospital expenses, will be compared to information from the U.S. Bureau of Labor Statistics' Employment Cost Index; changes in cost inflation will be assessed in light of information from the Producer Price Index for general medical and surgical hospitals; and changes in commercial prices will be analyzed by looking at resources such as reimbursement and cost coverage variation studies. *See* FY24 Hospital Budget Guidance Presentation (Mar. 29, 2023), 16;¹¹ FY 2024 Hospital Budget Guidance and Reporting Requirements (eff. Mar. 31, 2023).¹²

38. The Consumer Price Index (CPI) has eight major groups, one of which is the medical care index. The medical care index is divided into two main components, medical care services and medical care commodities, each containing several categories. *See* U.S. Bureau of Labor Statistics, Factsheets, Measuring Price Change in the CPI: Medical Care.¹³ Growth in the CPI for All Urban Consumers for medical care was 0.1% from June 2022 – June 2023. Looking at the individual categories, prices for hospital and related services grew 4.2%, with prices for inpatient services rising 3.7% and prices for outpatient services rising 5.7%. Prices for physician services grew by 0.5%. *See* Shameek Rakshit et al., Peterson – KFF Health System Tracker, *How does medical inflation compare to inflation in the rest of the economy?* (July 26, 2023).¹⁴

¹⁰ <https://gmcboard.vermont.gov/document/initial-economic-analysis-and-summary-consensus-recommendation-associated-gmcb-budgetary>.

¹¹ https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY24%20Guidance%202023_03_29.pdf

¹² https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY24%20Hospital%20Budget%20Guidance%20FINAL%20DRAFT_0.pdf

¹³ <https://www.bls.gov/cpi/factsheets/medical-care.htm>

¹⁴ [https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/#Annual%20percent%20change%20in%20Consumer%20Price%20Index%20for%20All%20Urban%20Consumers%20\(CPI-U\)%20for%20medical%20care,%20by%20category,%20June%202022%20-%20June%202023](https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/#Annual%20percent%20change%20in%20Consumer%20Price%20Index%20for%20All%20Urban%20Consumers%20(CPI-U)%20for%20medical%20care,%20by%20category,%20June%202022%20-%20June%202023).

39. Just recently, the Centers for Medicare & Medicaid Services (CMS) finalized a rule that will increase inpatient reimbursements made under the inpatient prospective payment system (IPPS) by 3.1% beginning October 1, 2023. The final increase is slightly higher than the 2.8% increase reflected in CMS’s proposed rule. *See* Dave Muoio, Fierce Healthcare, *CMS locks in 3.1% pay bump for hospitals, new equity requirements for fiscal 2024* (Aug. 1, 2023). This increase will affect the five prospective payment system hospitals in Vermont, which are generally larger than critical access hospitals.

40. When asked whether MVP concluded its proposed rates were affordable, MVP stated: “I don’t – I don’t have a definition for which to gauge that against, but I sitting here now, I – I wouldn’t make the statement without having something to measure against.” *See* Testimony of Christopher Pontiff, Hearing Tr. 161:16-19.

41. When asked whether MVP considers affordability, quality, and access in its provider reimbursement decisions, MVP pointed generally to its payment reform efforts – “trying to replace the traditional fee for service with something that does promote affordability, quality, and access through not just a, you know, pay – pay-when-you-go system.” While fee for service is the prevailing payment model utilized by MVP in these markets, MVP could not point to any concrete ways that it considers affordability, quality, and access in determining its fee for service rates or changes to these rates. *See* Testimony of Christopher Pontiff, Hearing Tr. 171:9 – 172:16.

42. Of all payments made by MVP in these markets in 2022, approximately 75% were paid under a fee for service model with no link to quality and value and approximately 25% were paid under an alternative payment mechanism built on a fee for service architecture (namely MVP’s shared savings program with the Accountable Care Organization OneCare Vermont). No payments were made by MVP under a fee for service model with a link to quality and value (e.g., pay for reporting or pay for performance). *See* Ex. 9, 2.

43. MVP utilizes different approaches when negotiating contact rates with Board-regulated hospitals and non-Board-regulated entities. The former typically receive rate increases equivalent to what the Board approves, while the latter are [REDACTED]. *See* MVP Response to 2024 VT Exchange Post-Hearing Questions, 1; Ex. 4, 2; Testimony of Christopher Pontiff, Hearing Tr. 170:21-171:8 (testifying that MVP uses Vermont hospital budget submissions to the Board and “ongoing negotiations or the best estimate of future negotiations” for providers not regulated by the Board); Testimony of Christopher Pontiff, Executive Session Tr., 32:21-34:12 ([REDACTED]).

44. MVP stated that it [REDACTED]. *See* Testimony of Christopher Pontiff, Executive Session Tr., 37:10-38:3. Consequently, MVP concedes that [REDACTED].

. *Id.* at 38:11; *see also id.* at 6:25-8:1 (

45.

See MVP Response to 2024 VT Exchange Post-Hearing Questions, CONFIDENTIAL_VT Phys and Facility Unit Cost Trend 2016 – 2023; see also Ex. 9, 6.

46. Under the risk adjustment program established by the Affordable Care Act (ACA), insurers that have an enrolled population with lower-than-average actuarial risk are required to make payments to insurers in their market that have an enrolled population with higher-than-average actuarial risk. *See* 42 U.S.C. § 18063. MVP consistently pays funds under this program. In these filings, MVP projected its expected 2022 risk adjustment transfer payments based on the most recent data available, which, at the time of the filing, was CMS’s interim risk adjustment report. However, actual 2022 payment amounts were published by CMS on June 30, 2023. Based on these final amounts, and calculations performed by L&E, MVP will owe less than it initially projected in both markets. L&E recommended that the risk adjustment figures be changed to reflect the final market-wide figure announced by CMS and the market-specific risk transfers estimated by L&E. *See Ex. 21, 10 – 11, 19; Ex. 22, 10 – 11, 16.* MVP agrees with this recommendation, which resulted in a 1.2% decrease to the proposed individual rates and a 0.4% decrease to the proposed small group rates. *Ex. 45; Testimony of Jackie Lee, Hearing Tr. 224:19 – 23.*

47. With the ending of the Public Health Emergency (PHE), COVID-19 services will no longer be required to be covered without cost sharing. MVP assumed a 10% reduction in COVID-19 testing utilization in each filing due to the reintroduction of cost sharing. This adjustment resulted in a 0.04% decrease in the individual rates and a 0.06% decrease in the small group rates. L&E concluded that MVP’s assumption of a 10% utilization reduction is reasonable. *Ex. 21, 8; Ex. 22, 8.* However, L&E also noted at hearing that “there really isn’t a lot of data to support [MVP’s] assumption” and L&E probably would have found a 20% reduction reasonable as well. *See Testimony of Jackie Lee, Hearing Tr. 266:10 – 16.*

48. When the Board asked MVP to provide support for the 10% reduction in COVID-19 testing utilization, MVP responded that it “was an assumption we made based on the available data at the time.” When the Board asked MVP to provide estimated ultimate claim counts for COVID-19 tests by month through June 2023, MVP provided counts through June 2023 but made no attempt to complete the data. The data MVP did produce shows a reduction of approximately 35% in COVID-19 tests for the period April 2022 - March 2023 compared to January 2022 - December 2022. *See MVP Response to 2024 VT Exchange Post-Hearing Questions, 5 – 6.*

49. The Biden Administration has announced that it lacks funding to purchase more COVID-19 vaccines and has begun preparing for the full transition of vaccine costs to the commercial market. MVP assumes that commercial payers will be responsible for paying the full ingredient cost of COVID-19 vaccines by 2024. Whereas MVP currently pays \$40 per vaccine for the cost of administering the vaccine, MVP expects to pay \$130 per vaccine in 2024 for both the

ingredient cost and the administration cost. This assumption, which L&E found to be reasonable, increased the rates by \$3.31 PMPM in the individual filing and \$3.35 in the small group filing, which equates to an increase of approximately 0.3% in each filing. Ex. 21, 8 – 9; Ex. 22, 8 – 9.

50. At the Board’s request, MVP contacted the Vermont Vaccine Purchasing Program (VVPP) and learned that COVID-19 vaccines will be covered by the VVPP in 2024. However, based on its flu vaccine utilization within the VVPP, MVP proposes to reduce its assumed additional COVID-19 vaccination costs by 40% rather than 100%. MVP explains that less than 60% of its members receiving flu vaccines were covered through the VVPP because they received a vaccine at a pharmacy or provider that didn’t participate in the VVPP. MVP also states that where a provider does participate in the VVPP, MVP is still responsible for cost of vaccine administration. Reducing the assumed additional cost by 40% would lower the small group rates by 0.16% and the individual rates by 0.14%. MVP Response to Post-Hearing Board Questions, 2.

51. In its review of the filings, L&E discovered that the trend in MVP’s pricing model was not input correctly, which impacted the paid-to-allowed ratios. L&E recommends that the paid-to-allowed ratios on Worksheet 2 of the Uniform Rate Review Template (URRT) be updated in conjunction with the correction to trend inputs in MVP’s pricing model. MVP agrees with this recommendation, which decreased the rates in each filing by approximately 0.2%. *See* Ex. 21, 19; Ex. 22, 16; Ex. 23, 2 – 3; Testimony of Christopher Pontiff, Hearing Tr. 32:16 – 17.

52. During the Board’s review of the filings, MVP modified the designs of its high-deductible health plans (HDHPs) to comply with final guidance issued by the Internal Revenue Service. These changes resulted in a decrease of 0.02% to the proposed rates in each filing, which L&E finds reasonable and appropriate. Ex. 21, 11; Ex. 22, 11.

53. The Board’s new guidance on calculating CSR loads results in MVP’s silver plans getting a higher rate increase on average than other plans in the individual market. However, MVP assumed no shift in membership out of silver plans, particularly non-CSR silver plans, into other metal levels. Ex. 21, 11. For several reasons, L&E disagrees with this assumption:

a. First, the savings from “buying down” to the cheapest bronze plan from the cheapest silver plan is increasing in 2024, and while the premium required to “buy up” from a silver plan to a gold plan is increasing on average,¹⁵ the “buy up” from the most expensive silver plan to the cheapest gold plan is decreasing on a revenue PMPM basis. Ex. 21, 12.

b. Second, when membership out of non-CSR silver plans is assumed, it increases the silver premiums, which decreases the amount required to “buy up” and increases the amount of savings from “buying down.” Ex. 21, 12.

c. Third,

¹⁵ This fact was cited by MVP as a rationale for not assuming any membership shifts out of silver plans.

[REDACTED] Ex. 21, 12.

d. Finally, Texas and New Mexico introduced CSR guidance recently and saw decreases of 11% and 22%, respectively, in the portion of members enrolled in silver plans in year one of implementation. While the guidance issued by Texas and New Mexico generated higher CSR loads than the Board’s guidance, this experience suggests that changes like the Board has implemented do impact enrollment decisions. *See* Ex. 21, 12 – 13.

54. L&E estimates a net enrollment shift of 30% of MVP’s non-CSR silver members (approximately 250 members) into other metal level plans, with the distribution of members mirroring the current distribution amongst MVP’s non-silver metal level plans. This would result in an approximate 5.0% decrease in the portion of members enrolled in silver plans. This estimate accounts for the fact that the Board’s CSR guidance will likely have a smaller impact compared to that of Texas and New Mexico, as well as observed migration patterns from 2021 to 2023 amongst MVP members receiving APTC, and the total enrollment decrease of approximately 23% observed by MVP in 2023. Ex. 21, 13; *see infra*, Findings, ¶ 14. MVP does not agree with this recommendation and does not believe there is enough support to assume a material membership shift in response to silver plans getting a higher-than-average rate increase. Ex. 23, 2.

55. Beginning in 2020, Vermont was required to maintain continuous health care benefits for Medicaid enrollees as a condition of receiving enhanced federal funding. *See* Families First Coronavirus Response Act, Pub.L. 116-127, Sec. 6008(b) (Mar. 18, 2020). In April 2023, this “continuous coverage” requirement ended, and Vermont started reviewing the eligibility of individuals enrolled in Medicaid once again. People who lose Medicaid eligibility through this “redetermination” process will be able to purchase a plan through VHC. *See* Vermont Agency of Human Services, Department of Vermont Health Access, Unwinding from Medicaid Continuous Coverage (Mar. 2023), 13, 26.¹⁶

56. MVP assumed no membership shifts into its CSR variants as a result of Medicaid redeterminations, citing a lack of data. Ex. 21, 13. For several reasons, L&E disagrees with MVP’s assumption:

a. First, a recent study by NORC at the University of Chicago estimated that approximately 2,700 Vermonters will enter the marketplace due to Medicaid redeterminations, approximately 1,400 (or about 52%) of whom will be subsidized. Ex. 21, 13.

b. Second, Medicaid members moving to the ACA market had to qualify for Medicaid within the last few years and some of these households will continue to have Medicaid-eligible incomes but will have lost eligibility for other reasons. Even among those who lose Medicaid eligibility due to income changes, it is not reasonable to assume their incomes will be independent of their prior incomes and will be distributed like the rest of the market, as MVP implicitly assumes. Because CSR variants are only available to people with incomes below

¹⁶https://dvha.vermont.gov/sites/dvha/files/doc_library/Medicaid%20Unwind%20Operations%20Plan%20March2023.pdf

300% FPL in Vermont, disproportionately allocating these members to CSR variants would reasonably reflect that they will likely continue to have lower incomes. Ex. 21, 13.

c. Finally, Medicaid members moving to the ACA market have been paying no premium and it would therefore be reasonable to expect these members to preferentially choose the least expensive plans in the marketplace. Members eligible for CSRs also see relatively little variation in benefits between plans, making the premium the main determinant in their plan selection. Ex. 21, 14.

57. L&E estimates an additional 700 subsidized individual members will select MVP plans in 2024 due to Medicaid redeterminations. L&E also estimates that these members will disproportionately be distributed in the 87% AV and 94% AV CSR variants and in MVP's lowest premium silver plan, the HDHP Non-Standard plan. Ex. 21, 14. MVP does not agree with this recommendation and asserts that it does not have support for a material membership shift due to Medicaid redeterminations and does not know how many members will be eligible for CSR or which CSR levels they will be eligible for. *See* Ex. 23, 2.

58. L&E's recommended assumptions regarding enrollment shifts due to the Board's guidance on CSR loading and Medicaid redeterminations would increase MVP's individual rates by 0.30% overall, with premiums for on-Exchange silver plans increasing by 1.2% to 2.2%, depending on the plan, and premiums for other plans decreasing by approximately 0.10%. *See* Support for 2024 INDV Objection #10. However, members receiving PTC would either not be harmed or would benefit. *See* Testimony of Christopher Pontiff, Hearing Tr. 77:20 – 22.

59. MVP's proposed individual and small group premiums include a contribution to reserve (CTR) of 1.5%, which is consistent with MVP's proposed CTR in last year's filings. *See* Ex. 21, 17; Ex. 22, 14. The purpose of CTR is to account for adverse deviation (i.e., protect against the risk of experience not materializing as projected) and to help support minimum reserve requirements. *See* Testimony of Christopher Pontiff, Hearing Tr. 50:21 – 51:24.

60. Between 2019 and 2022, MVP realized an actual CTR of -16.6% on its individual plans and an actual CTR of -8.0% on its small group plans. Ex. 21, 17; Ex. 22, 14. This equates to a loss of approximately \$30.2 million over these years, a substantial portion of which (\$28.5 million), MVP attributes to rate adjustments. *See* Ex. 46. MVP also lost money on its individual and small group plans in Vermont in 2018; its cumulative operating margin on these plans from 2018 through 2022 was -\$30.8 million. MVP is projecting substantial losses on these plans in 2023 as well (approximately \$14.3 million). *See* Ex. 9, 4.

61. As a reasonableness check of MVP's proposed CTR, L&E reviewed data published by CMS. The data showed that 359 carriers filed 2023 on-Exchange individual or small group rates in states with a federally facilitated exchange. The approved CTR varied from -24% to +9%, but most often fell between 0% and 5%, with the mode being between 2% and 3% and the premium weighted average CTR for all carriers being 2.8%. L&E calculated that MVP's filed CTR of 1.5% would place it at around the 23rd percentile. *See* Ex. 21, 18; Ex. 22, 14; Testimony of Jackie Lee, Hearing Tr. 263:9 – 264:24.

62. In assessing the reasonableness of MVP’s proposed CTR, L&E also reviewed MVP’s risk-based capital (RBC) ratio for the past three years. An RBC ratio is a metric used to quantify the solvency of an insurer. *See* Testimony of Jackie Lee, Hearing Tr. 57:11 – 12. RBC is measured at the company level (i.e., for MVP Health Plan, Inc.) and is not specific to MVP’s Vermont business. *See* Testimony of Christopher Pontiff, Hearing Tr. 106:17 – 18. The following table shows MVP’s RBC in each of the past three years:

Year	RBC Ratio
2020	429.4%
2021	354.0%
2022	369.3%

Ex. 21, 18; Ex. 22, 15.

63. L&E believes it is slightly concerning that MVP has experienced an overall negative profit in the last few years and that there was a significant decrease in MVP’s RBC ratio in 2021. While noting that MVP’s Vermont business is not a significant factor in determining the company’s RBC ratio, L&E states that it is not sustainable to have long-term negative profits and a higher CTR could therefore be justified. L&E concludes that a CTR of between 0.5% and 3.0% would be reasonable and that MVP’s CTR assumptions are reasonable and appropriate. L&E also recommends that any solvency analysis performed by DFR be considered. Ex. 21, 18; Ex. 22, 15.

64. In its solvency opinions, DFR explains that it contacted MVP’s primary solvency regulator, the New York Department of Financial Services, and did not learn of any solvency concerns. DFR also notes that MVP currently meets Vermont’s foreign insurer licensing requirements. Finally, DFR states that MVP Holding Company’s operations in Vermont accounted for approximately 7.5% of its total premiums written in 2022. Thus, DFR concludes that MVP’s Vermont operations pose less risk to its solvency than its New York business. Nevertheless, DFR notes that adequacy of rates and contribution to surplus are necessary for all health insurers to maintain strength of capital that keeps pace with claims trends. Ex. 19, 2; Ex. 20, 2.

65. New York State requires MVP to maintain a 12.5% ratio of reserves to premiums. As of December 31, 2022, MVP had total net assets of \$413.5 million on \$3.14 billion in revenue, or a 13.16% ratio of reserves to premiums. *See* Ex. 9, 4. MVP’s current best estimate of its year-end 2023 RBC is 384%. MVP Response to Post-Hearing Board Questions, 5.

66. The Board received approximately 147 written comments on the 2024 individual and small group rate filings. Comments were submitted by individuals and small businesses and non-profits. Commenters expressed frustration at continually increasing premiums and cost sharing requirements. Many commenters described how their lives are affected by these increases. For example, some commenters described how they have foregone medical care due to high out of pocket costs and others wrote about the burden that large premium increases place on their budgets. A small business owner described how premium increases this year may require the business to pass premium increases on to employees or to stop offering health care coverage

altogether, while an employee wrote about the impact of premium increases on their wages. *See* Compilation of 2024 Vermont Individual and Small Group Rate Filing Comments.

67. MVP submitted a post-hearing memo on July 28, 2023, in which it emphasizes the multi-million-dollar losses it has experienced in recent years on its individual and small group plans in Vermont, as well as the contribution of rate cuts to these losses. MVP maintains that continued losses in these markets are not sustainable. According to MVP, each of the markets it serves must be self-sustaining and should contribute to a healthy overall reserve level, and markets that do not meet this expectation due to circumstances outside its control must be re-evaluated. MVP cautions the Board not to cut its proposed CTR, noting that L&E and DFR agree that the proposed CTR supports MVP's solvency and that the proposed CTR is in the 23rd percentile for all 2023 QHP filings nationally. MVP asserts that any modifications to the proposed rate increases based on hospital budgets should be consistent with approved hospital budgets; if the Board does not reduce hospital budgets this year, MVP says that its average requested rate increases are 14.98% for individual plans and 15.39% for small group plans. Finally, MVP claims that it offered substantial evidence that it is lowering costs and promoting quality care, access, and affordability, and the Board should not reduce the proposed rate increases on any of these bases.

68. The HCA submitted a post-hearing memo on July 28, 2023, in which it argues that MVP only meaningfully addressed some of the rate review factors and failed to offer evidence to prove that the rates are affordable or promote access. Accordingly, the HCA asserts that MVP failed to justify the proposed rates and the Board should modify the rates downward to the lowest practicable level. The HCA says that public comments from roughly 140 Vermonters speak to an affordability crisis and demonstrate that MVP's proposed rates are not affordable and undermine access. The HCA also presents its own calculations. Specifically, the HCA calculates that MVP's rate increases for individual and small group plans have far outpaced both real GDP and real wage growth in Vermont for the period 2014 – 2022 and that the approval of the proposed rates would only accelerate this trend. Based on a metric it developed to capture the burden of premiums and deductibles on Vermonters, the HCA also calculated that MVP's 2023 Standard Silver plan is already unaffordable to large numbers of Vermonters not income-eligible for Medicaid whose income is less than or equal to 500% FPL. Finally, the HCA points to lingering impacts of the pandemic, high inflation, and costs associated with recent flooding, and urges the Board to approve the lowest practicable rate changes this year.

Authorities and Standards of Review

The Board is required to approve, modify, or disapprove a rate request within 90 calendar days of receiving an initial rate filing. 8 V.S.A. § 4062(a)(2)(A). The Board reviews proposed rates to determine whether they are affordable; promote quality care; promote access to health care; protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; and are not excessive, inadequate, or unfairly discriminatory. 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b). In its review, the Board considers changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000, § 2.401. The Board must also consider DFR's analysis and opinion regarding the impact of the proposed rates on the insurer's solvency and reserves, as well as any

public comments the Board receives. 8 V.S.A. §§ 4062(a)(2)(B), (a)(3), (c)(2)(B); GMCB Rule 2.000, §§ 2.201(d), 2.401(d).

The Board's review of proposed rates is plainly not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that the general and open-ended nature of the rate review standards reflects the practical difficulty of establishing more detailed, narrow, or explicit standards – a difficulty due to the fluidity inherent in concepts of quality care, access, and affordability. *See In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16 (internal quotations and citations omitted).

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

In addition to its authority to approve, modify, or disapprove rate requests, the Board is authorized to make reasonable supplemental orders and attach reasonable conditions and limitations to such orders as the Board finds necessary to ensure that benefits and services are provided at reasonable cost under efficient and economical management. *See* 8 V.S.A. §§ 4513(c) (applicable to nonprofit hospital service corporations), 4584(c) (applicable to nonprofit medical service corporations), 5104(b) (applicable to health maintenance organizations). This authority has been found to authorize supervision over an insurer's contracting process with health care providers. *See In re Vermont Health Serv. Corp.*, 144 Vt. 617, 624 – 25 (1984).

Finally, the Board has temporary authority through March 31, 2024, to waive or permit variances from State laws, guidance, and standards with respect to health insurance rate review, among other regulatory activities, as necessary to prioritize and maximize direct patient care, safeguard health care provider stability, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic. Act 4, § 5 (2023).

Conclusions of Law

As we have recognized in prior decisions, the rate review criteria are interrelated and often in tension with one another and we seek to balance them as best we can in light of the facts and circumstances before us. *See In re MVP Health Plan, Inc. 2023 Individual and Small Group Market Rate Filings*, GMCB-005-22rr & GMCB-006-22rr, Decision and Order (Aug. 4, 2022), 16.

Vermont's return to "normal" from the shocks of COVID-19 has faced previously unanticipated challenges. The long-term impact of COVID-19 on the health care sector is evidenced by the extension for an additional year of the regulatory flexibilities initially given to the Board and other agencies during the pandemic. *See* Act 4, § 5 (2023). Higher than normal inflation rates continue to erode the fiscal wellbeing of many Vermonters. *See* Findings, ¶ 20. Many people are returning to the individual and small group markets after having lost Medicaid coverage following the resumption of Medicaid redeterminations. *See* Findings, ¶ 56.a. Compounding these challenges, in July, Vermont experienced severe flooding; in many cases the devastation it wrought exceeded that of Tropical Storm Irene. In connection with the flooding,

Vermont received a Presidential Major Disaster Declaration. *See* Addendum 2 to Executive Order No. 03-23 (Jul. 19, 2023).

MVP's proposed premium increases for 2024 are high and come on the heels of even higher increases implemented for 2023. *See* Findings, ¶¶ 13, 16 - 17. Even setting aside these two years and looking only at 2014 – 2022, prices for these plans have risen much faster than economic indicators such growth in real wages and GDP. *See* Findings, ¶ 19. While ARPA's enhancements to the PTC will continue to be in place through 2025, subsidies are not available for most employees of small employers or for people who enroll in an individual plan directly with MVP (or who are otherwise ineligible). *See* Findings, ¶ 21. We received many comments describing the real hardship that rising premiums and out of pocket costs cause for individuals, businesses, and nonprofits. *See* Findings, ¶ 66.

Given these facts, we have closely scrutinized the filings and are requiring MVP to make several adjustments that are necessary to ensure that premiums are appropriate in light of the Board's statutory charge. However, adjusting premiums will not bring about the kind of change that current circumstances require. We are therefore exercising our authority to require MVP to act to ensure that its benefits and services are provided at reasonable cost under efficient and economical management.

I

First, MVP must (1) change its risk adjustment figures to reflect the final market-wide figures announced by CMS and the market-specific risk transfers estimated by L&E; (2) update the paid-to-allowed ratios on Worksheet 2 of the URRT in conjunction with corrections to trend inputs in the pricing model; and (3) reflect updates to the HDHP plan designs that were required by final IRS guidance. The impact of these modifications is already reflected in MVP's final proposed rates. Findings, ¶¶ 46, 51 - 52. MVP must also reduce the assumed additional COVID-19 vaccination cost by 40%, which will reduce the final proposed rates by approximately 0.14% in the individual market and 0.16% in the small group market. Findings, ¶ 50.

II

Second, MVP must assume the enrollment shifts calculated by L&E in connection with the Board's new guidance on CSR loading and Medicaid redeterminations.

MVP's assumption that there will be no enrollment shifts resulting from the Board's guidance and from Medicaid redeterminations is not reasonable. *See* Findings, ¶¶ 53, 56. L&E's estimates are supported by data and reasonable inferences about consumer behavior. *See* Findings, ¶¶ 53 – 57. While requiring MVP to utilize L&E's estimates will result in a 0.3% increase in the individual rates overall, there will be a significant benefit resulting from an increase in PTC. *See* Findings, ¶ 58. Given that we must consider affordability in our decisions, we cannot ignore this impact, especially since this was one of the anticipated impacts of our guidance on CSR loading. *See* Findings, ¶ 25.

III

Third, MVP must assume a 35% reduction in COVID-19 testing utilization between the experience period and the projection period.

While L&E found MVP's assumption of a 10% reduction reasonable, L&E also noted that the assumption was not well supported and that a 20% reduction would have been reasonable as well. *See Findings*, ¶ 47. We asked MVP to provide estimated ultimate claim counts for COVID-19 tests by month through June, but MVP made no attempt to complete the data it provided. *Findings*, ¶ 48. Ignoring the last three months of this data (May – July 2023) and comparing April 2022 – March 2023 to January 2022 – December 2022, there was a reduction of approximately 35% in COVID-19 testing. *Id.* We find a 35% reduction to be a more reasonable and supported assumption than 10%, and we therefore require MVP to use it.

IV

Fourth, MVP must use the FY 2024 hospital rate requests calculated by Board staff and assume that the Board will reduce these requested rates by 50%.

The timelines for the Board's review of individual and small group rate filings and hospital budgets present a challenge every year. We would prefer to complete our review of the rate filings after having established hospital budgets for the upcoming year. Unfortunately, we have yet to find a reasonable way to make this work. *See GMCB Regulatory Alignment White Paper, Part 2: Options for Regulatory Timeline and Logistics (July 2021)*.¹⁷

It is unclear what MVP's assumptions are regarding hospital budgets. *See Findings*, ¶ 17 n.3. In our decision on MVP's 2023 individual and small group filings, we ordered MVP to assume a 17% reduction to hospital budgets as filed based on an analysis that L&E performed of historical budget submissions and approvals. *See Findings*, ¶ 32. However, since this is the second year of very high hospital budget requests and since the Board has implemented significant changes to the process this year, historical budget submissions and approvals are not likely to predict the outcome of the hospital budget process this year. *See Findings*, ¶ 37. The Board will be using a variety of new factors and external benchmarks to scrutinize hospital budgets. *Id.* This improved, data-driven hospital budget review process is likely to increase accountability and ensure Vermont hospitals appropriately control their costs. Hospitals' expense growth, and the revenue and rate that such growth drives, are likely to be impacted.

While we cannot know the outcome of our hospital budget review process at this point, several factors suggest that hospital requests may be modified significantly more than in prior years. First, despite having received large increases last year, Vermont hospitals are proposing rate increases for FY 2024 that significantly exceed the increases MVP is expecting to pay to hospitals not regulated by the Board. *See Findings*, ¶¶ 35 - 36. MVP has not explained why Vermont hospitals should obtain rate increases that are significantly larger than those in New Hampshire and/or New York. Second, price growth nationally for hospital and related services between June 2022 and June 2023 was 4.2%, with prices for inpatient services rising 3.7% and prices for

¹⁷ https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCBRegulatoryAlignment_Part2_20210730.pdf

outpatient services rising 5.7%. Prices for physician services, meanwhile, rose 0.5%. *See Findings, ¶ 38.* These growth trends are much lower than Vermont hospitals’ rate proposals for FY 2023 or FY 2024. Third, the FY 2024 increase for Medicare inpatient reimbursements will be slightly higher for prospective payment system hospitals than anticipated and this will likely reduce the amount of revenue and “rate” that these hospitals need from commercial payers such as MVP. *See Findings, ¶ 39.* Lastly, Vermont hospital budget submissions generally requested significant rate increases despite multiple Board members indicating that the Board would closely scrutinize rate-based growth in hospital budgets. *See Recording of May 31, 2023, Green Mountain Care Board Meeting.*¹⁸

Accordingly, we conclude that a 50% reduction is a more appropriate and reasonable assumption than 17% this year and we require MVP to use it to calculate its 2024 individual and small group rates. This will reduce MVP’s medical unit cost assumptions and make the rates more affordable.

VI

As explained above, MVP bears the burden of justifying its requested rates and, in connection with making that determination, the Board reviews whether 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 the laws of this State; and are not excessive, inadequate, or unfairly discriminatory. 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, §§ 2.104(c), 2.301(b).

MVP failed to provide sufficient evidence to demonstrate that its proposed rates are affordable and promote access and quality. When asked whether MVP concluded its proposed rates were affordable, MVP stated “I don’t – I don’t have a definition for which to gauge that against, but I sitting here now, I – I wouldn’t make the statement without having something to measure against.” *Findings, ¶ 40.* MVP attempted to argue that it considered affordability, access, and quality by pointing to its payment reform efforts – “trying to replace the traditional fee for service with something that does promote affordability, quality, and access through not just a, you know, pay – pay-when-you-go system.” *Findings, ¶ 41.* Despite fee for service being MVP’s prevailing payment model, MVP could not point to any concrete ways that it considers affordability, quality, and access in determining its fee for service rates or changes to these rates. *See Findings, ¶ 41.* Notably, of all payments made by MVP in these markets in 2022, approximately 75% were paid under a fee for service model with no link to quality and value and approximately 25% were paid under an alternative payment mechanism built on a fee for service architecture (namely MVP’s shared savings program with the Accountable Care Organization OneCare Vermont). No payments were made by MVP under a fee for service model with a link to quality and value (e.g., pay for reporting or pay for performance). *Findings, ¶ 42.* We believe there is great potential for MVP to expand its engagement in health care reform and to slow health care cost growth and improve quality. MVP should make meaningful progress towards value-based care, consistent with the state’s health care reform efforts in Vermont.

¹⁸ Available at <https://www.youtube.com/@GreenMountainCareBoard/videos>.

Moreover, MVP does not consistently or uniformly consider affordability, access, or quality in connection with its provider contract negotiations. MVP utilizes different approaches when negotiating contact rates with Board-regulated hospitals and non-Board regulated entities. The former typically receive rate increases equivalent to what the Board approves, while the latter are [REDACTED]. Findings, ¶ 43. Moreover, MVP stated that it [REDACTED]

[REDACTED] Findings, ¶ 44. Consequently, MVP concedes that [REDACTED]

Id.

The rate increases allowed by the Board in the hospital budget process, however, are a ceiling, not a floor. A central function of an insurance company is to negotiate rates on behalf of its members, and to properly execute that responsibility, affordability, quality, and access must be considered. We do not condone any effort by Board-regulated entities to utilize approved rates as an entitlement. Board-approved hospital rate increases are a cap, not a sword to be wielded in negotiations with insurers. This dynamic has resulted in [REDACTED]

[REDACTED] See Findings, ¶ 45. Negotiated rate increases that award more money to an entity simply because it is regulated by the Board—as opposed to whether an entity provides affordable services, has high quality, and is accessible—are highly unlikely to result in affordable rates that promote access and quality.

The Board could conclude that MVP has failed to satisfy its burden of justifying the requested rates because there is insufficient evidence demonstrating the rates are affordable and promote access and quality. While such a conclusion may be warranted, outright rejecting the rates could negatively impact solvency and/or access. Consequently, we are requiring MVP to consider affordability, access, and quality in its negotiations with its provider network, both in fee for service and by moving forward with payment reform consistent with the State’s efforts. Specifically, we require MVP to consider affordability, access, and quality in connection with negotiating contracts with Board-regulated and non-Board-regulated entities and to report back to the GMCB describing the rates awarded to Board-regulated and non-Board-regulated entities and explaining how MVP considered and utilized affordability, access, and quality in negotiating rates.

Order

For the reasons discussed above, we order MVP to do the following in each filing: (1) change the risk adjustment figure to reflect the final market-wide figures announced by CMS and the market-specific risk transfers estimated by L&E; (2) update the paid-to-allowed ratios on Worksheet 2 of the URRT in conjunction with corrections to trend inputs in the pricing model; (3) reflect updates to the HDHP plan designs that were required by final IRS guidance; (4) reduce the assumed additional COVID-19 vaccination cost by 40%; (5) increase the assumed reduction in COVID-19 testing utilization from 10% to 35%; and (6) use the FY 2024 hospital rate requests calculated by Board staff and assume that the Board will reduce these requested rates by 50%. In the individual filing, we also order MVP to (7) implement the revisions calculated based on L&E’s

recommended assumptions regarding enrollment shifts for CSR loads and Medicaid redeterminations.

With these required modifications, we expect that the overall average rate increase for MVP’s individual plans will be reduced from approximately 15.0% to approximately 11.4% and we expect the overall average rate increase for MVP’s small group plans will be reduced from approximately 15.4% to approximately 11.5%.

SUPPLEMENTAL ORDERS

For the reasons discussed above, we also order MVP to (8) consider affordability, access, and quality in connection with negotiating contracts with Board-regulated and non-Board-regulated entities; and (9) report back to the GMCB describing the rates awarded to Board-regulated and non-Board-regulated entities and explaining how MVP considered and utilized affordability, access, and quality in negotiating rates.

SO ORDERED.

Dated: August 7, 2023, at Montpelier, Vermont

s/ Owen Foster, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Thom Walsh)
)
s/ David Murman)

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made (email address: Tara.Bredice@vermont.gov).

Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further Order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed within ten days of the date of this decision and order.