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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2026 Individual Market Rate Filing	))))	GMCB-002-25rr SERFF No. MVPH-134522721
In re: MVP Health Plan, Inc. 2026 Small Group Market Rate Filing	))))	GMCB-003-25rr SERFF No.: MVPH-134522718

DECISION AND ORDER

Introduction

MVP Health Plan, Inc. (MVP), one of two carriers offering individual and small group health insurance coverage in Vermont, submitted filings to increase its premiums in 2026 by an average of 6.2% for its individual plans and an average of 7.5% for its small group plans. Based on our review of the record, including the testimony and evidence presented at a hearing on July 21, 2025, we modify the proposed rates and then approve the filings. As modified, we expect premiums to increase, on average, approximately 1.3% for MVP's individual plans and approximately 2.5% for MVP's small group plans. In orders issued today in connection with this decision, we also require MVP to implement reforms aimed at reducing future premium increases and improving quality care.

MVP's requests highlight the tension inherent in the rate review standard, which requires the Board to consider competing factors, including consumer affordability, access, and fairness, as well as actuarial soundness and insurer solvency. The affordability and access challenges presented by these filings are substantial; Vermont already has some of the highest individual and small group rates in the country. MVP may have lower rates than its competitor, but its increases since 2021 have exceeded Vermont wage growth. Moreover, changes in federal law will make individual rates more expensive for most people.

The Department of Financial Regulation (DFR) recently issued an order prohibiting MVP and Blue Cross and Blue Shield of Vermont, the other carrier in these markets, from contracting with certain hospitals without first demonstrating that the agreements "support a material reduction in commercial insurance premiums while protecting insurer's solvency." The provision, in conjunction with the Board's supplemental orders, will ensure fair and equitable contracting, support appropriate claims management, and reduce the need for large premium increases.

Procedural History

1. On May 12, 2025, MVP filed its 2026 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 14, 2025, 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 14 through July 18, 2025, MVP responded to a series of interrogatories issued by the Board and its contracted actuaries at Lewis & Ellis, Inc. (L&E). *See* Exs. 3-6, 8-17, 42-43. The interrogatories included questions from the HCA. *See* Ex. 12.

4. L&E reviewed the filings on behalf of the Board and issued actuarial reports on July 11, 2025, in which it summarized its review and recommended adjustments to the filings. Exs. 21-22. Also on July 11, 2025, the Vermont Department of Financial Regulation (DFR) issued opinions regarding the impact of the filings on MVP's solvency. Exs. 19-20.

5. On July 16, 2025, MVP filed an updated rate increase summary table reflecting the impact on the proposed rates of the hospital budget submissions, Act 55, and the L&E recommendations with which it agreed. Ex. 29.

6. On July 18, 2025, with the consent of the parties, the Board extended the review period for the filings, moving the deadline for a decision from August 11 to August 22, 2025, and moving the deadline for filing post-hearing memoranda back from August 1 to August 8, 2025. *Compare* Scheduling Order *to* First Amendment to Scheduling Order.

7. The Board held a hearing on the filings on July 21, 2025. The hearing was held remotely. The Board designated its offices at 112 State Street in Montpelier as a physical location where members of the public were able to attend; they were also 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, Ryan Long, and Alexa Blaise 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 Eric Bachner, Director, Commercial Market and Valuation 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 Jackie Lee, Vice President & Consulting Actuary at L&E. *See* Hearing Transcript (Tr.).

8. On July 24, 2025, the Board held a public comment forum from 4:00 to 5:00 p.m. to hear from the public on the 2026 individual and small group rate filings of MVP and Blue Cross and Blue Shield of Vermont (BCBSVT). *See* Public Comment Forum Tr.

9. On July 25, 2025, MVP responded to interrogatories from L&E regarding the impact of hospital budget submissions. *See* MVP Response to 2026 Ind. VT Exchange Objection #10 (Jul. 25, 2025); MVP Response to 2026 SG VT Exchange Objection # 10 (Jul. 25, 2025).

10. Just before midnight on July 28, 2025, the Board closed a special comment period that it had opened on May 12, 2025, regarding the 2026 individual and small group rate filings.

The Board received approximately 97 comments during the public comment period. *See* Compilation of 2026 Vermont Individual and Small Group Rate Filing Comments.

11. On August 1, and August 18, 2025, MVP responded to post-hearing questions from the Board. MVP Responses to Post-Hearing Board Questions; MVP Confidential Response to Post-Hearing Board Questions Extension.

12. On August 7, 2025, the HCA and MVP each filed post-hearing memorandums pursuant to GMCB Rule 2.000, § 2.307(g). HCA Post-Hearing Memorandum; MVP Post-Hearing Memorandum. MVP also submitted a letter on August 7, 2025, in response to the Board's query whether a final decision in these dockets could be postponed until after September 15, 2025, when the Board announces FY2026 hospital budgets. MVP opposed any delay of the Board's decision beyond the agreed-upon August 22, 2025 deadline and in the alternative asked that the Board issue its decision no later than September 1, 2025.

13. On August 14, 2025, MVP responded to questions regarding the impact of mandating a cap on hospital prices. MVP Response to 2026 Ind. VT Exchange Objection #11 (Aug 14, 2025); MVP Response to 2026 SG VT Exchange Objection #11 (Aug 14, 2025).

14. On August 14, 2025, the Commissioner of DFR issued an order prohibiting BCBSVT and MVP from entering, renewing, or amending agreements with certain hospitals on or after January 1, 2026, unless the terms of the agreements meet requirements relating to premium reduction, solvency protection, and cost containment. *In re Blue Cross and Blue Shield of Vermont and MVP Health Plan, Inc.*, Docket No. 25-024-I, Order. The Board took official notice of the DFR order on August 18, 2025.

Findings of Fact

15. 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. 18, 1.

16. MVP's filings outline the development of premiums or "rates" for health benefit plans that the carrier will offer to individuals and small employers for calendar year 2026 coverage. The plans will be available either through Vermont Health Connect (VHC or the "Exchange") or directly from MVP. *See* Ex. 1, 2, 14; Ex. 2, 2. 10.

17. Premiums for MVP's individual and small group plans increased significantly last year. While the Board ordered MVP to reduce its proposed 2025 premiums, the final approved rates were, on average, 14.2% higher in the individual market and 11.1% higher in the small group market than 2024 premiums. Ex. 21, 2; Ex. 22, 2; *See In re MVP Health Plan, Inc. 2025 Individual and Small Group Market Rate Filings*, GMCB-005-24rr & GMCB-006-24rr, Decision and Order (Aug. 12, 2024), 1.

18. As of February 2023, there were 12,790 members enrolled in MVP's individual plans and 17,397 members enrolled in MVP's small group plans. MVP's membership in these

markets increased from 2024 to 2025; MVP's individual membership increased by 20.5% and MVP's small group membership increased by 19.4%. Ex. 21, 1; Ex. 22, 1.

19. 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.[1] 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, 112; Ex. 2, 93.

20. In its individual filing, MVP proposed premiums that were, on average, 6.2% or $64.65 per member per month (PMPM) higher than 2025 premiums, with plan-level changes ranging from -14.4% to +10.3%. Ex. 21, 2; Ex. 1, 8. In its small group filing, MVP proposed premiums that were, on average, 7.5% or $61.45 PMPM higher than 2025 premiums, with plan-level increases ranging from 5.9% to 11.6% in the small group filing. Ex. 22, 2; Ex. 2, 5. The following tables show how MVP's proposed 2026 premiums compare to its 2025 premiums across different types of plans, as well as the percent of membership in each plan type:

2026 PROPOSED INDIVIDUAL RATE CHANGES

Plan Type	Average 2025 Premium PMPM	Average 2026 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$487.17	$416.95	-14.4%	-$70.22	0.1%
Bronze	$768.51	$831.47	+8.2%	$62.95	30.0%
Silver Loaded	$1,250.71	$1,335.11	+6.7%	$84.40	22.7%
Silver Reflective	$808.17	$865.86	+7.1%	$57.70	3.3%
Gold	$1,109.49	$1,165.22	+5.0%	$55.73	39.6%
Platinum	$1,271.44	$1,333.03	+4.8%	$61.59	4.3%
Overall	***$1,035.71***	***$1,100.36***	***+6.2%***	***$64.65***	***100.0%***

Ex. 21, 2.

2026 PROPOSED SMALL GROUP RATE CHANGES

Plan Type	Average 2025 Premium PMPM	Average 2026 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Bronze	$642.26	$705.39	+9.8%	$63.13	18.9%
Silver	$733.05	$793.05	+8.2%	$59.99	34.0%
Gold	$906.66	$966.99	+6.7%	$60.33	34.4%
Platinum	$1,067.72	$1,133.55	+6.2%	$65.83	12.7%
Overall	***$818.10***	***$879.55***	***+7.5%***	***$61.45***	***100.0%***

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

Ex. 22, 2.

21. 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, 89; Ex. 2, 70.

22. People who purchase one of MVP's individual plans through VHC may be eligible for subsidies that help lower premiums, cost sharing, or both. Subsidies are not available for most employees of small group employers or for people who enroll in an individual plan directly with MVP, instead of through the Exchange. *See* 26 C.F.R. § 1.36B-2(a)(1).

23. 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). The mechanics of the federal subsidies are described briefly below.

24. The PTC is typically paid directly by the federal government to an insurer to lower an eligible individual's monthly premium.[2] The PTC covers the difference between the premium for the second lowest cost silver plan in the market (the "benchmark plan") and a specified percentage of an individual's household income (the "applicable percentage"). *See* 26 U.S.C. § 36B(b). While the PTC is calculated by reference to the benchmark plan, 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. 25, 2024).

25. In 2021, the American Rescue Plan Act (ARPA) made significant enhancements to the PTC. *See* 26 U.S.C. § 36B(c)(1). 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, but under current law, will no longer be available in 2026. *See* Pub.L. 117-169, Sec. 12001.

26. The table below shows how the applicable percentages used to determine an individual's eligibility for PTC will change from 2025 to 2026 due to the expiration of ARPA's PTC enhancements:

Household income as % of FPL	2025 Applicable Percentage	2026 Applicable Percentage
<133% FPL	0.00%	2.10%
133%-150%	0.00%	3.14% - 4.19%
150%-200%	0.00%-2.00%	4.19%-6.60%
200%-250%	2.00%-4.00%	6.60%-8.44%

[2] 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.

250%-300%	4.00%-6.00%	8.44%-9.96%
300%-400%	6.00%-8.50%	9.96%
>400%	8.50%	Unlimited

See IRS Rev. Proc. 2024-35, https://www.irs.gov/pub/irs-drop/rp-24-35.pdf; Rev. Proc. 2025-25, https://www.irs.gov/pub/irs-drop/rp-25-25.pdf.

27. According to data from CMS, approximately 91% of households in Vermont's individual market received PTC in 2024. *See* CMS, *Effectuated Enrollment: Early 2024 Snapshot and Full Year 2023 Average*, 3.

28. If ARPA's PTC enhancements expire at the end of 2025, most of MVP's individual subscribers will experience net premium increases that are higher than the increases reflected in the individual filing and described in this decision. *See* Testimony of Eric Bachner, Tr., 140:9 – 13; Ex. 21, 3. The net premium increases experienced by subscribers above 400% FPL will be especially large, as they will no longer receive any PTC, effectively going from a premium limit of 8.5% of their income to no limit. *See* Findings of Fact (Findings), ¶ 25, *supra*. In one example using 2025 premiums, the cliff for a family of four whose income exceeds 400% FPL by $10 (e.g., income rises from $128,600 to $128,610) would result in the family paying an additional $32,000 in premiums. *See* HCA Post-Hearing Memorandum, 7.

29. 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. *See* 45 C.F.R. § 156.420. 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. 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, 113-14.

30. Beginning with the 2025 plan year, the Board established guidance on silver loading. *See* Green Mountain Care Board Guidance on Silver Loading (eff. Mar. 8, 2024). The guidance had the effect of increasing PTC amounts substantially. The silver load for 2026 is 41.94%. Ex. 21, 2.

31. L&E reviewed MVP's 2026 individual and small group filings to assist the Board in determining whether the proposed rates are excessive, inadequate, and unfairly discriminatory, according to guidance set forth in Actuarial Standard of Practice (ASOP) No. 8. Rates may be

considered excessive under ASOP No. 8 if they exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees and reasonable contingency and profit margins. Rates may be considered inadequate under ASOP No. 8 if they do not provide for payment of claims, administrative expenses, taxes, regulatory fees and reasonable contingency and profit margins. Finally, rates may be considered unfairly discriminatory under ASOP No. 8 if they result in premium differences among insureds within similar risk categories that are not permissible under applicable law or regulation or, in the absence of an applicable law or regulation, do not reasonably correspond to differences in expected costs. *See* Ex. 21, 3; Ex. 22, 2.

32. L&E did not review or opine on whether the proposed rates are affordable, promote quality care, promote access to health care, protect insurer solvency, or are unjust, unfair, inequitable, misleading, or contrary to law. Ex., 21, 3; Ex. 22, 3; Testimony of Jackie Lee, Hearing Tr., 177:12 – 25.

33. Based on its review, L&E makes six recommendations in each of the filings. The recommendations relate to medical trend (medical utilization and medical unit cost trends), new legislation, morbidity adjustment, risk adjustment transfers, and non-essential health benefits (EHB). Ex. 21, 20-21; Ex. 22, 19-20.

34. Actual 2024 claims experience in the individual market was lower than had been projected in last year's filing, resulting in an impact of -2.2% in the current individual filing; there was no such difference for the small group. The difference between the 2024 to 2025 trend projected in last year's rate filing and the current projection results in a -1.5% impact to the individual filing and a -1.3% impact to the small group filing. See Ex. 21, 5, Ex. 22, 4. The Board's orders enforcing FY2023 overages at Rutland Regional Medical Center (RRMC) and University of Vermont Medical Center (UVMMC) were the primary drivers of the decreased assumed trend. Ex. 21, 6; Ex. 22, 5 While the assumption in MVP's prior filing was that GMCB-regulated Vermont hospital commercial rate increases would be consistent with GMCB hospital budget guidance at 3.4%, the overage charge adjustments for RRMC and UVMMC effectively reduced their approved rate changes to 1.2% and - 0.9%, respectively. Ex. 21, 6; Ex. 22, 5.

35. For projected trend from 2025 to 2026, MVP initially proposed a total allowed trend of 5.9% in the individual filing and 6.2% in the small group filing. In the individual filing, the 5.9% total allowed trend was comprised of an allowed medical trend of 4.9% and an allowed pharmacy trend of 12.1%. In the small group filing, the 6.2% total allowed trend was comprised of an allowed medical trend of 5.2% and an allowed pharmacy trend of 12.2%. *See* Ex. 21, 5-6; Ex. 22, 4-5.

36. The allowed medical trends reflect projected changes in the utilization of medical services (medical utilization trend) and the price of those services (medical unit cost trend). *See* Ex. 21, 6; Ex. 22, 5. For utilization changes, MVP projected 1.1% in the individual filing and 1.2% in the small group filing. Ex. 21, 6; Ex. 22, 5.

37. In developing its medical utilization trends, MVP created a new utilization trend model based on linear regression of historical claim data. The resulting two-year annualized trend was then blended with a 0% utilization trend, weighted according to the R-squared value of the

regression. Ex. 21, 7-8; Ex. 22, 6-7. L&E does not support MVP's blending methodology, in particular the use of R-squared as the blending weight, and believes the unadjusted utilization trend of 3.7% in both filings from MVP's regression analysis before the applied blending is a reasonable and appropriate assumption. Ex, 21, 8; Ex. 22, 7. MVP disagrees with L&E's recommendation and maintains that the trend should be blended to ensure an actuarially sound rate. Testimony of Eric Bachner, Tr., 35:8 – 15. L&E's recommendation would result in a 4.5 % and a 4.3% increase to the rates as filed in the individual and small group filings, respectively. Ex. 25, 2-3.

38. For unit cost changes MVP projected 3.8% in the individual filing and 4.0% in the small group filing. Ex. 21, 6; Ex. 22, 5. These trends are 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 hospital budget review process account for more than half of the allowed medical costs in each filing. *See* Ex. 21, 7; Ex. 22, 6.

39. As part of the hospital budget review process, the Board limits the amount that Vermont hospitals can raise their charges or rates. In its filings, MVP initially assumed that the hospital rate in 2026 will match the FY 2025-approved increases, prior to any overage charge adjustments. This assumption produced a medical unit cost trend for Board-regulated facilities and providers of 3.3% in both filings. MVP's medical unit cost trend for other facilities and providers was 4.5% in the individual filing and 4.9% in the small group filing. Ex. 21, 6; Ex. 22, 5.

40. L&E concluded that MVP's unit cost trend for Board-regulated facilities and providers is reasonable and recommends updating the assumed unit cost trends in each filing if new information is known at the time of the Board order. *See* Ex. 21, 7; Ex. 22, 6.

41. On June 11, 2025, the Governor signed H. 266, a bill relating to the 340B prescription drug pricing program, codified as Act 55 (2025). Act 55 prohibits certain hospitals from charging insurers more than 120 percent of the average sales price (ASP) as calculated by the Centers for Medicare and Medicaid Services (CMS) for prescription drugs administered in an outpatient or office setting.[3] Act 55 (2025), § 4. Assuming reduced costs are not offset by increases in other areas, the bill is expected to significantly lower claims for MVP policies in 2026. MVP estimates that Act 55 will reduce individual premiums by 3.6% and small group premiums by 2.7%. *See* Ex. 25, 2-3. L&E concluded that MVP used reasonable methods to estimate the impact of the legislation and recommends that the final premiums reflect these adjustments. *See* Ex. 21, 14; Ex. 22, 12; Findings, ¶ 49, *infra*.

42. Vermont hospitals submitted their FY2026 budgets to the Board in early July 2025. At the time of hearing, MVP calculated that replacing its initial assumption regarding rate increases for Board-regulated facilities and providers with its best interpretation of the proposed hospital budgets, its agreed-upon changes from L&E's memo, and the impact of Act 55 would result in a

[3] For prescription drugs administered in an outpatient or office setting for which a hospital charged an insurer 120 percent or less of the ASP in effect as of April 1, 2025, the hospital may not charge the insurer a greater percentage of the ASP. ASPs will be updated annually on January 1 and July 1 based on CMS's ASP calculations for the most recent calendar quarter. Hospitals are not permitted to offset the impact of the Act 55 price cap by increasing other charges. Act 55 (2025), § 4.

total rate increase of 2.84% in the individual filing and 2.98% in the small group filing. Ex. 29, 1; Testimony of Eric Bachner, Tr., 25:4 – 26:4. However, hospital budgets were inconsistent in their treatment of Act 55. The Board's staff and MVP sought to understand how hospitals accounted, or did not account, for Act 55 in their submissions and, where Act 55 was accounted for, to back it out so that it is not "double counted." *See* Ex. 25, 3.

43. On July 22, 2025, L&E provided MVP with a table that reflected the Board staff's understanding of hospitals' FY2026 rate requests, excluding the impact of Act 55. MVP calculated that using these numbers would result in rate increases in each filing that are approximately 1.3% lower in the individual filing and 1.2% lower in the small group filing than MVP initially projected based on its own analysis of hospital budget submissions. *See* MVP Response to 2026 Ind. VT Exchange Objection #10 (Jul. 25, 2025), 1; Response to 2026 SG VT Exchange Objection #10 (Jul. 25, 2025), 1. Since then, the Board's understanding of budget requests has changed slightly with respect to several hospitals, and the following table reflects the Board's current understanding of the requests excluding Act. 55.[4]

Hospital	
Brattleboro Memorial Hospital	3.0%
Central Vermont Medical Center	2.3%
Copley Hospital	4.2%
Gifford Medical Center	3.0%
Grace Cottage Hospital	0.0%
Mt. Ascutney Hospital & Health Ctr	3.0%
North Country Hospital	0.5%
Northeastern VT Regional Hospital	3.0% composite; 3.3% IP/OP, 0.0% Phys
Northwestern Medical Center	2.6% composite; 3.0% IP/OP, 0.0 Phys
Porter Medical Center	2.7%
Rutland Regional Medical Center	1.5% composite; 2.3% IP/OP, 0.0 Phys
Southwestern VT Medical Center	7.8%
Springfield Hospital	3.0%
The University of Vermont Medical Center	-0.8%

44. L&E also recommends that new information regarding potential hospital budget adjustment and enforcement actions be considered by the Board, noting UVMMC and Central Vermont Medical Center (CVMC) requested mid-year adjustments to their FY2025 budgets and that the Board could also enforce the FY2024 budget deviations of CVMC and Springfield Hospital though reductions to those hospitals' commercial rate caps. *See* Ex. 21, 7; Ex. 22, 6.

[4] The hospitals are Central Vermont Medical Center, Rutland Regional Medical Center, and Southwestern Vermont Medical Center. The impact of the changes for these four hospitals compared to the numbers that were previously shared is expected to be minimal.

45. In total, the FY2024 budget deviations of CVMC and Springfield Hospital amount to approximately $25.3 million. If the Board were to "enforce" the full amount of these deviations through a reduction to the hospitals' FY2026 commercial rate caps, the estimated premium impact would be -0.6% in each filing. Enforcing half of the overages in this manner is estimated to have a premium impact of -0.3% for each filing. *See* L&E Budget Deviation Impact Letter (Aug. 1, 2025).

46. UVMMC and CVMC are implementing rate reductions for major commercial payers (BCBSVT, MVP, and Cigna) for the remainder of 2025. *See* Letter from University of Vermont Health Network (UVMHN) to GMCB (July 1, 2025).[5] These actions are projected to reduce revenue from these payers by approximately $20 million for UVMMC and $6 million for CVMC. *Id.* at 4. To understand how these actions might impact MVP, the Board asked L&E to calculate what the impact would be on 2026 rates if the reductions were applied in 2026. L&E calculated that the -$20 million for UVMMC would amount to a rate impact of approximately -0.5% in each filing and the -$6 million for CVMC would amount to a rate impact of approximately -0.2% in each filing. *See* L&E Budget Deviation Impact Letter (Aug. 1, 2025).

47. MVP will discontinue coverage of weight-loss GLP-1 drugs in plan year 2026 and agrees with L&E that this requires an adjustment which results in a decrease to 2026 premium rates of approximately 1.5% in the individual market and 1.6% in the small group market. Ex. 25, 2-3; Ex. 21, 20; Ex. 22, 19.

48. In the individual filing, the anticipated expiration of enhanced PTCs will have a significant impact on population morbidity and therefore the filed rates. The expiration of the enhanced PTCs is expected to lead relatively healthy people to discontinue health insurance coverage in the individual market. *See* Ex. 5, 9. MVP assumes an overall lapse of 17% across MVP's individual market membership, resulting in a projected morbidity impact of 7.1%. MVP's assumptions are consistent with estimates from the Congressional Budget Office and a carrier survey, and L&E considers MVP's morbidity adjustments to be reasonable and appropriate. Alone, the impact of the expiration of enhanced PTCs would increase individual rates by 7.1%. The net impact on individual rates of the changes to the population morbidity adjustment is 6.1% when including the impact of MVP's change in treatment of GLP-1 drugs. *See* Ex. 21, 11, 21.

49. Changes to other factors, including Leap Year, Act 111 (2024), and prior authorization practices will have a 1.3% impact on individual rates and a 1.2% impact on small group rates. Ex. 21, 13; Ex. 22, 11. L&E considers these "other" adjustments to be reasonable and appropriate. Ex. 21, 14; Ex. 22, 12. MVP calculated the premium impact of H.266 (Act 55) to be -3.6% in the individual filing and -2.7% in the small group filing. L&E recommends the rates be revised to reflect MVP's estimated impact of Act 55 and MVP agrees. Ex. 21, 13-14; Ex. 22, 12; Ex. 25, 2-3. *See* Findings, ¶ 41, *supra*.

50. L&E recommends the filing be updated to reflect final risk adjustment numbers. Under the Affordable Care Act's risk adjustment program, premiums are transferred between

[5] https://gmcboard.vermont.gov/sites/gmcb/files/documents/2025-7-1%20Proposed%20FY25%20Mid-Year%20Commercial%20Rate%20Reduction%207.1.25.pdf.

carriers in the individual and small group markets based on the age, sex, and health status of the enrolled members. *See* 42 U.S.C. § 18063. MVP consistently pays funds under this program. MVP will owe more than it initially projected in both markets. *See* Ex. 21, 14; Ex. 22, 13. MVP agrees with L&E's recommendation, which results in approximately a 2.0% increase to the proposed individual rates and approximately a 1.1% increase to the proposed small group rates. *See* Ex. 21, 21; Ex. 22, 20; Ex. 25, 2-4.

51. MVP projects its 2026 general administrative costs to be 5.5% of premium or $60.61 PMPM in the individual filing and 6.0% of premium or $52.73 PMPM in the small group filing. The overall impact is a decrease of 0.3% in the individual filing and 0.2% in the small group filing. Ex. 21, 15; Ex. 22, 13. As a reasonableness check, L&E reviewed the Center for Consumer Information & Insurance Oversight (CCIIO) public use files (PUFs), containing 2025 data on all individual and small group carriers nationwide. There were 359 carriers that filed 2025 On-Exchange individual or small group Affordable Care Act (ACA) filings nationally. Evaluating MVP's administrative costs in comparison to other individual and small group carriers nationwide, L&E notes that MVP's administrative costs for the individual filing are in the 30th percentile on a PMPM basis and the 1st percentile as a percentage of premium, and for the small group are in the 12th percentile on a PMPM basis and the 3rd percentile as a percentage of premium. L&E concludes that the assumed 2026 administrative costs are reasonable and appropriate. Ex. 21, 17; Ex. 22, 15.

52. L&E recommends that MVP represent benefits for sex-trait modification under Benefits in Addition to EHB consistent with the CMS proposed rule. Ex. 21, 20; Ex. 22, 19. MVP agrees, and the change has no impact on filed rates. Ex. 25, 2-3.

53. MVP's proposed contribution to reserves (CTR), consists of a provision for a risk margin of 2.0% in both filings and provisions for bad debt of 0.4% and 0.2% in the individual and small group filings, respectively. *See* Ex. 21, 17; Ex. 22, 16. MVP has lost money on its individual and small group plans in Vermont from 2021 to 2024; its cumulative operating margin on these plans for those years was -$67 million. MVP is projecting losses on these plans in 2025, as well. *See* Ex. 30, 1.

54. As a reasonableness check of MVP's proposed CTR, L&E again compared it to individual and small group carriers nationwide. The filed CTR varied from -14.2% to +8.7%, but most often fell between 0% and 5%, with the premium weighted average CTR for all carriers being 3.1%. L&E calculated that MVP's filed CTRs, including the margin for bad debt, of 2.4% in the individual filing and 2.2% in the small group filing place it at around the 40th and 36th percentiles, respectively. Ex. 21, 18; Ex. 22, 17.

55. 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 and is measured at the company level (i.e., for MVP Health Plan, Inc.) and is not specific to MVP's Vermont business. See Ex. 18, 9. The following table shows MVP's RBC in each of the past three years:

Historical RBC Ratio

Year	RBC Ratio
2022	369.3%
2023	416.5%
2024	377.8%

Ex. 21, 19; Ex. 22, 17.

56. L&E believes it is concerning that MVP has experienced consistent material losses in the last few years. While noting that MVP's Vermont business is not a significant factor in determining the company's RBC ratio, L&E states that persistent losses are not sustainable over the long term and a higher CTR could therefore be justified. L&E concludes reducing CTR below the filed 2.0% presents significant risk of inadequate premium rates that are not actuarially sound. L&E also recommends that any solvency analysis performed by DFR be considered. Ex. 21, 19; Ex. 22, 17-18.

57. 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 8% of its total premiums written in 2024. 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

58. Earlier this year, the Board issued guidance describing analyses that it would begin to request and consider in determining whether a carrier's proposed individual and small group rates are affordable under 8 V.S.A. § 4062. *See* Green Mountain Care Board, Guidance on the Assessment of Affordability in the Review of Health Insurance Rates (Apr. 2, 2025), 2 (Affordability Guidance).[6]

59. The guidance explains that premium and cost sharing analyses will be performed for different types of households at different income levels. The premium analysis compares each household's expected premium burden – "net premiums" for individual plans and "expected employee premium contributions" for small group plans – to the ACA's "required contribution percentage." The "required contribution percentage" is also sometimes referred to as the "affordability percentage" because it is used to determine whether employer-sponsored health coverage is affordable under the ACA. This percentage is set for 2025 at 9.02 percent of household income. The cost sharing analyses outlined in the guidance compare each household's expected cost sharing burdens to standards adapted from the Commonwealth Fund's definition of "underinsurance:" a deductible of 5% or more of household income, and total out of pocket costs

[6] https://ratereview.vermont.gov/sites/dfr/files/documents/Rate%20Review%20Affordability%20Guidance%20-%20Adopted.pdf.

equal to 10% or more of household income for households at or above 200% FPL and 5% of household income for households below 200% FPL. Affordability Guidance, 2-3.

60. The guidance states that "[i]t is not intended to prevent the parties to health insurance rate review proceedings from presenting, or the Board from requesting, other information regarding the affordability of proposed rates." Affordability Guidance, 2. Indeed, in addition to premium and cost-sharing analyses described above, the guidance explains the Board will continue to request data from carriers regarding the extent to which they are engaged in efforts to control health care cost growth and the effectiveness of these efforts. Such requests, the guidance states, will be designed to assess issuers' efforts in several domains, including 1) reducing or constraining growth of unit prices for health care services, particularly hospital inpatient and outpatient facility prices; 2) expanding adoption of value-based payment methodologies; 3) reducing or constraining growth of prescription drug costs, for example through formulary or benefit design; 4) reducing the wasteful and unnecessary use of health care services; 5) limiting fraud and abuse; and 6) reducing administrative costs. Affordability Guidance, 5.

61. MVP's actuarial team disagrees "that a single metric (or set of metrics) can adequately speak to a plan's affordability." MVP maintains that affordability is not and should not be considered during the creation of premium rates. MVP asserts that accounting for affordability as a rating variable goes against ASOP #26 because if rates are adjusted for affordability, they are no longer adequate to provide for all expected costs. Ex. 18, 27-28. Yet, MVP's witness acknowledges that Vermont law requires GMCB to consider affordability and that the burden is on MVP to show that the rate is affordable. Testimony of Eric Bachner, Tr., 99:3 – 13.

62. MVP also asserts that the template does not provide a comprehensive summary of the various considerations that should go into determining whether rates are affordable and the data in the template is not sufficient to make such a determination. It does not account for the requirement that plans meet a prescribed AV, which limits carriers from lowering deductible and cost sharing amounts, or raising them in order to lower premiums. Cost sharing and deductible scenarios do not reflect that some services are covered before the deductible. In addition, in the small group template, there is no consideration of employer funding or employee salaries, over which an insurer does not have control. Ex. 18, 28-29.

63. The templates that MVP was required to complete and submit in connection with the Affordability Guidance contain a great deal of data, summarized in general terms, as follows:

a. Individual market:

i. Premiums: At incomes of 400% and above, due to the absence of premium assistance, the disparity in affordability is very large when compared to income levels receiving premium assistance. As such, the net premium for MVP's standard gold plan exceeds the affordability benchmark at around 400% FPL for all household types (i.e., single adult, two adults, parent and two children, and family of 4). MVP's standard bronze plan also exceeds affordability at around 400% FPL for all household types. At income levels just over the level receiving subsidies, the jump in premium costs and

impact on affordability are dramatic. For example, a household consisting of two adults at 400% FPL ($84,600) would have to pay nothing to purchase MVP's standard bronze plan. At 450% FPL ($95,175), that same household would have to pay 2.36 times the affordability benchmark because they would receive no PTC. Their net premium would be approximately $20,261, where the affordability metric would be $8,585 ($20,261/$8,585=2.36). Premiums for MVP's standard platinum plan exceed the affordability benchmark at 200%-250% FPL, depending on family composition. Premiums for MVP's silver plans exceed the affordability benchmark at about 300% FPL for all households. Similarly, to purchase MVP's standard gold plan, a family of four with a household income of 450% FPL ($144,675) would have to pay the full sticker price of $39,162, which is 3.00 times the affordability metric of $13,050. *See* Ex. 24, Individual Table 1.

ii. Deductibles: Deductibles for MVP gold plans are lower than the affordability benchmark at higher incomes, but higher than the benchmark at lower incomes. Deductibles for bronze plans are not affordable for households at any income studied. And deductibles for standard silver plans are generally not affordable for households unless their income is above 450% FPL. *See* Ex. 24, Individual Table 3.

b. Small Group Market:

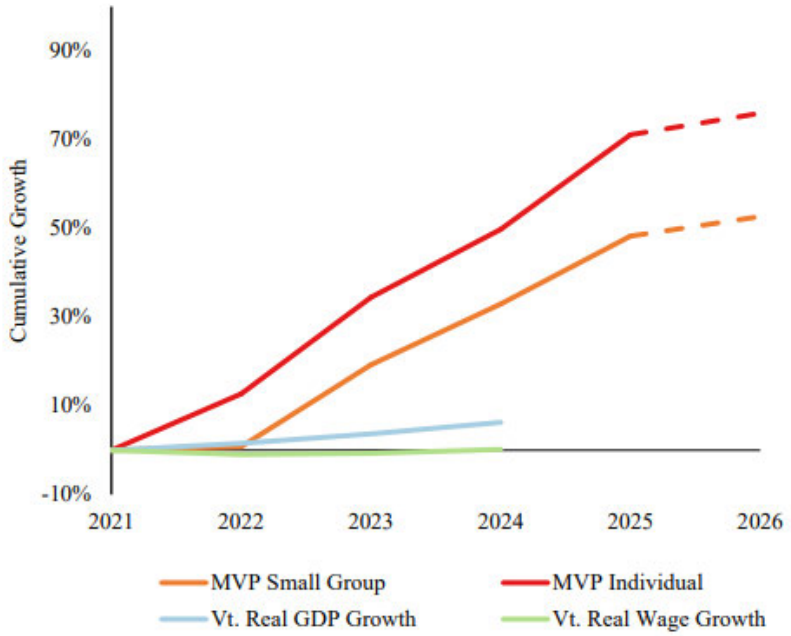
i. Premiums: As would be expected, affordability in the small group market is generally correlated with household income levels due to the absence of premium assistance for lower income households. The income level at which a plan becomes affordable varies greatly by household type. For example, for a single adult, MVP's standard gold plan is considered affordable at 250% FPL; for two adults, it is not considered affordable until 500% FPL. Similar discrepancies in affordability among household types exist for all standard plans. *See* Ex. 24, Small Group Table 1.

ii. Deductibles: MVP gold plan deductibles are lower than the affordability benchmark at higher incomes, but higher than the benchmark at lower incomes. Deductibles for bronze plans are not affordable for individuals at any income. And deductibles for standard silver plans are not affordable at any income level below 500% FPL for a two-adult household and for a parent-and-two-children household. For a single-adult household and a family-of-four household, deductibles for standard silver plans are not affordable unless income is above 450% FPL. *See* Ex. 24, Small Group Table 3.

64. Cost is a significant barrier to accessing care. *See* generally Vermont Department of Health, 2025 Household Health Insurance Survey (May 2025), Ex. 44.

65. If the Board approved 2026 rates for MVP that are, on average 2.84% greater than 2025 rates in the individual market and 2.98% greater than 2025 rates in the small group market, then since 2021, MVP's rates would have increased 76% in the individual market and 53% in the small group market. *See* HCA Post-Hearing Memorandum, 8.

66. The chart below shows the extent to which MVP's individual and small group rate increases have outpaced Vermont real GDP and Vermont real wage growth since 2021, as well as the degree to which the proposed rates, represented by the dashed lines, would continue the trend:



HCA Post-Hearing Memorandum, 9; *see* Ex. 21, 1; Ex. 43; Ex. 44; Ex. 45.

67. MVP states that affordability is not considered during the creation of its premium rates. Ex. 18, 27; Testimony of Eric Bachner, Tr., 98: 4 – 10. MVP lists 16 efforts it has made to promote affordability, access to care, and quality of care. *See* Ex. 18, 9-13. At hearing, MVP acknowledged that many of these efforts are already mandated by state and Federal laws and regulations, including federal and state subsidies, silver loading, and reflective silver plans. *See* Ex. 18, 10-11; Testimony of Eric Bachner, Tr., 94:7 – 95:3; 97:9 – 98:3; *see also* Findings, ¶¶ 22-29, *supra*.

68. None of the changes that led to the decrease in MVP's proposed rate from 6.24% to 2.84% in the individual market were based on affordability; they were purely actuarial adjustments. Testimony of Eric Bachner, Tr., 141:8 – 21.

69. The Health Care Advocate testified that he had not seen anything in his review or anything discussed at hearing that pointed to a specific review of affordability by MVP. Testimony of Mike Fisher, Tr., 212:6 – 11.

70. In years past, Vermont has tended to be healthier than the market in New York, and other states, as well. Testimony of Eric Bachner, Tr. 108:4 – 9. Vermont tends to have higher commercial insurance rates than other states, which MVP's witness attributes to a variety of factors, including the fact that services in Vermont tend to be utilized in a hospital-based outpatient center, as opposed to a physician's office.[7] *Id.* at 108:15 – 25; *See* MVP Response to Post-Hearing Questions (Aug. 1, 2025), 6. MVP's witness testified: "it's not necessarily that more members in Vermont are… using hospital outpatient services when there are physician services available. Some of it could just be that there are not physician services available[.] … In New York we have a much different landscape of care[.]" Testimony of Eric Bachner, Tr., 158:18 – 25.

71. Apart from inpatient services for the rental network, MVP pays higher rates to Vermont hospitals than New York hospitals. Ex. 17, 3; Testimony of Eric Bachner, Tr., 104:10 – 105:13. Compared with New York, medical Rx payments have been 150% higher,[8] outpatient services are 47% higher, and professional services are 15% higher. Ex. 17, 3. Given that the majority of claims are outpatient and professional, these price differentials drive a lot of the expense. If Vermont hospitals had the same reimbursement prices as New York hospitals, it would cost less to provide care for MVP's QHP population. Testimony of Eric Bachner, Tr., 105:14 – 106:12.

72. [redacted] MVP Response to Post-Hearing Questions (Aug. 1, 2025), 6.

73. MVP reimburses most physician services based on a Medicare fee schedule, using CMS fee schedules as reference points. Ex. 17, 3; Testimony of Eric Bachner, Tr., 132:14 – 17. Many MVP contracts are written as a percentage of Medicare, but with differing Medicare base rates. The Medicare base rate changes every year, so instead of changing the base rate (e.g., 2023 vs. 2024), MVP will negotiate a percentage increase to the prior year's base rate. Testimony of Eric Bachner, Tr., 132:14 – 22.

74. [redacted] Ex. 18, 22. [redacted] Testimony of Eric Bachner, Confidential Tr., 5:11 – 22.

[7] The difference between Vermont and New York that is at issue is hospital-based outpatient as opposed to non-hospital outpatient. This is in contrast to inpatient versus outpatient, where outpatient is more the cost effective site of care. See Testimony of Eric Bachner, Tr., 109:15 – 110:8.

[8] [redacted]. *See* Ex. 17, 3.

75. [redacted]
Ex. 10, 1; Testimony of Eric Bachner, Confidential Tr., 13:2 – 18.

76. [redacted] *See* Testimony of Eric Bachner, Confidential Tr., 14:19 – 16:16.

77. MVP pointed to its website and its telemedicine app, Gia, as efforts to promote affordability, access to care, and quality of care. Ex. 18, 10. However the number of visitors MVP lists for its company-wide website reflects both VT and NY members, as well as providers. MVP's witness had no additional information on usage. The witness had not visited the website himself. For the Vermont-specific website, the witness did not know if the number of visits reflected unique visitors and did not know if the number of visits excluded automated bots. Testimony of Eric Bachner, Tr., 87:1 – 15; 88:2 – 89:10.

78. MVP's Gia telehealth app directs patients to the proper level of urgent or emergency care. Testimony of Eric Bachner, Tr., 126:24 – 127:1. However, MVP's witness did not know how many Vermonters had a Gia consult in 2024. Testimony of Eric Bachner, Tr., 91:3 – 12. He was also not aware of the telehealth app's impact on reducing overutilization of expensive services. Testimony of Eric Bachner, Tr., 127:14 – 19.

79. MVP asserts that it has a robust PCP network so that people have PCPs available within a reasonable area of where they live. Testimony of Eric Bachner, Tr., 153:10 – 25. MVP has not dropped any providers in the past two or three years for exhibiting low quality. MVP does not encourage members to go to facilities or providers that have been certified to be of supreme quality outside of providing information. MVP's witness expressed reluctance to speak on behalf of the entire company but acknowledged that MVP could do more to steer its members toward higher quality and lower cost providers. Testimony of Eric Bachner, Tr., 152:2 – 153:2. He also acknowledged that MVP could do more to ensure that all members in the individual and small group market have access to a PCP. Testimony of Eric Bachner, Tr., 154:14 – 18.

80. There have not been any discussions at MVP about whether MVP has any opportunity to steer patients to an appropriate or more affordable site of care. And, outside of Vermont's overall landscape of care, MVP's witness had no specific answer as to why MVP has not steered members away from hospital-based outpatient care and toward a physician setting. Testimony of Eric Bachner, Tr., 159:9 – 160:2.

81. Every year, the Board asks MVP to complete a table that breaks down the payments it has made in the individual and small group markets under different payment models, using the framework of the Health Care Payment Learning & Action Network (HCP-LAN). Below are the results for calendar year 2024:

CY 2024			
HCP-LAN Category	**Program or Payment Arrangement(s)**	**$ value**	**% of total**
Category 1: FFS-No link to Quality and Value			
1: FFS-No link to Quality & Value		$102M	48.3%
Category 2: FFS-Link to Quality and Value			
2A: Foundational payments for infrastructure & operations		$0	0%
2B: Pay for reporting		$0	0%
2C: Pay for performance		$0	0%
Category 3: APMs Built on FFS Architecture			
3A: APMs with shared savings		$0	0%
3B: APMs with shared savings and downside risk	OneCare VT	$108M	51.7%
3N: Risk based payments NOT linked to quality		$0	0%
Category 4: Population-Based Payment			
4A: Condition-specific population-based payment		$0	0%
CU4B: Comprehensive population-based payment		$0	0%
4B with reconciliation to FFS and ultimate accountability for TCOC		$0	0%
4B with NO reconciliation to FFS		$0	0%
4C: Integrated finance & delivery system		$0	0%
4N: Capitated payments NOT linked to quality		$0	0%

Ex. 17, 1-2. Allowed charges in this table include all payments to providers such as OneCare Vermont (OCV), and fee-for-service claims and capitations. Of all payments made by MVP in the individual and small group markets in 2024, approximately 48.3% were paid under a fee for service model with no link to quality and value and approximately 51.7% were paid under an alternative payment mechanism built on a fee for service architecture. Ex. 17, 2.

82. The table below is a summary of the data in the preceding table from 2020-2024, combining the four different categories into two, fee-for-service (FFS) and alternative payment model (APM).

HCP-LAN Category	Year				
	2020	2021	2022	2023	2024
APM	29.0%	23.7%	25.4%	22.8%	51.7%
FFS	71.0%	76.3%	74.6%	77.2%	48.3%

Ex. 17, 2. MVP's APM payments increase from 22.8% in 2023 to 51.7% in 2024 because of increased attribution its MVP's shared savings program with OCV. 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). MVP is currently in discussions to establish a new risk/alternative payment model with the winding down of OCV in 2025. Ex. 17, 1-2

83. [redacted] MVP Response to Post-Hearing Questions (Aug. 1, 2025), 4. MVP's witness states that the GDR has been lower, not because MVP has not been steering enough members toward utilizing generics versus brands for existing drugs. Rather it is the result of new drugs coming into the market as brand drugs for which there is no viable generic alternatives. Testimony of Eric Bachner, Tr., 146:14 – 147:13.

84. MVP has identified some individual service categories reflecting significant intensity trends. Such issues are brought to the attention of MVP's fraud, waste, and abuse teams or medical economics team to get programs in place to ensure proper coding. Testimony of Eric Bachner, Tr., 137:5 – 16.

85. For MVP's administrative contracts, MVP states that it engages in a competitive bidding process as a way to keep administrative costs down. MVP asserts that it regularly updates its information technology infrastructure to increase efficiency and reduce administrative expense. Ex. 18, 18.

86. The Board received approximately 97 written comments on the 2026 individual and small group rate filings and 12 members of the public spoke at the public comment forum. Comments were submitted by individuals and small businesses. Commenters expressed concern that they, loved ones, or members of their community will be unable to absorb the premium increases. People expressed that they would need to make difficult choices such as dropping insurance coverage or moving out of the state. Particular concern was expressed about the impact of the expiration of the enhanced PTCs. *See* Compilation of 2026 Vermont Individual and Small Group Rate Filing Comments.

87. MVP submitted a post-hearing memorandum on August 7, 2025, in which it encourages alignment of the Board's hospital budget decisions, health care legislation implementation, and these rate decisions. MVP notes that H.482 (Act 49) allows an insurer in "significant financial distress" to make reduced hospital reimbursements and argues that the Board should fairly align any such reductions across both carriers. MVP asserts 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. MVP cautioned the

Board against cutting MVP's proposed 2% risk margin because continued losses in MVP's Vermont business are not sustainable.

88. The HCA also submitted a post-hearing memorandum on August 7, 2025, in which it argues that MVP has failed to show that the rates are affordable and that MVP addresses only whether the rates are actuarially reasonable. The HCA requests that the Board adopt the consensus rate modifications, reject L&E's recommendation on utilization trend, and continue to define non-actuarial rate review factors. The HCA pointed to the cumulative increase of MVP's rates since 2021 and demonstrated that these rate increases have outpaced Vermont real GDP and Vermont real wage growth. The HCA points to the public comments and notes that while many Vermonters cannot afford MVP's 2025 rates, even more Vermonters will not be able to afford MVP's rates in 2026.

Authorities and Standards of Review

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). Finally, the Board is required to execute its duties, including those related to rate review, consistent with certain principles that the General Assembly has adopted as a framework for reforming health care in Vermont. 18 V.S.A. §§ 9371, 9375(a).

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.

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) (appliable 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 hospitals, as well

as measures aimed at limiting administrative expenses. *See In re Vermont Health Serv. Corp.*, 144 Vt. 617, 624-25 (1984); *In re Vermont Health Serv. Corp.*, 155 Vt. 457, 464 (1990).

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.

I. Not Excessive, Inadequate, or Unfairly Discriminatory

For the rates not to be excessive, MVP must adjust its population morbidity, projected risk adjustment payment, other factors, and medical unit cost trend.

A. Population Morbidity

First, MVP must adjust its population morbidity to reflect discontinuing coverage of weight-loss GLP-1s in plan year 2026, which will result in a decrease of approximately 1.5% and 1.6% in the individual and small group markets, respectively. Findings, ¶ 47.

B. Risk Adjustment

Second, MVP must change its risk adjustment figures to reflect the final market-wide figure announced by CMS, which results in approximately a 2.0% increase to the individual filing and approximately a 1.1% increase to the small group filing. Findings, ¶ 50.

C. Changes to Other Factors

Third, MVP must reflect the impact of H. 266 (Act 55) in other factors, resulting in a -3.6% premium impact in the individual filing and -2.7% premium impact in the small group filing. Findings, ¶ 49.

D. Medical Unit Cost Trend

Fourth, MVP must use the Board's calculation of hospital budget submissions, excluding the impact of Act 55, as reflected in this order for hospital budgets, and assume 50% enforcement of CVMC's FY2024 overages. *See* Findings, ¶ 44-45.

II. Additional Actuarial Conclusions

We decline to adopt L&E's recommendation regarding medical utilization trend at this time, as MVP maintains its belief that its medical utilization trend should be blended to ensure an actuarially sound rate. Findings, ¶ 37.

We do adopt L&E's recommendation and order MVP to represent benefits for sex-trait modification under Benefits in Addition to EHB. This change has no impact on rates. Findings, ¶ 52.

III. Non-Actuarial Criteria

MVP has not met its burden to demonstrate that its filing meets the "non-actuarial criteria," including that the proposed rates are affordable, promote quality care, promote access to care, and are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State. *See* 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b). In fact, MVP states that affordability is not considered during the creation of its premium rates. Findings, ¶ 67.

MVP acknowledges the role of these non-actuarial criteria in GMCB's rate review process and that MVP bears the burden to show that the rate is affordable. Findings, ¶ 61. Yet, as in recent years, MVP offers only its actuary to submit prefiled testimony and to testify at hearing. *See* ¶ 7. MVP has provided no evidence reflecting a specific review of affordability. Findings, ¶ 69. MVP's witness provided capable testimony in many areas, particularly on actuarial matters, contract negotiations, and comparing MVP's experience in Vermont with New York. *See e.g.,* Findings, ¶¶ 37, 72-76. Yet the witness reflected no specific knowledge of many of the measures MVP set forth as promoting affordability, access to care, and quality care. *See* Findings, ¶¶ 77-80. Some measures listed by MVP are already mandated by state and federal laws and regulations. Findings, ¶ 67. Many of the measures listed lack metrics or benchmarks to demonstrate their effectiveness. The witness acknowledged that MVP could do more to ensure that members have access to a PCP, and to steer members to higher quality and lower cost providers. *See* Findings, ¶¶ 79-80.

IV. Affordable

MVP has not demonstrated that the proposed rates are affordable.

The Board issued guidance earlier this year informing carriers that they would need to complete affordability data templates as part of the 2026 individual and small group rate review cycle. These templates analyze, for a variety of different household types and income levels, the expected premium and cost-sharing burdens associated with the carriers' standard plans in relation to well-established standards from the ACA and the Commonwealth Fund. The Board's guidance also notified the HCA and the carriers that the template data was not the only data the Board might consider regarding affordability; they could submit, and the Board could request, additional data. Findings, ¶ ¶ 58-59.

The Affordability Guidance explained how the Board would also request data from the carriers regarding their efforts to control health care cost growth and the effectiveness of these efforts, focusing on the following areas: 1) reducing or constraining growth of unit prices for health care services, particularly hospital inpatient and outpatient facility prices; 2) expanding adoption of value-based payment methodologies; 3) reducing or constraining growth of prescription drug costs, for example through formulary or benefit design; 4) reducing the wasteful and unnecessary use of health care services; 5) limiting fraud and abuse; and 6) reducing administrative costs. Findings, ¶ 60.

A. Template Data

The template data are very troubling. They validate, in numeric terms, what the Board has long heard from Vermonters—that affordability is a tremendous problem in these markets.

Although subscribers' experiences vary depending on their household composition, income, plan choice, and how much health care they and their family members use during the year, the tables are filled with red numbers, indicating that the variable being measured (i.e., the premium, the deductible, or the total cost sharing burden), is greater than the relevant standard. *See* Findings, ¶ 63.

In the individual market, MVP's affordability data is not as dire as BCBSVT's, both because its rates are lower overall and because it is the carrier offering the benchmark plan from which subsidies are calculated. As a result, for incomes under 400% FPL, premiums are generally affordable. However, at income levels that do not receive premium assistance (i.e., 400% FPL and above), the disparity in affordability is very large. For example, a two-adult household at 400% FPL would pay $0 in premium for MVP's standard bronze plan, but at 450% FPL, that same household would have to pay $20,261 in premium, 2.36% multiplied by the affordability benchmark of $8,585, because they receive no PTC. Deductibles for bronze plans are not affordable for any household sizes or income levels included on the template, and deductibles for standard silver plans are generally not affordable for households unless their income is above 450% FPL. Findings, ¶ 63

In the small group market, as would be expected, affordability is generally correlated with household income. Premium affordability varies greatly by household composition, with plan premiums generally more affordable for smaller household types. Deductibles for bronze plans again are not affordable for any of the household sizes or income levels studied. Deductibles for a standard silver plan are not affordable for households with two adults at any income level studied, nor for a family of four until household income is above 450% FPL. Findings, ¶ 63.

B. Other Affordability Data

Expiration of Enhanced PTC: If ARPA's enhancements to the PTC expire at the end of 2025, as they are expected to, most of MVP's individual subscribers will experience net premium increases that are higher than the increases reflected in the decision. While the template data described above reflect the net premiums that different households could be expected to pay without the enhanced PTC, they do not reflect the *increase* in net premiums that most individuals will experience from 2025 to 2026. Findings, ¶ 28. For individuals above 400% FPL, this increase will be especially large as they will lose eligibility for any premium assistance. Findings, ¶ 26.

Cumulative Rate Growth Compared to Wage and GDP Growth: The rate at which premiums have grown in relation to other economic metrics is relevant to whether the rates are affordable. If the Board approved rate increases for MVP of 2.84% in the individual market and 2.98% in the small group market, then MVP's individual and small group rates would have increased by 76% and 53% respectively since 2021. Findings, ¶ 65. MVP's individual and small group rate increases have outpaced Vermont real GDP and Vermont real wage growth since 2021 and the proposed rates would continue that trend. Findings, ¶ 66.

C. Efforts to Reduce or Constrain Unit Cost Growth

The rates at which MVP reimburses Vermont hospitals are generally higher than New York hospitals. Outpatient services are 47% higher and professional services are 15% higher. Findings, ¶ 71. The disparity in outpatient prices has a substantial impact on overall claims costs because for a given service, services in Vermont tend to be utilized in a hospital-based outpatient center, as opposed to a physician's office. Findings, ¶ 70.

[redacted] Findings, ¶ 74.

MVP reimburses most physician services based on a Medicare fee schedule. Many MVP contracts are written as a percentage of Medicare fee schedule the first year; in subsequent years the fee is negotiated as a percentage increase to the prior year's base rate, rather than adopting the new Medicare base rate. Findings, ¶ 73.

No payments were made by MVP under a fee for service model with a link to quality and value, such as paying for reporting or for performance. Findings, ¶ 82.

D. Efforts to Expand Adoption of Value-Based Payments

MVP's APM payments increased substantially from 22.8% in 2023 to 51.7% in 2024 because of increased attribution in MVP's shared savings program with OneCare Vermont (OCV). OCV is winding down in 2025 and MVP has not established a new risk/APM model to replace it. Findings, ¶¶ 82-83. [redacted] *See* Findings, ¶ 76.

E. Efforts to Reduce or Constrain Prescription Drug Cost Growth

MVP did not provide any specific evidence on efforts to reduce or constrain prescription drug cost growth other than contracting with a PBM. However, how MVP measures the PBM's performance was not provided, nor was information on how frequently MVP issues competitive bids for the PBM. MVP provided its GDR, [redacted]. Findings, ¶ 83.

F. Efforts to Reduce Wasteful and Unnecessary Use of Health Care Services and Limit Fraud and Abuse

While MVP pointed to its telehealth app as a way to direct patients to the proper level of urgent or emergency care, it offered no information on Vermont-specific app usage. MVP was unable to provide data on the impact of telehealth on reducing overutilization of expensive services. Findings, ¶ 77.

MVP watches for and has identified some individual service categories reflecting significant intensity trends and brings these issues to the attention of MVP's fraud, waste, and abuse teams or medical economics team to review and establish programs to ensure proper coding.

Findings, ¶ 84. The carrier did not offer specific information about the extent of the problems discovered or the impact of its review on reducing wasteful and unnecessary use of health care services or addressing fraud and abuse.

G. Efforts to Reduce Administrative Costs

MVP has been determined to have reasonable and appropriate administrative costs, ranking in the 30th and 12th percentiles nationally on a PMPM basis in the individual and small group markets, respectively. Findings, ¶ 51.

H. Conclusion

Based on the above, we conclude that MVP has not demonstrated that its proposed rates are affordable. We acknowledge that MVP's rates meet affordability standards for some, depending on household size, income and availability of subsidies, and believe MVP can do more both to demonstrate in these proceedings that it has made efforts to make its rates affordable and to take action to make its rates more affordable for its Vermont members.

V. Promotes Access and Quality

This criterion overlaps somewhat with the affordability criterion. For example, high costs- in the form of high health insurance premiums, deductibles, copayments, and coinsurance- are a significant barrier to Vermonters' ability to access care. *See* Findings, ¶ 64. Poor quality care (e.g. avoidable hospital readmissions and unnecessary or duplicative tests and procedures) also increases the underlying claims costs that must be covered by premiums and member cost sharing, negatively impacting affordability. Therefore, our discussion of the affordability criterion is also relevant here.

MVP can do more to proactively educate its members about cost and quality differences among providers, steer members to low-cost/high quality providers, and educate legislators and the public about problems in health care financing and delivery. *See* Findings, ¶¶ 79-80.

We also note our concern that MVP does not have any quality incentives in its contracts with hospitals. If a hospital's quality declines, there is no impact on the rates MVP pays that hospital. Findings, ¶ 82. Moreover, MVP does not have any APM arrangements to replace OCV after it winds down at the end of 2025. Findings, ¶ 82. MVP has acknowledged that it could do more to steer members toward higher quality and lower cost providers, and to ensure that all members in the individual and small group markets have access to PCPs. MVP has not engaged in internal discussions about opportunities to steer patients to more appropriate or more affordable sites of care. Findings, ¶¶ 79-80.

VI. Not Unfair, Unjust, or Misleading

The increase in MVP's premiums relative to other metrics such as Vermont real GDP and Vermont real wage growth is unfair to Vermonters, especially in light of the fact that Vermont's QHP membership has been healthier than other states, including New York, where MVP also provides health insurance services. *See* Findings, ¶¶ 66, 70-71. Part of this problem may stem from

the dynamic of a relatively high level of services being provided in the relatively high priced hospital-based outpatient setting. *See* Findings, ¶ 71.

V. Not Contrary to Law

MVP's proposed rates include an anticipated medical loss ratio above 80%, as required by 33 V.S.A. § 1811(j), and were developed using an acceptable community rating methodology, as required by 33 V.S.A. § 1811(f)(1). As required by 33 V.S.A. § 1813(a), MVP's proposed rates for On-Exchange silver plans include funding to offset the loss of federal cost-sharing reduction payments and MVP's proposed rates for Off-Exchange reflective silver plans do not include such funding. Also as required by 33 V.S.A. § 1811(e), the rate structure used by MVP differentiates among single person, two person, and family rates.

Pursuant to 18 V.S.A. § 9375(a), the Board "shall execute its duties consistent with" the principles of healthcare reform found at § 9371. The Board's duties include reviewing health insurance rates. 18 V.S.A. § 9375(b)(6). Indeed, 18 V.S.A. § 9375(b)(6) requires the Board to review proposed rate requests "taking into consideration the requirements of the underlying statutes . . .." The underlying statutes, 18 V.S.A. § 9375(a) specifically, require the Board to consider the reform principles. It should be noted that the rate review criteria at 8 V.S.A. § 4062 overlap in many respects with the principles of health care reform. For example, the principles in § 9371(1)-(2) that "[s]ystemic barriers, such as cost, must not prevent people from accessing necessary health care," and "[o]verall health care costs must be contained, and the growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care" clearly correspond with the requirement that the Board consider affordability and access in reviewing proposed rates. Similarly, the principle in § 9371(11) that "[t]he financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably" is in accord with the requirement that the Board consider whether proposed rates are unjust or unfair.

MVP has provided insufficient evidence, however, to allow the Board to conclude that the proposed rates are consistent with the principles of healthcare reform.

VII. Supplemental Orders

In addition to the Order modifying and approving MVP's individual and small group rate filings below, today we issue supplemental orders. Briefly, we explain the rationale for each supplemental order:

1. Risk Sharing Arrangement with UVMHN (Supplemental Order 1)

To provide benefits and services at reasonable cost under efficient and economical management, MVP should seek to mitigate its risk as much as possible through provider contracting. A risk sharing arrangement with UVMHN based on a PMPM revenue cap that corresponds with the assumptions in these rate filings would provide MVP protection from potential overpayment. This requirement will also allow MVP's negotiations with UVMHN to be in alignment with BCBSVT's. *See* Findings, ¶ 87. [redacted]. Findings, ¶ 76.

2. Revenue Neutrality (Supplemental Orders 2-3)

To provide benefits and services at reasonable cost under efficient and economical management, MVP must reject any demands for "revenue neutrality"[9] and insist that hospitals remain within their rate caps. [redacted] The Board's regulation of hospital budgets provides no basis for demands for revenue neutrality. *See* Findings, ¶ 74. This requirement will again allow MVP's negotiations with UVMHN to be in alignment with BCBSVT's. *See* Findings, ¶ 87.

3. Incorporating Quality (Supplemental Orders 4-5)

A key tenet of payment reform is that payments to providers should increasingly correlate to quality and value, including effective cost management. MVP presently has no fee for service arrangements linked to quality and value. Therefore, if a hospital's quality declines, there is no impact on the rates that MVP pays the hospital. Findings, ¶ 82. MVP must do more to promote lower cost, higher quality care. Payments are one of the primary ways MVP can influence provider behavior. For the benefit of its members, it should be financially incentivizing high quality care and disincentivizing poor quality care.

Order

For the reasons discussed above, we modify and then approve MVP's individual and small group rate filings. Specifically, we order MVP to do the following in each filing: (1) adjust population morbidity to reflect discontinuing coverage of weight-loss GLP-1 drugs; (2) change the risk adjustment figure to reflect the final market-wide figures announced by CMS; (3) reflect the impact of Act 55 in the other factors category by reducing the individual premiums by -3.6% and the small group premiums by -2.7%; (4) use, as set forth in Findings, ¶ 43, the Board's calculation of hospital budget submissions excluding the impact of Act 55 in its medical unit cost assumptions in each filing; (5) adjust the medical unit cost assumptions for CVMC in each filing by assuming that the board will enforce half of CVMC's FY 2024 budget deviation through a reduction to the hospital's FY 2026 commercial rate cap; and (6) represent benefits for sex-trait modification under Benefits in Addition to EHB.

With these required modifications, we expect that the overall average rate increase for MVP's individual plans will be reduced from approximately 6.2% to approximately 1.3% and the overall average rate increase for MVP's small group plans will be reduced from approximately 7.5% to 2.5%.

[9] Revenue neutrality in this context reflects a hospital's insistence that revenue reductions, whatever their source, must be made up by increasing prices in other areas, even when it reflects revenue beyond Board-ordered levels because of overpayments. *See In re Blue Cross and Blue Shield of Vermont 2026 Individual and Small Group Market Rate Filings*, GMCB-004-25rr & GMCB-005-25rr, Decision and Order (Aug. 22, 2025), 23, 36.

Redacted- Highlighting

SO ORDERED.

Dated: August 22, 2025, at Montpelier, Vermont

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

Filed: August 22, 2025

Attest: s/ Jean Stetter, Administrative Services Director
Green Mountain Care Board

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.

Redacted- Highlighting

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	MVP Health Plan, Inc. 2026 Individual Market Rate Filing	))))	GMCB-002-25rr SERFF No. MVPH-134522721
In re:	MVP Health Plan, Inc. 2026 Small Group Market Rate Filing	))))	GMCB-003-25rr SERFF No.: MVPH-134522718

SUPPLEMENTAL ORDERS

1. MVP is encouraged to negotiate a risk sharing arrangement with UVMHN based on a PMPM revenue cap for services provided to MVP QHP members at UVMHN facilities in 2026. MVP should negotiate a model that will provide it with substantial protection from the risk of revenues exceeding the cap. No later than February 15, 2026, MVP shall submit a report to the Board describing the outcome of its negotiations.

2. MVP shall not permit a Vermont hospital to be held harmless for all or any portion of a negotiated reimbursement reduction or negotiated change in payment methodology (e.g., reformed outlier provisions), or from a claim edit, claim recoupment, or similar payment integrity or fraud, waste, and abuse activity, unless MVP has determined that doing so is consistent with its obligation to provide benefits and services at reasonable cost under efficient and economical management. MVP shall keep a record of all such determinations. In the event a Vermont hospital asserts that it has a right or entitlement to a particular rate or revenue in connection with the Board's hospital budget orders, MVP shall promptly notify the Board and assist the Board in resolving the matter.

3. MVP shall not permit its rate of reimbursement for any specific code to increase in 2026 by more than the commercial rate cap approved by the Board for that hospital unless MVP first determines that doing so is consistent with its obligation to provide benefits and services at reasonable cost under efficient and economical management. MVP shall keep a record of all such determinations. MVP shall submit a report to the Board on or before February 15, 2026, describing how it has complied with the requirements of this section.

4. MVP shall make substantial progress in maximizing the value generated for its members from the increasing levels of reimbursement MVP pays to providers (e.g. by paying providers for quality outcomes and including effective cost management). MVP shall submit a report to the Board on or before May 1, 2026, describing how it has complied with this requirement.

5. MVP shall not agree to reimburse hospitals for expenditures that MVP determines are unnecessary or do not contribute to efficient, high quality health services or improve health outcomes. No later than November 15, 2025, MVP shall submit a report to the Board describing the outcomes of its negotiations with hospitals that have an October 1 contract renewal date. No later than February 15, 2026, MVP shall submit a report to the Board describing the outcome of its negotiations with hospitals that have a January 1 contract renewal date. The reports shall describe the adjustments MVP has made to reimbursement amounts or methodologies pursuant to this order.

SO ORDERED.

Dated: August 22, 2025, at Montpelier, Vermont

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

Filed: August 22, 2025

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