STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-007-16-RR

VERMONT HEALTH CONNECT RATE REVIEW HEARING
(MVP HEALTH CARE, INC.)

July 21, 2016
9 a.m.
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89 Main Street
Montpelier, Vermont

Hearing held before the Green Mountain Care Board, at the City Center, 89 Main Street, 2nd Floor, Montpelier, Vermont, on July 21, 2016, beginning at 9 a.m.

P R E S E N T

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I N D E X

CHAIRMAN GOBEILLE: Good morning. I'll call this meeting of the Green Mountain Care Board to order today. The only matter before the Board today is MVP's rate hearing. At this point I'll turn it over to the Hearing Officer. Noel, if you want to take it from here.

HEARING OFFICER HUDSON: Good morning everybody. My name is Noel Hudson. I'll be the Hearing Officer in this matter today. At this point I would like to request that everybody turn their cell phones off so that we can produce a clear record in a distraction-free environment for the Board, the parties, and the public in attendance. We have a court reporter with us as well, Miss JoAnn Carson, and she needs to be able to record the proceeding and produce a transcript without any interruptions or hearing noise. So thank you very much.

As I said my name is Noel Hudson. I'm the Director of Health Policy for the Green Mountain Care Board by day, and today I'm the Hearing Officer. For the record it is July 21, 2016. This is a hearing in the matter of MVP Health Care, Inc.'s Vermont Health Connect 2017 rate filing. The docket number is GMCB-007-16RR. The parties to this proceeding are MVP Health Care, Inc., the Vermont

Office of the Health Care Advocate, and appearing as a witness -- not a party but appearing as a witness today by statute is the Vermont Department of Financial Regulation as well.

So at this time I would like to call all planned witnesses to the stand so that they can be sworn in by the court reporter. So that is Matt Lombardo of MVP, Ryan Chieffo of DFR, and Jacqueline Lee of Lewis & Ellis.

(Witnesses Matt Lombardo, Ryan Chieffo, and Jacqueline Lee were duly sworn.)

HEARING OFFICER HUDSON: All right. The order of business today is going to be entering stipulated exhibits, opening statements from the parties, parties will be presenting witnesses in order; MVP, then the Department of Financial Regulation, then the Board's actuary from Lewis & Ellis will be testifying. The ACA has not -- is not calling a witness today, but will be here questioning witnesses, and then we'll move on to the public comment section of this hearing.

So at this time I would like to request that we enter the stipulated exhibits into the record.

MR. KARNEDY: Thank you. My name is

Gary Karnedy. I represent MVP. Everyone should have a binder in front of them. By everyone I mean the Board and opposing counsel. We have stipulated to 15 exhibits which are referenced on the exhibit list which we'll describe more fully when I put the witness on the stand, but I would move that they be allowed into evidence.

HEARING OFFICER HUDSON: And they will be so allowed.

(MVP Exhibits 1-15 admitted.)

MR. KARNEDY: Thank you very much.

HEARING OFFICER HUDSON: Let the record reflect the binders are entered into evidence. At this point let's move on to opening statements.

MR. KARNEDY: Thank you very much. As I said my name is Gary Karnedy and I have represented MVP in the past few years in these hearings. I would like to introduce Matt Lombardo who is Associate Director of Actuarial Services. Matt has worked on these filings for the last several years. This is his first year taking the lead testifying so be gentle with him. I want to thank the Board for your time today and your public service.

This year's MVP proposed -- this year MVP proposes a rate increase of 6.3 percent and L&E

proposes that the rate increase be instead 3.7 percent. The Board is well aware of a judicial notice of substantial rate increases that are being sought across the United States this year. In this context MVP's 6.3 percent increase is relatively modest. It is important that MVP continues to be a competitive player in Vermont. We need to maintain competitive options for insureds in Vermont so they can buy health insurance.

I'm happy to report that the difference between the MVP actuaries and the L&E actuaries this year appears to be based on one central relatively simple issue. Nonetheless, it's an important one relating to the risk adjustment program and its significant financial implications for MVP and its insureds. I think it's relatively simple after you hear the testimony, but we'll explain the gobbledygook as the Chair Gobeille described it yesterday.

We believe your task is this year actually relatively simple compared to some of our heavy lifting in prior rate filings. It's simply choosing between two different methodologies employed by dueling actuaries.

Let me give you an analogy that I think

frames your task today for the issue before you. This will sound a bit like a bad joke. Two actuaries and the Green Mountain Care Board Chair walk into a bar, but just bear with me for a second. So you have two actuaries and the Green Mountain Care Board Chair and they walk into a bar. They have a few beers and then they spy a dart board in the back of the wall. It has three darts. The Chair steps up. He doesn't have a lot of history or experience throwing darts and mind you he's also had a few beers. So he takes the first dart and he throws it and it lands about seven inches from the bull's eye up on the left-hand side. He then takes the second dart and he throws it and it lands about four inches to the right. Again not in the bull's eye, but closer.

The two actuaries are standing there and then they want to have some fun. They use their expertise to wager on where that third dart is going to land. The first actuary looks solely at the second dart to predict where the third dart will land. The other actuary looks at both the first and the second darts. He's more clever. He gives substantially more weight to the second dart, but then he considers both darts to predict where that third dart is going to hit.

So my two actuaries and a Green Mountain Care Board Chair walking into a bar that's a joke, but it's analogous to the issue before the Board today. We believe the evidence presented today will cause the Board to agree that MVP's weighted consideration of both darts, both 2014 and 2015 risk adjustment data, is a superior actuarial approach and that should be adopted by the Board.

The evidence will show that MVP's methodology was superior because it considered more data points. Data for two years rather than one year. In contrast, you will hear evidence that L&E only used the 2015 risk adjustment and that they declined to include 2014 risk adjustment information. In taking up your statutory charge determining the best rate to approve for MVP in 2017 this Board should consider multiple year data points. That is because the evidence will show that the risk assumption data so far has been highly volatile between 2014 and 2015, volatility like those first two darts that were thrown on a dart board by someone whose had a few beers.

Furthermore, the evidence will show that we only have two years to go on. This is not a case where we have 30 darts on a dart board and we're able

to look at those to determine where the 31st dart is going to land. The evidence will show that MVP's expert actuarial view, because of that volatility between 2014 and 2015, two darts are better than one to estimate where the third dart might land.

The evidence will show that MVP's actuaries have done two things. First, they give the second dart, the 2015 risk assumption, more weight, but, second, they also consider the 2014 data. In doing so they derive what they believe is a superior measure of the risk adjustment and that's reflected in the 6.3 MVP rate increase request. We trust that after hearing that evidence the Board will do the same.

Part of MVP's rate increase request includes a 1 percent contribution in reserves. The evidence will show that L&E finds that contribution reasonable, although the HC expert, Donna Novak, testified yesterday and challenged Blue Cross Blue Shield's contribution to surplus. She did not stay overnight last night to testify here today relating to MVP's filing. In the trial business we call that the empty chair witness which we'll talk about a little more today. So there appears to be no dispute on that issue of contribution to reserves that's

supported by any expert testimony. Thank you.

HEARING OFFICER HUDSON: Thank you. Does the Health Care Advocate have an opening statement?

MS. KUIPER: Good morning. As many of you know my name is Kaili Kuiper and I'm a Staff Attorney with the Office of Health Care Advocate at Vermont Legal Aid. We represent Vermont policy holders in rate review cases before the Green Mountain Care Board and we also run a hotline, a free hotline, offering advice for Vermonters who have issues with their health care.

The hearing today is about producing rates that are both reasonable and affordable. MVP's original filing proposed an average rate increase of 8.8 percent. As MVP has stated, they have recently modified their proposal asking for a rate increase of 6.3 percent. Even this modified proposal far outpaces average wage increases in Vermont. MVP argues that its methodology will bring in -- which brings in more money for the company will help to ensure that MVP is a strong business.

While solvency is important the Board must consider affordability for Vermonters and that MVP's rate increases come out of the pockets of those

Vermonters. We heard public comment yesterday from Vermonters who spoke of how health care costs are negatively impacting individuals, families, communities, and small businesses in Vermont. They described how health care costs are impeding their access to care, taking a huge chunk out of their budgets, and they are asking what will they have to give up to afford future rate increases.

It's no wonder that they feel trapped. As we know most health emergencies or long term costs for chronic care conditions are affordable without health care -- health insurance, but in addition Vermonters are living under a federal mandate that requires them to buy health insurance, yet they can't simply shop around for a better deal because individuals and small businesses their only option is to purchase health insurance on the Vermont Health Insurance Exchange. This is why the Board's regulatory process for health insurance is so critical.

The Board's actuary L&E has opined that MVP's methodology for predicting risk adjustment was unsound and as a result MVP's rates should be lowered by 4.2 percent, and L&E will be testifying today. At the conclusion of this hearing I will ask you to find

that MVP has not met its burden of proof and that L&E's recommendation to lower MVP's rates is reasonable and appropriate and also in the best interest of Vermonters. Thank you.

HEARING OFFICER HUDSON: Thank you. All right. In accordance with the order of business that I announced at the outset of the hearing it is time for MVP to call any witnesses it wishes.

MR. KARNEDY: We call Matt Lombardo.

MATT LOMBARDO,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KARNEDY:

Q. Good morning, Matt. How are you?

A. Good. How are you, Gary?

Q. Good. Would you say your complete name for the Board please?

A. Matthew Lombardo.

Q. Where are you employed, Matt?

A. MVP Health Care.

Q. And what is MVP Health Plan, Inc. please?

A. MVP Health Plan is a non-profit subsidiary of MVP Health Care. MVP offers health insurance coverage under numerous legal entities. MVP Health Plan is one of

those legal entities.

Q. And the rate filing was filed by MVP Health Plan, Inc.; is that correct?

A. That's correct.

Q. What is your position at MVP?

A. Associate Director of Actuarial Services.

Q. And how long have you held that position?

A. Just about one year.

Q. And how long have you worked at MVP?

A. Eight years.

Q. How long in the health care insurance industry?

A. A little over 10.

Q. And do you have any professional certifications?

A. Yes. I'm a Fellow in the Society of Actuaries and a member of the American Academy of Actuaries.

Q. And as it relates to Vermont insurance rate filings what's your experience?

A. I've worked on them for several years. I've signed the actuarial opinions on them since the Green Mountain Care Board has been introduced with the exception of maybe one or two filings.

Q. So when Mr. Lopatka was here testifying you were backing him up; is that right?

A. That's correct.

Q. And Ms. Fish who testified last year you were backing her up as well, correct?

A. That's correct.

Q. Thank you. Now I would like to refer to the exhibit list. You have a binder in front of you, correct?

A. Yes.

Q. And on the front page there's an exhibit list. Do you see that?

A. Yes.

Q. So I'm just going to walk through these exhibits and identify them. It will be easier for folks to follow us during the hearing, and you will see numbered 1 through 7 is our rate filing and the various letters back and forth, the interrogatories and responses between L&E and MVP, correct?

A. That's correct.

Q. And you have reviewed those and are familiar with them, correct?

A. Correct.

Q. And to the extent that MVP makes representation in the rate filings in those letters you would adopt those as your own testimony in this case, correct?

A. Correct.

Q. Then exhibit 8 is the DFR solvency analysis letter, correct?

A. Correct.

Q. You have reviewed that?

A. Yes.

Q. And exhibit 9 is the L&E actuarial opinion of July the 11th. Do you see that?

A. Yes.

Q. And you have reviewed that and understand it, right?

A. Yes. That's correct.

Q. And exhibit 10 that's your CV?

A. Yes.

Q. And exhibit 11 is the July 13th MVP rate increase modification that was filed with the Board, correct?

A. Correct.

Q. And you have reviewed that and helped prepare that, correct?

A. That's correct.

Q. Substantive content came from you?

A. Correct.

Q. Correct?

A. Correct.

Q. And then exhibits 12, 14, and 15 are some

summaries that we've prepared, correct?

A. Correct.

Q. And you helped prepare those, correct?

A. That's right.

Q. Substance in those came from you, correct?

A. Yes.

Q. And then exhibit 13 is from the Centers For Medicare and Medicaid Services Appendix A June 30, 2016 Summary Report HHS Risk Adjustment Program State Specific Data. That's a CMS document, correct?

A. Yes. That's correct.

Q. And that's something you pulled from the internet, correct?

A. Yes.

Q. And I would just note to follow, if you turn to like the first exhibit, we have numbered pages again this year for the exhibits, right, in the bottom right-hand corner, and they are in red. Do you see that?

A. Yes.

Q. So I would ask you to refer to page numbers as we talk through some of these issues, okay?

A. Okay.

Q. So first I want to just explain our rate increase at a high level. Start at a high level. If you would please turn to exhibit 1 and go to page 19 of

exhibit 1?

A. Okay.

Q. And I'm focused on the last sentence in the first paragraph. Let me know when you're there.

A. Okay. I'm there.

Q. Okay. This was MVP's original filing, correct?

A. That's correct.

Q. And when was that filed roughly?

A. May 11th.

Q. May 11th. Thank you. And so that last sentence what was the rate that was being proposed by MVP?

A. 8.8 percent.

Q. Language ranging from 3.5 to 13.5. Can you explain that please?

A. Yes. So MVP offers a number of different benefits on Vermont Health Connect and not every benefit plan went up by 8.8 percent. So the range, the minimum that a plan went up was 3.5 percent and the most the plan went up was 13.5 percent.

Q. Thank you. And then I want to ask you about book of business. If you go under market benefits, do you see that second section on the page?

A. Yes.

Q. The last sentence makes reference to book of

business and provides some numbers. Could you explain that and give the numbers please?

A. Yes. So as of March 2016 there are 2987 policy holders, 4354 subscribers, and 6614 members enrolled in the products affected by this rate filing. So policy holders are in a small group setting. It's the group, and the individual setting it's the subscriber, and then the members are all the employees plus the dependents are -- all the subscribers plus the dependents.

Q. And roughly are you familiar with MVP's market share roughly this year?

A. Yes. About 10 percent.

Q. If you please go to exhibit 9, exhibit 9 --

A. Okay.

Q. -- what is this?

A. This is L&E's actuarial opinion of our initially proposed rate filing that was submitted on May 11th.

Q. Okay. And then if you would go to page 11 of it, page 11 of the exhibit --

A. Okay.

Q. -- and what is L&E recommending?

A. L&E's recommending that the overall rate increase is reduced from 8.8 percent to 3.7 percent.

Q. And if you turn back a page to page 10, do you

see there's two bullets at the bottom of the page?

A. Yes.

Q. And what do those two bullets show us?

A. L&E, after reviewing our filing, proposed two modifications to our rate filing. One of them was a calculation of the average actuarial value and induced demand factor. L&E argued there was some interdependency of the two which MVP did not capture in its proposed rate filing and MVP agreed with L&E on that modification.

The second bullet is to reduce the assumed risk adjustment payment that MVP was reflecting in its rates from $29.42 per member per month to $9.75 per member per month.

Q. So we agreed on the first one and the second one we have a dispute that we're going to talk about today, correct?

A. That's correct.

Q. And then in exhibit 11 please back to exhibit -- exhibit 11. What is this document?

A. This is a document that was prepared -- the substantive information was prepared by MVP staff and then forwarded to you, Gary, and it includes MVP's proposed modification of MVP's initially proposed rate filing after reviewing L&E's opinion.

Q. Okay. And so you see in the letter there's

two bullets in this letter and those are the same bullets that were in their letter, right? We've reproduced those?

A. Yes.

Q. And then we responded to them, correct?

A. That's correct.

Q. So on the first issue, the .5 relating to normalization for AV, we agreed with them, right?

A. That's right.

Q. Now on the second issue, risk adjustment, we disagreed and we explain our rationale, correct?

A. Correct.

Q. And if you go to exhibit 15 please, and again this is just at a high level, I'm just trying to frame this for the Board, exhibit 15 shows MVP's initial rate filing proposal, 8.8 percent, right?

A. Yes.

Q. And then we reduced it to 6.3, right?

A. That's correct.

Q. Based on our view on the risk adjustment and the agreement on the AV, right?

A. Yes.

Q. And then down below it shows L&E's recommended rate of 3.7, right?

A. Correct.

Q. After reviewing other filings and the opinions

set forth therein do you believe MVP's proposed increase of 6.3 is superior to the 3.7 increase suggested by the Green Mountain Care Board actuary in meeting the statutory standards?

A. Yes.

Q. And that would include that it's adequate, fair, just, equitable, and affordable?

A. That's correct.

Q. And it is not excessive, unfairly discriminatory, or misleading?

A. Yes.

Q. And that it promotes quality of care and access to health care, correct?

A. Correct.

Q. Superior, correct?

A. Correct.

Q. So let's get to the meat of it. Let's talk about this risk adjustment program. Will you please go to exhibit 12?

A. Okay.

Q. Let me know when you're there.

A. I'm there.

Q. Okay. So this is a summary that we prepared and we're going to walk through it in a minute, but first could you just tell us generally what is the risk

adjustment program?

A. Sure. The risk adjustment program was introduced with the Affordable Care Act. The concept of it is to level the playing field amongst carriers that are competing to stabilize premium rates. In general, if a carrier has a population that has a lower morbidity than the statewide average they will pay into the system, and carriers with higher morbidity than the statewide average will receive payments. In total there's -- it's a zero sum game so the total dollars paid out equal the total dollars coming in.

Q. You referenced morbidity. What do you mean by that?

A. It's a commonly used term to describe health care utilization and, you know, the sickness of members within a population.

Q. And looking at exhibit 12 it looks like MVP's been making some payments in for the last few years; is that right?

A. That's correct.

Q. So let's go through this. We've blown this up -- parts so you can see it, but let's talk about 2014 first.

A. Okay.

Q. So that's at the top of your exhibit. So if

you could explain, please, what happened in 2014?

A. Yes. So in 2014 MVP paid into the program 2.67 million dollars. Because there was only two carriers effectively that just means that Blue Cross Blue Shield received 2.67 million dollars, and the bigger, the more important fact is the per member per month amount, which is the column next to the total 2.67 million. Because MVP only has 10 percent of the market share the 2.67 million dollars translated to 44 dollars on a per member per month basis which represented about 12 percent of our overall premium. The reason why MVP paid so much is because in the last column where you see the risk score, MVP's risk score was a 1.187, and as I had referred to carriers who are below the statewide average have to pay in while carriers above the statewide average receive money. The statewide average risk score is 1.462 and because MVP was so far away from that, so much lower, we had to pay a substantial amount of money in.

Q. Can you explain a little bit about the health of insureds for different insurance companies and how that factors into this?

A. Yes. So what generates a risk score is the demographic profile as well as utilization of health care services that a population, you know, has throughout a given year. So everything is calendar year. So

essentially what that means that in 2014 MVP's population was healthier than the statewide average.

Q. And healthier than Blue Cross Blue Shield's?

A. Yes.

Q. Thank you. Let's look at 2015 then. Walk us through what happened in 2015 please.

A. So 2015 -- this is the same table as the first table that was shown, the first blowup slide, and it's just the 2015 risk adjustment results which we received on June 30th of this year. So in 2014, again, MVP paid 2.67 million dollars into the risk adjustment program, and in 2015 that number, that figure, was dropped substantially down to $581,000 on a per member per month basis. It changed from 44 dollars down to $9.55. So from 12 percent of premium down to about a little over 2 percent of premium and that's driven by the change in MVP's risk score if you look at the last column.

Q. Okay. So risk score -- this is where it gets kind of in the gobbledygook for us. There's an asterisk next to it. Can you explain the asterisk and the work that you did?

A. Yes. So because there's only two carriers in the state CMS publishes statewide risk scores and general information about the population that's readily available on the web. So we went out to the web and pulled down the

2014, 2015 risk score information for the statewide average, and then using that information we were able to back into Blue Cross Blue Shield's risk score.

Q. Let's go to exhibit 13 please. Exhibit 13. So you just described how you were able to determine Blue Cross Blue Shield's risk score, correct?

A. That's correct.

Q. And so does that relate to exhibit 13?

A. Yes.

Q. So explain what this is and how you did it?

A. Yes. So this is from the CMS web site, Center for Medicare and Medicaid Services, and as I was saying they produce -- or they publish statewide risk score information. So I went out to the web and downloaded a file which can be seen on page 2 of this exhibit. The link is where it says Appendix A under June 30th, 2016, and that just led you to an Excel document and Vermont --

Q. That's on the third page? Just so we're following you, the third page is what you're talking about now?

A. Yes. After I clicked on that link it brought me to an Excel file which is on the third page of this exhibit, and the third page details the information that I used to calculate Blue Cross Blue Shield's risk score as well as the statewide total or the statewide information.

Q. So just walk through briefly those columns, what they say and how you use it?

A. Yes. So the first column is just calling out that the state is Vermont that's being focused on. The second column just tells you what the overall statewide average monthly premium is that's being charged, and then the third column is the one that's being shown on the slide on the easel which is the state average plan risk score.

Q. So you were not privy to Blue Cross Blue Shield's confidential financial data in doing this work, right?

A. No.

Q. So why is this valid then?

A. Because there's only two carriers in the state I can -- you know using this information along with MVP's information I was able to reproduce Blue Cross Blue Shield's risk score, and in general the real meat of the calculation is the total information which is shown on this slide.

Q. So what you're saying, and this is numbers stuff not lawyer stuff, but what you're saying is by having the total number and having MVP's number you were able to back it out and figure out Blue Cross Blue Shield; is that right?

A. Yes.

Q. And would L&E be privy to confidential information that would cause their opinion about 2015 to be superior to your opinion of 2015?

A. They did have more information because they had both carriers' risk scores which by metal level and by plan, but in general, you know, we manage Affordable Care Act filings in two states and you can kind of usually see the pattern. Members in the bronze plans are generally healthier. They pay into the risk adjustment program, while the platinum members they usually utilize more services and they usually receive money. So they did have more information, but the high level calculation I think we can get -- you know we're getting there with our information.

Q. This is pretty simple math, right?

A. Yes. It's just algebra. Yes.

Q. Okay. The third part of exhibit 12 is down on the bottom. We've blown that up and this relates to volatility. I hope everyone can see that. Matt, will you please explain this volatility table please?

A. So what we're comparing is just MVP's risk score in 2014 and 2015 versus Blue Cross Blue Shield and statewide average risk scores in 2014, 2015, and what you can see is that MVP's risk score changed by 20.1 percent

year over year while Blue Cross Blue Shield's only changed by 5.3 percent and the statewide total changed by 6.4 percent.

Q. So is 20.1 percent significant in your opinion?

A. Yes. That's very volatile.

Q. What does that mean in lay terms it's very volatile?

A. It means that it will be hard to pinpoint exactly where it's going to land in the future. So we did a little more digging on our data and 80 percent of our members who enrolled in 2015 were also enrolled in Vermont Health Connect in 2014, and on top of that we looked at statewide average enrollment information and it doesn't appear statewide total enrollment changed too significantly. So that kind of gives us a feel for how much that in 2014, 2015 the market was relatively stable, yet MVP's risk score did change by significantly more than Blue Cross Blue Shield's. Almost four times more.

Q. So as an actuary you want to use all the good data you have to best value this risk adjustment payment, correct?

A. Correct.

Q. Okay. I would like to compare next MVP and L&E's adjustment calculations. I have another exhibit.

A. Okay.

Q. Exhibit 14. So based on all of that MVP did something and L&E, we know from their report, they did something else. Would you please walk us through and describe the difference at a high level?

A. Yes. So when we initially filed our rates for 2017 we didn't have our 2015 risk adjustment results. Once we received those results we saw that our risk payment -- our risk adjustment payment did change substantially, but as we did more and more calculations on our data we were able to see how volatile our risk score was. So rather than just using 2015 data to -- for our risk adjustment we decided to put two-thirds weight on our 2015 risk adjustment results and then one-third weight on 2014 risk adjustment results while L&E's estimate puts all the weight on 2015's risk adjustment results.

Q. So then our amended filing we ended up doing an additional reduction as a result of what you just described, right?

A. Yes.

Q. And that was 1.8 percent?

A. Yes.

Q. And that's different than the 4.2 that L&E had, right?

A. Correct.

Q. So MVP used two data points. L&E -- well two years of data points and L&E used one year of data points, right?

A. Yes. To the best of my knowledge, yes.

Q. Just a couple of followups to that. Did MVP include a risk adjustment payment in our rate filing last year?

A. No. We did not.

Q. Why not?

A. So when 2016 rates were set we used 2014 data and we did not have our 2014 risk adjustment results at the time our rates were set. So when we initially proposed our rates we built a 1.0 or no risk adjustment payment or receipt into our rates. We did receive our risk adjustment information before the Green Mountain Care Board made their final decision and we did choose not to change our rates because there were a couple of reasons. One, 2014 risk adjustment results were a little bit -- they weren't as trustworthy because a lot of people did not enroll in the exchange until May of 2014. So that could skew the risk score of the members.

We also wanted to offer very competitive premium rates which you could see by us building in zero percent contribution to reserves in our rates last year.

Q. So that second thing you just said that's a

business reason, right?

A. Yes.

Q. And the first was you just said the 2014 data was less than perfect, right?

A. Right which is why we put twice the amount of weight in our 2015 results in our revised calculation?

Q. You didn't have 2013 results. You just had the one year and it was less than perfect, correct?

A. Yes.

Q. And last year at the time these decisions were made had the State of Vermont done a market simulation?

A. No. They had not.

Q. Okay. So let's -- we went back in time. Now let's go back to the current, and in May our original filing you treated the risk adjustment program differently than we did in the amended filing, right?

A. Correct.

Q. Can you explain why?

A. Yes. So in 20 -- we were setting our rates for 2017. We had 2014 data and then CMS issued an interim risk adjustment -- interim risk adjustment results about a month before we set our rates. That information indicated that MVP would go from paying 2.7 million dollars to receiving almost 2 million dollars in the risk adjustment program. There were some questions about that

information, though, because we didn't know how much information Blue Cross Blue Shield had submitted which could skew the results.

So we had two data points at that point and we said we don't know how much we trust this interim result because we don't know how Blue Cross Blue Shield is submitting this data. So -- but we do think that this does suggest that our risk adjustment payment will go down. So rather than building in the full amount of our risk adjustment payment we took two-thirds of our 2014 payment and reflected it in our initially proposed rates.

Q. And that was based on two data points you said, right?

A. Yes.

Q. And then you go forward and we modify, we amend, our filing, right, which is exhibit 11. Going to page 2 of exhibit 11, you have already reviewed this, I just want to briefly ask you on this data point when we amended that was in -- when was that? What's the date of our filing?

A. July 13th.

Q. Okay. So July 13th and that was just after L&E's recommendation was filed, right, two days later?

A. That's correct.

Q. So this amended modified request how many data

points did you use?

A. Two.

Q. And by two you mean two years of data?

A. Yes.

Q. So if you can go to exhibit 15 please, exhibit 15 you provided the content on this, right?

A. Yes.

Q. So just to summarize MVP was initially at 8.8, right?

A. Uh-huh.

Q. And then we did the risk adjustment we felt was appropriate of 1.8 modification, right?

A. Yes.

Q. The .5 we agreed on, right?

A. Yes.

Q. That got us to 6.3, right?

A. Uh-huh.

Q. You got L&E's recommended rate down here of 3.7, correct?

A. Yes.

Q. And then can you explain the table in the middle. You prepared that, right?

A. Yes. The table is just comparing the initially proposed rate change, the modified rate change, based on metal level. So as we had talked about initially

the range of increase has varied based on metal level. So you can see that in general, though, all the reductions are between 2.1 and 2.3 percent which is the last column.

Q. I would like to turn to solvency now. Matt, what is MVP seeking this year in terms of contribution to surplus?

A. One percent of premium.

Q. And why that amount in comparison to last year please?

A. Last year, as I had mentioned earlier, we were trying to offer the most competitive rate possible to gain market share. We reflected in our actuarial memorandum we did not think that was a sustainable method. So we reverted back to one percent of the premium which is consistent with other filings that we've submitted.

Q. So other filings you submitted. There was a decision in May of 2016 on large group EPO/BPO for MVP where there was an one percent contribution to surplus. You're familiar with that, right?

A. Yes.

Q. Different risk pool, but the surplus for the same company was allowed, right?

A. Yes.

Q. And you're familiar with the November 16, 2016 decision on grandfathered small groups were at two percent

contribution to surplus was allowed by the Board, correct?

A. That's correct.

Q. Again different risk pool, but the same company, right?

A. Yes.

Q. And if you turn to exhibit 9 please, this is L&E's memorandum, right?

A. Yes.

Q. Go to page 9 paragraph 10. Would you please read the last two sentences in that paragraph?

A. "The proposed one percent contribution to reserves, while higher than approved last year, is more consistent with the assumptions found in MVP's other previous filings. We note that a zero percent margin is not sustainable in the long run and believe that the contribution to reserves appears to be reasonable and appropriate."

Q. So -- and you would agree with that statement?

A. Yes.

Q. So MVP and L&E are in agreement on the one percent to surplus, right?

A. Yes. Correct.

Q. And then if you go to exhibit 8 please, exhibit 8, would you identify the document please?

A. This is the DFR solvency opinion on our

exchange rate filing.

Q. And would you please read on page 1 the first -- well the only sentence under summary of opinion please?

A. "DFR is of the opinion that the rate as proposed will have the impact of sustaining the current level of solvency of MVP Health Plan."

Q. And then go to the last page under impact of the filing on solvency, just read the last clause please after inadequate?

A. "DFR's opinion is that the proposed rate will likely have the impact of sustaining MVP Health Plan's current level of solvency."

Q. Okay. What's the date of this letter?

A. July 8th.

Q. So this solvency -- this excellent solvency opinion from DFR was on our original filing not on our modification, right?

A. That's right.

Q. Okay. So we've gone from 8.8 to 6.3, but we'll be hearing from DFR today on the amended filing, correct?

A. Correct.

Q. In your opinion will the reduction from 8.8 to 6.3 in our modified filing adversely impact the solvency of MVP Health Care, Inc.?

A. No.

Q. I want to run through the statutory elements with you.

A. Okay.

Q. Are MVP's rates excessive or unfairly discriminatory?

A. No. The proposed rates are reasonable relative to the benefits that are offered.

Q. Are the rates inadequate?

A. No.

Q. Why not?

A. Because we've done a thorough analysis of our data and project it forward and we're comfortable that the premiums that we're offering or proposing are reasonable relative to the benefits that we're -- that are included in the filing.

Q. Will they cover your claims cost to your best estimate?

A. Yes.

Q. Will they cover the expected cost of the delivery of health care for these products?

A. Yes.

Q. Are the rates unjust, unfair, inequitable, misleading, or contrary to Vermont law?

A. No.

Q. Why not?

A. Because they promote all of Vermont statutes of quality of care and affordability and the rates are reasonable based on the data that we have.

Q. Are they actuarially sound?

A. That's correct. Yes.

Q. Do you believe the MVP rates promote quality of care and access to health care?

A. Yes.

Q. Why?

A. MVP does a lot of work credentialing its providers and also through NCQA accreditation. We also offer an out-of-network benefit for Vermonters purchasing our products that go outside the State of Vermont so that they can seek care if it's needed when they are traveling.

Q. And if you would go please to exhibit 1 page 26, let me know when you're there. The third paragraph under the bold heading, Matt, there's a reference here to funding for the Health Care Advocate. Do you see that?

A. Yes.

Q. Just at a high level what's that about as it relates to MVP promoting quality of care and access to health care?

A. Well the Health Care Advocate speaks on behalf of the consumers and, as Kaili had mentioned earlier, they

have a free hotline so -- for consumers to call with questions. This fee is going to be used to help fund the Health Care Advocate which is looking out for Vermonters.

Q. And there's a reference to MVP being responsible for an approximately $70,000 payment towards that, correct?

A. Yes.

Q. Do the MVP rates meet the standard of affordability in your view?

A. Yes.

Q. Are they actuarially justified?

A. Yes.

Q. Final piece is on administrative savings and innovations by MVP in the last few years, in particular, this last year. Would you please review some of that for the Board?

A. Okay. Yes. So MVP has been doing a lot of work on quality improvement expenses. We're also analyzing all of our administrative expenses and special projects that we're taking on to ensure that it isn't just a project that's going to fix something in the short term. It can actually lead to long term efficiencies and savings, and you know we participate in the Vermont Blueprint for Health and as well as a number of other -- we're always in discussions with other programs that are

proposed to help promote affordability, access to care.

Q. If you would go to exhibit 5 please, which was one of the interrogatory letters, page 4 of that?

A. Okay.

Q. I think you touched on this, but number 12 -- the answer to number 12 talks about quality improvement cost containment program. Can you give us a little more detail on that?

A. Yes. So the Vermont Blueprint is a statewide -- both payers are participating in it, and the concept is to have community health teams and patients in medical homes where other providers of health care coverage can actually -- members can visit with them to help create efficiency and reduce costs, and then MVP is also participating in Health First IPAQI program. That was the first year last year that I'm aware of. So the calculation of if there's some sort of reward given back to the providers for finding efficiencies of care, it was still being calculated at the time of this filing.

Q. And then finally if you would go to exhibit 9, I think L&E sets out their thoughts on these issues. Go to exhibit 9 page 9 number 9 please.

A. Okay.

Q. Are you there?

A. Yes.

Q. So the first paragraph they are reviewing our changes in administrative costs. Do you see that?

A. Yes.

Q. And does L&E indicate that they are basically unchanged from 2016?

A. Yes.

Q. And that our assumptions are based on actual 2015 MVP expenses?

A. Yes.

Q. And they found it reasonable and appropriate, correct?

A. Correct.

Q. And then the second paragraph.

A. Okay.

Q. They indicate that the administrative expense as a percent of premium is decreasing, correct?

A. Correct.

Q. They also indicate the costs have fallen substantially since 2013, correct?

A. Correct.

Q. And the historic reductions could not continue indefinitely, right?

A. Yes.

Q. So L&E generally accepts the steps MVP's taken as it relates to their administrative costs, correct?

A. Correct.

MR. KARNEDY: Thank you, Matt. I think other folks may have questions for you.

HEARING OFFICER HUDSON: And do I have any questions from the Board at this time?

MS. HENKIN: I would like to ask a couple questions first.

HEARING OFFICER HUDSON: That's fine.

CROSS EXAMINATION

BY MS. HENKIN:

Q. Matt, maybe we'll do the dart analogy a little bit for the Board here. You said you used two darts this time and you weighted the 2015 dart heavier than the 2014?

MR. KARNEDY: May I just ask a procedural question? I'm not sure of the General Counsel's role in examining witnesses and how it works. I'm fine with it. I just don't understand the procedure.

HEARING OFFICER HUDSON: Well under Rule 2 the Board or its designee or its attorney can question witnesses.

MR. KARNEDY: Fair enough. Sorry to interrupt.

BY MS. HENKIN:

Q. And I just want to clarify something before

the Board asks their questions because it's something here I was a little interested in this answer. So you did this same exercise last year in figuring out a risk adjustment, correct?

A. Well we only had one piece of data last year. So the timing of our results were similar. So I guess I'm a little unclear about the question.

Q. How did you determine your risk adjustment last year? Did you use the 2014 data?

A. Last year we didn't build any risk adjustment payment into our rates because we had, you know, as I mentioned we wanted to offer the most affordable rate, and if we reflected the 2014 risk adjustment results, it would raise our premiums by about 12 percent which would have been uncompetitive and we would have not been able to have any market share.

Q. So in I guess it's exhibit 11 on page 2, this letter, in the next to last paragraph says the 2014 -- you don't ignore the 2014 results as valid and real. You stand by that statement?

A. Yes. You know you can't ignore the fact that both years MVP did pay into the risk adjustment program. We do think 2015 is more reliable, but we don't think it's appropriate to ignore 2014 completely which is why we put twice the amount of weight on 2015.

Q. Do you remember responding to a question after the final CMS report came out last year about the 2014 -- how you were going to -- if you were going to do risk adjustment -- let me just read this to you.

"MVP does not believe that 2014 risk adjusted results should be used to indicate a carrier's relative risk position for a number of reasons," and then you listed that a significant percentage of members were not enrolled in a plan subject to risk adjustment and it could skew the results, it was not a full year of claims, did not reflect the small group expansion to a hundred employees, two-thirds of the membership were not enrolled in ACA compliant plans, and something about the model of MVP 2014 relative risk position isn't the same as the model used in the projection period. Do you remember saying that?

MR. KARNEDY: I wonder if he could see the document. It might be helpful.

MS. HENKIN: I'll offer it. I'm going to see if he remembers this document first.

A. In general I'm familiar with it. I don't remember the exact details of the response, but I'm generally familiar with it.

Q. All right. Provide one to the Hearing Officer. Question two.

A. Okay.

Q. Do you remember that now?

A. Yes.

Q. So based on what you said last year are you still standing by your statement now that the data from 2014 is valid and reliable?

A. Well I would say it's less reliable than 2015, but again I don't think it's something you kind of ignore completely. It did happen. So, you know, the fact that we are still payers, the fact we have such a small market share, and there have been -- consultant studies have been done which speak to the fact that carriers with a small portion of the market do have volatile risk scores, I think it's valid to weight it in.

Q. What did you use this year then to account for population differences in 2017 versus 2014 and 2015?

A. We assumed that the 2017 population, our non-ACA complaint data that was used to set the premium rates, was consistent with our population enrolled in the exchange.

Q. What about the 51 to 100 moving in or the Medicaid changes?

A. Well we looked at the allowed costs. So the total cost of those members. We did not account for the Medicaid changes. I'm not really familiar with that. We

don't have any data in the Medicaid program. So we did have 51 to 100 in our data pool use of premium rates, though, we analyzed their costs relative to the exchange block and they were relatively reasonable.

Q. In your opinion is it the place in this particular change -- there's different components to a rate?

A. Yes.

Q. And you're changing the rate based on this risk adjustment. Is that where your calculation should account for volatility because of size of membership or plan? Where do you generally put into your rates the protections against volatility?

A. In this case because it will be driven by the risk adjustment program that's where we chose to build it in. We could also build in through a higher contribution to reserves, but we didn't choose to do that.

Q. Okay. So this year you used two darts, but last year you thought one was good?

A. We didn't really think the one was good last year, but as we've gotten more data we have a little more faith in that one dart.

Q. I'm talking about the last year you didn't use that first dart, correct?

A. That's correct.

MS. HENKIN: Okay. Thanks.

HEARING OFFICER HUDSON: Any further questions from the Board?

MS. RAMBUR: I have one. I just want to make sure I'm clear on this. So you had 80 percent retention, correct?

MR. LOMBARDO: Correct.

MS. RAMBUR: And you had quite a dramatic change in the risk score in those years. So I was curious is this new people who are more ill coming in or that 80 percent becoming more ill or using more services? Can you just --

MR. LOMBARDO: We didn't look at the difference between the AD20 of the population that was new versus the existing population. That wasn't part of our analysis, but in general to see a 20 percent swing it would mean we would inherit primarily only very sick members. So I think it just speaks more to the volatility of the risk adjustment program when you have a small membership base.

MS. RAMBUR: Thank you.

MR. LOMBARDO: You're welcome.

HEARING OFFICER HUDSON: Hearing no further questions --

DR. RAMSAY: I have one. So, Mr.

Lombardo, has this competitive rate model that you started last year, has that shown a growth in your membership for the exchange?

MR. LOMBARDO: We have grown. Not to the degree that we anticipated, but we did grow slightly.

DR. RAMSAY: Because it is true the more members you have the more you are more able to distribute this risk we keep talking about, correct?

MR. LOMBARDO: Correct.

DR. RAMSAY: How did you determine that one-third/two-thirds breakdown? Why not one-fifth/four fifths? Why not 10 percent/90 percent? What's the -- is there some precedent? Is there a formula? What went into your mind in terms of -- or was it just what you thought we would feel is reasonable? I don't know.

MR. LOMBARDO: There isn't that much science to it to be honest. It's, you know, as actuaries we use as much data that's reliable and that's trustworthy in our calculations, and we just chose two data points and then we thought it was appropriate to put twice the amount of weight on the most current results. We thought that was just a fair ratio. It's not really a calculation that I can

say oh yeah we can refer to some math formula in how we got there. It's just more of a -- it felt like a reasonable assumption.

DR. RAMSAY: And, lastly, you have been at MVP for like eight or nine years where before being kind of the lead actuary here what were you in another -- what was your other role at MVP and was it in operations? All in finance? What --

MR. LOMBARDO: So I've always been an actuary in the actuarial department. So I was just kind of working my way up and I was an analyst to start and, you know, as time has moved on I kind of just moved up a little bit in the department.

DR. RAMSAY: Because, you know, as a physician I'm always intrigued by the quality improvement initiatives and innovations, and again it's probably not appropriate to focus more questions specifically to you around more details so that's why I'm asking. You enjoyed being in the first chair today?

MR. LOMBARDO: Yeah. It's kind of cool.

DR. RAMSAY: Okay. Good. I know you were here last year, but it's a whole different model.

MR. LOMBARDO: Yes.

DR. RAMSAY: That's all I have.

MR. LOMBARDO: Thank you.

HEARING OFFICER HUDSON: Hearing no further questions does the HCA have questions?

MS. KUIPER: I just have a couple quick questions.

CROSS EXAMINATION

BY MS. KUIPER:

Q. So you have testified today that in your analysis the difference between your recommendation on the risk adjustment and L&E is that you incorporate 2014 data and they don't; is that correct?

A. Correct.

Q. And initially you were only looking at 2014 data and you didn't look at 2015 data, correct, when you did your initial filing?

A. 2015 data wasn't available at the time we set our rates.

Q. But there was interim 2015 data that you decided that wasn't reliable, correct?

A. We didn't think it was reliable. It did indicate a big swing from a 2.7 million dollar payment to a 1.9 million dollar receipt approximately. So we thought directionally, you know, it suggests our data was going that way which is why we chose two-thirds of our 2014

results, but we didn't have much faith in it at all. There was a couple of different reasons why we didn't have faith in it, but we thought directionally it suggested improvement for us.

Q. Okay. And then when you received the final 2015 results you still initially didn't incorporate it until after L&E's opinion came out; is that correct?

A. Yeah. It was just really -- it's a tight timeline so when we received the final risk adjustment results from CMS it was late in the day on June 30th, Thursday I believe, and then July 1st we received an objection from L&E asking us I think the question that you're referring to, and we just continued to do analysis. By the time our response was due to L&E we didn't feel like we had done a thorough enough look at all the data, the statewide average data, and kind of were uncomfortable to make a recommendation at that point.

Q. All right. Can we just look at that? I believe it's exhibit 6, objection letter number 5. So would it be accurate to say that in your response here you say that the 2015 results didn't raise any concerns? You didn't say you were looking at the data further or you were doing further analysis, but it doesn't raise any concerns, correct?

A. Yes I did make that statement, but I would

like to -- you know, I think the phrasing of the question it concerned has a negative connotation to it. So we weren't concerned that our rates were going to be inadequate because of the --

Q. All right. That's fair that you weren't concerned your rates would be inadequate. All right. And I just want to turn you to exhibit 2 and page 6 question 6, and I believe this is the first time that --

A. I'm sorry to interrupt, but you said page 2?

Q. Sorry. Exhibit 2 page 6 and also question 6.

A. Question 6. Okay.

Q. I'm sorry. Question 16. I'm sorry. No wonder you're confused. Probably everybody is confused. So I believe this is one of the first times that L&E had asked you about your risk adjustment calculation and you had -- that you had put into your filing, and you're discussing the fact that you had relied on 2014 data and just used two-thirds of it, and would you just read your response here, let's see, just the first three sentences?

A. "The extended open enrollment period in 2014 does not necessarily indicate MVP's relative risk position will increase or decrease, but it puts a high degree of uncertainty around every carrier's relative risk position in 2014. MVP's preliminary risk adjustment results for 2015 were drastically different than actual 2014 results.

See our response to question 18 below. Because there's so much uncertainty in the actual 2014 risk adjustment results representing the market wide average risk and there are significant changes between 2014 actual results versus 2015 preliminary results, MVP chose to estimate a risk adjustment factor equal to two-thirds of its 2014 risk adjustment results for the proposed rates."

Q. Thank you. So you say here that the extended open enrollment period in 2014 had a high degree of uncertainty in the 2014 data, and then you repeat again that there is so much uncertainty in the actual 2014 data, is that correct, that's in there?

A. Yes.

MS. KUIPER: Thank you. I have no further questions.

HEARING OFFICER HUDSON: And were there any further questions?

DR. RAMSAY: Could you explain to me how MVP is going to reconcile this risk volatility over time with such a small market share? How are you going to do that? Are we going to hear every year picking and choosing the year that seems to work best for such a small membership? How are you going to do that?

MR. LOMBARDO: It's going to be really

challenging until we can gain more market share and, you know, it is going to be a volatile risk score potentially from year-to-year. The challenge could be -- it could be addressed maybe through some revisions to federal legislation or federal -- the federal law where they may make -- you know, put a cap on certain risk score or risk adjustment changes, but as we get more data there's also the chance that, you know, if we continue to see a high degree of volatility I think we're going to have to take a similar approach. Hopefully it will smooth out over time, but there's nothing that we can really do to basically ensure ourselves that there won't be a big -- a large swing in our risk score, and it's also important to keep in mind that we basically are at the mercy of Blue Cross Blue Shield. So to the extent that they increase their coding or do things like that, if their risk score goes up and MVP's risk score stays the same, MVP's payment will continue to grow.

DR. RAMSAY: Right. That's all. Thank you.

MR. KARNEDY: Redirect briefly?

HEARING OFFICER HUDSON: Yes.

REDIRECT EXAMINATION

BY MR. KARNEDY:

Q. Just a couple. You explained on direct exam and then were asked on cross, let me just ask it again. This year you used two data points. You used the 2014 data as well as 2015, correct?

A. Correct.

Q. And why did you feel more confident in using 2014 this year than last year?

A. Because we had 2015 results and both years MVP was a payer and showed we had a healthier population than the statewide average, and we also did more research which indicated that a carrier with a small market share is subject to significant volatility in the risk adjustment results from year-to-year.

Q. So having the second year caused you to feel you have got two data points here and we can use some of 2014 to try to get the best number possible; is that right?

A. That's right.

Q. And then the great question from Dr. Ramsay on the two third/one-third, how did you come up with that? Can you explain how actuaries -- you know, the art of being an actuary, not just the science please?

A. It's -- yeah I guess -- again we just try to look at as much data as possible and there is a range of

reasonable results that we can use to formulate our assumptions which are going to drive our proposed rates. So we try to just look at both data points. We try to take as much reliable data or data that we trust and reflect that, but how we choose to put different weights on the two -- on the various data elements is a little bit more of an art than a science.

Q. Is that uncommon for actuaries to exercise their professional views and weight things?

A. No.

MR. KARNEDY: Thank you very much.

HEARING OFFICER HUDSON: Hearing no further questions thank you very much, Mr. Lombardo.

MR. LOMBARDO: Thank you.

HEARING OFFICER HUDSON: At this point in the hearing I would like to call to the stand the Vermont Department of Financial Regulation's Commissioner or his designee.

MR. CHIEFFO: Thank you.

HEARING OFFICER HUDSON: Good morning.

MR. CHIEFFO: Good morning.

HEARING OFFICER HUDSON: Sir, would you briefly state your name, title, and basic job description for the record?

MR. CHIEFFO: Sure. My name is Ryan

Chieffo C-H-I-E-F-F-O. I am the Assistant Director of Rates and Forms for the Department of Financial Regulation. Statutorily the Department is here today as a witness. I think technically our Commissioner is the witness. I am his designee.

My job description currently is pretty broad. My technical responsibilities are for all life and health rate and form filings. There's a team of three analysts and myself that approve -- review and approve or ask for modifications or reject health insurance forms including, you know, applications, group forms, policies, certificates, riders, amendments, anything like that. We also address rates for all health lines that are not what the Board does for their rates.

I also have a role in a number of the other aspects of the Department's regulation including solvency, some licensing and analysis background from when I used to be the Assistant General Counsel for the Department. We also weigh in on matters of consumer services, matters of market conduct, and just general subject matter experts for the life and health.

HEARING OFFICER HUDSON: Thank you. Could you briefly identify in the stipulated exhibits

the written commentary that the DFR has submitted and that you may be commenting on?

MR. CHIEFFO: Absolutely. So in the stipulated exhibit list we are exhibit 8. It's our July 8th, 2016 letter which provides our solvency analysis and opinion which is required by statute for the same statute under which we're here today.

HEARING OFFICER HUDSON: Thank you. Please proceed with your commentary.

MR. CHIEFFO: Sure. Thank you very much. I have just some brief remarks to kind of set the stage generally for the Department's role in solvency regulation for out-of-state companies, and then I would like to address specifically both our opinion and our solvency analysis for this filing in particular.

Very broadly in the United States insurance regulation is state based. The state where an insurance company is domiciled, their home state essentially, is the primary regulator for that company. As we spoke about yesterday, Blue Cross Blue Shield of Vermont is a Vermont domiciled company. DFR is their primary regulator. This is necessary having the home state be the primary regulator with other states secondary since many

companies, I believe most companies, operate in multiple states or all over the country. In Vermont alone we have approximately 1,000 out-of-state insurers licensed to do business here. So for DFR to be effective solvency regulators for all of those companies would be just an absolutely enormous use of resources, and it would also be wasteful in that every other state would be doing the same thing creating tremendous redundancies.

So what we do and what other state insurance departments do is rely heavily on a company's home state for solvency regulation. In MVP's case that state is New York. So all the regulatory tools that we discussed yesterday that DFR brings to bear on Blue Cross Blue Shield of Vermont so too does New York have those tools at their disposal in regulating MVP; and just to recap quickly, you know, that includes comprehensive financial examinations, consistent access to all the books and records of the company, interviews with the board and management, analysis of non-insurance risks, analysis of non-insurance lines, non-insurance entities, and the holding company, and many other tools, analytical and otherwise.

For DFR's part in regulating the

solvency of MVP we have access to those New York regulators to understand better, you know, in-depth regulation that they are doing. We also have access to non-public solvency related analytics, and we also have our own foreign company licensing standards that themselves are solvency based. So before MVP can gain a license to do business here and in order to maintain that license DFR does have minimum solvency and minimum licensing standards that we apply as well, and to map on to all of that as a general matter DFR's level of solvency regulation for out-of-state companies is somewhat dependent on a company's footprint in Vermont. So, for example, if half of MVP's business were Vermont based, we would assuredly have a much more significant engagement than the solvency outlook and the regulation than we do because MVP's actual footprint here is much smaller than that.

So against that backdrop our opinion of this filing's effect on MVP's solvency is the same as it has been in prior opinions. If the actuaries find the rates to be adequate and not excessive, then the rates will likely have the effect of maintaining MVP's current level of solvency. Our conclusion has remained consistent across many filings for a number

of reasons, but in large part that is based on the fact that MVP's Vermont operations account for less than five percent of its total business, and drilling down on that further we're here discussing the qualified health plan which is less than MVP's total book of business in Vermont. That also doesn't account for other entities and other operating entities in the holding company. So due to that volume of business and our own solvency assessment and the lack of any indication from New York of any solvency concerns, our conclusion regarding the originally filed rates is that they will have the effect of maintaining MVP's current level of solvency. We have also reviewed MVP's amended filing which decreases their average rate increase to 6.3 percent and our conclusion remains the same.

I will add as a final note that our conclusions are contingent upon the actuaries finding that the rates are adequate and not excessive. As a matter of long term health and solvency, which I think has been addressed at least somewhat in testimony you have already heard, as a matter of long term health and solvency adequate rates and reasonable contributions to reserve are necessary for all health insurers. Assuming those actuarial

findings are present here, then we come to our conclusion. Thank you.

HEARING OFFICER HUDSON: Are there any questions from the Board for this witness?

MR. HOGAN: Have you done a review of the 3.7?

MR. CHIEFFO: We have. We've reviewed the Lewis & Ellis opinion and we have reviewed their recommendation. Our primary responsibility is to opine on the rates as filed, but, you know, as you have heard I think the big issue here is one of methodology, actuarial approaches, and that's I think the difference here between MVP's 6.3 and L&E's 3.7, and I alluded to just before, you know, we defer on that sort of thing to the actuaries. DFR does not bring its own actuaries into the solvency analysis, and so given that this is an out-of-state company and given that this is, I think, pretty purely a question for the Board in determining what is the most adequate or whether these rates are adequate or excessive, our conclusion would remain the same. I think if the Board comes to that conclusion that anything in that range is adequate, non-excessive rates, as long as they, the actuaries, support that then that would support our conclusion.

MR. HOGAN: Thank you.

DR. RAMSAY: Thank you, Ryan. So your role in Blue Cross Blue Shield versus MVP is completely different?

MR. CHIEFFO: Yes.

DR. RAMSAY: You don't have all of those tools, but you rely on the New York regulators to use those tools. Is there -- explain to me how a company as big as MVP with its -- which is domiciled in New York could possibly become insolvent related to this small book of business?

MR. CHIEFFO: For --

DR. RAMSAY: They have got resources, you know, throughout their entire organization that could -- that basically protects them from insolvency for this small number of members, wouldn't you agree?

MR. CHIEFFO: So maybe for some context and I don't have specific numbers here, but I do think, you know, in thinking about the truly huge health insurance companies and holding companies I don't think MVP ranks up there nationally with the truly giant ones, but that being said I understand your question, and I think that any given filing in Vermont or any given filing of this size, even if it were in New York, on its own likely would not impact

the solvency of MVP.

You know that being said, I'm not sure as a solvency regulator that's an appropriate way to look at health insolvency. Certainly any one drop in any one bucket is not going to make the bucket overflow. However, enough drops, you know, without looking at any of the drops before or after could do so.

So I think the way we approach it is that all rates should be adequate. All rates should support the long term health of the company, and I think by actuarial standards that does include paying claims, paying taxes and fees, paying reasonable administrative costs, that includes the reasonable contribution to surplus. So to answer your question I don't know the number that would sink all of MVP in Vermont, but I don't know that that's the way we would approach it.

DR. RAMSAY: So if I was a regulator in New York looking at -- and I doubt that New York regulators spend a whole lot of time looking at this particular rate filing, you know, and its impact on solvency for this particular book of business, I can't imagine that they would, but you would agree that if I'm a regulator in looking at MVP's solvency

as a domiciled company in New York, I would feel pretty confident whatever happened in this particular filing?

MR. CHIEFFO: I guess I can't speak to that directly because I'm not a New York regulator.

DR. RAMSAY: I'm sorry. It's not an easy -- I'm just opining.

MR. CHIEFFO: I understand.

DR. RAMSAY: Thank you.

CHAIRMAN GOBEILLE: I'll just play devil's advocate. I think the point you're making is there's no way in 2006 anyone would have thought that you should short the housing market. That something that big could never actually fail.

MR. CHIEFFO: I think that's a fair point.

CHAIRMAN GOBEILLE: Meaning that you want every single product that you have as an insurance company to meet a certain level of solvency so that it can -- so that it can withstand something happening, and if something happens on a health basis, meaning, you know, cataclysmic health event, New York is not very far from Vermont meaning the populations will be affected at the same time.

MR. CHIEFFO: Yes, and maybe to the

housing analogy, you know, there is a finite number of lives here and there's an open amount of risk. This is complete risk. You know this is true insurance risk that MVP is taking. So I'm not qualified to speculate on what type of events could occur, whether they would occur across geographic lines or anything like that. You know DFR I think was accused of being very conservative yesterday and I think any insurance regulator would be the same.

CHAIRMAN GOBEILLE: You were complimented.

MR. CHIEFFO: Maybe we were complimented for being conservative yesterday, but I think that any insurance regulator is going to be the same because, as you say, you know each product and each line and each filing really does need to stand on its own because to pick and choose which ones support the others is getting towards sort of an unfair subsidization, and even beyond that you know it's one of those things that to degrade a level of solvency and of surplus, you know, based on some filings and not others it's not as easy to flip that switch back and to gain that back whether through the same filings or from the ones that were lowered too much, and so we can't predict the future, but what we can

do, even on a small filing on a small line of business that is volatile, is just generally advocate, and again we are not the primary regulators, but what role we do have is to generally advocate that, assuming the actuaries find the rates to be adequate and assuming they are not excessive, is to then support that those rates will help to maintain the solvency of the company.

HEARING OFFICER HUDSON: Hearing no further questions from the Board -- no further questions from the Board does MVP have questions for this witness?

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Just one just to follow up on what you just said. You referenced that the business is volatile in your opinion, right? Based on what you have reviewed MVP's business is volatile in Vermont from year-to-year?

A. I would say from my own purposes that's really more coming from this filing and seeing -- reviewing this filing and reviewing other filings. For our purposes just purely looking at solvency our opinion MVP solvency has been fairly consistent.

Q. So your comment about volatility relates to this volatility from what you saw in 2014 to 2015?

A. That's correct. That's correct.

MR. KARNEDY: Thank you very much.

HEARING OFFICER HUDSON: Any further questions? Thank you very much, Ryan. All right. I've got requests from the Board at this point for a brief recess. Let's please try to keep it to five minutes.

(Recess.)

HEARING OFFICER HUDSON: Welcome back everybody. The next item on our agenda is to hear from the Board's contracted actuaries Lewis & Ellis and I will turn that over to the Board's attorney Judy Henkin.

MS. HENKIN: Thank you, Noel.

JACQUELINE LEE,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HENKIN:

Q. Good morning, Jackie. Can you tell who you are and who you work for?

A. Sure. I'm Jackie Lee. I work at Lewis & Ellis.

Q. What's your title there?

A. I'm a Vice President and Principal at L&E.

Q. And what is your job that you do?

A. I am a consulting actuary. I work primarily in the health -- or mainly on the health side working on rate filings and other pricing projects.

Q. What are your professional credentials?

A. I'm a Fellow in the Society of Actuaries and a member of the American Academy of Actuaries.

Q. How long have you worked for L&E?

A. I've been at L&E for just over eight years. I have a similar story as Matt.

Q. And how long have you worked for the Board?

A. Worked for the Board since January of 2014.

Q. Have you been here for all of these exchange hearings over the years?

A. Yes. Yes.

Q. Have you worked on each of the exchange filings for Vermont?

A. Yes, I have.

Q. And how many filings in total have you worked on for Vermont?

A. Since 2014 we've done about 40 filings in the State of Vermont between all the carriers that file.

Q. Do you work on other state's exchange filings also?

A. Yes.

Q. Do you know how many states?

A. There's about nine states that our firm works with over the last several years.

Q. And David testified that he had worked on -- I can't remember how many he said, but about how many exchange filings have you done around the country?

A. About 300.

Q. You have worked on MVP's filings before, correct?

A. Yes.

Q. What is the process? Who first reviews the filings when they come in from MVP?

A. The process when we get a filing in-house is we have a team that works on each filing. We try to be consistent, however, this year we had a change on MVP and now Kevin Ruggeberg is the primary reviewer of the filing. He's an Associate in the Society of Actuaries. He started working on it about -- the exchange filing last year though he was not the primary reviewer, Rita Tansen was, but he worked in conjunction with her to learn the ropes and then started taking over from there because she left our firm. So he's been around doing most -- the most recent filing so he's gotten familiar with Matt and Eric over at MVP.

After he does his reviews he puts together the

first round of questions. I am the peer reviewer on this filing so I work closely with him to understand the issues of the filing, the questions, and then we begin an open dialogue through our inquiry letters back and forth within MVP. Based on the responses we may have followups.

Additionally, I work closely with Dave Dillon who works as the peer reviewer of the Blue Cross Blue Shield filing to make sure that the market-wide issues and that there are just general consistencies between all the carriers in Vermont so that there could just be just some general market consistencies.

Q. So is it fair to say that you peer review both carriers in Vermont?

A. Yes. I know both carriers in Vermont pretty well.

Q. For the Board you always produce a report on these exchange filings, correct?

A. Yes. That's true.

Q. Let's look at that. It's exhibit -- I have a wrong number here, but it's exhibit 9.

A. Yes. I'm there.

Q. You're familiar with this report, correct?

A. Correct.

Q. I would like to just go to -- first you put in a standard of review. Are you familiar with that standard

of review?

A. Yes, I am.

Q. Wouldn't you say -- we had testimony about this yesterday, but when you say rates are not excessive, inadequate, or unfairly discriminatory are those -- do they have their own definition in the actuarial world?

A. Yes. We have an actuarial standard of practice number 8 that references health rate filings and it provides definitions for these particular terms.

Q. You gave us some charts in this report and I would like to just refer to those briefly. On page 1 can you explain that chart and let us know what the percent change would be for the biggest section of membership?

A. Sure. So the first chart on page 1 is just a brief overview of the rate increase request of 8.8 percent by metal tier. There are several standard and non-standard plans that fall under these metal tiers. So we took a weighted average by metal tier of the rate increase that was proposed by MVP. According to this chart the greatest percentage of their membership is within the bronze metal tier at 35 percent and the percentage change there is 10.4 percent.

Q. And was the -- what's the range of proposed changes?

A. The range of proposed changes by metal tier is

7.0 percent to 10.4 percent.

Q. And you did hear today that -- and you knew this already, that they have modified their proposal at this point?

A. Yes.

Q. Does that change where the largest membership will fall?

A. No. In general that change was an uniform change. So these would all just be less magnified.

Q. So the largest percent change is in the bronze?

A. Yes.

Q. And that is also the largest percentage of membership?

A. Yes. That's correct.

Q. And will that remain the same with the modification?

A. To the best of my knowledge, yes. That's how they presented it so far.

Q. You reviewed a number of things and you compiled them, the components of the rate increase, in a chart also, correct?

A. Yes. The one on page 3.

Q. Yes. And can you explain why you put this in a chart like this?

A. Yes. The carriers since the Affordable Care Act and prior to that had their own rating practices. However, beginning in 2014 the unified rate review template came out which was a reporting tool that standardized the way the rates were presented so that they could be easily compared across carriers.

Since the -- since the market here only has two carriers on Vermont Health Connect we decided an easier presentation than having two different methodologies presented in our report to the Board that we would put it on a URT basis. So there are times where within the MVP memorandum and filing and their exhibits, particularly exhibit 3, where they show their breakdown of the rates, our numbers will differ slightly just due to order of operations and just how we've presented it, but at the end of the day it does come up to the telling the same story, and we make sure we're able to back it up and it also helps us make sure that the URT reporting tool, which goes up to CMS and HHS, that it's done properly.

Q. So this is also comparative for our review up here --

A. Right.

Q. -- at the Board? Let's look at the medical trend. How do they calculate medical trend?

A. They calculate medical trend by breaking it

down into two components which is similar to how most carriers look at it. It's -- we'll start with utilization trend.

Q. What was the utilization trend used by MVP?

A. MVP used zero percent which was consistent with all their prior filings. They have generally used the argument that it's very volatile and inconsistent, and I know that in the past they have had a push back from filings, however, within this particular filing because we have had some time with them we decided to ask for some support, and we did not find any conclusive evidence that we needed to make changes here within the utilization trend. That we will continue to monitor it to try to see if we can start maybe setting this more appropriately going forward.

Q. And so for the Board and everyone to follow we're looking at page 4 of the report, which is page 4 in red also, is where this discussion starts. What was the trend that MVP proposed?

A. So the second component was unit cost trend. Their allowed trend for medical was 2.5 for the unit cost and how they projected unit cost was to look at their current contracts with their providers, those that are under the hospital budget and those that are outside of that, looking at their current contracts and either making

estimations on what changes would occur or the actual changes that have already been in place.

Q. Do you know how that would compare to last year's medical trend?

A. This was lower than last year's medical trend I believe, and -- but they used a similar process looking at the contracts making sure that those were -- making sure that we were using the most up-to-date information since it was driven by these contractual changes.

Q. Did you recommend any change to the medical trend?

A. No, we did not.

Q. What about the prescription drug trend, is that calculated the same way?

A. The prescription drug trend is calculated differently because it is information that comes from the PBM. There was a major change.

Q. And a PBM can you explain?

A. Pharmacy benefit manager. It's the vendor that they use to help administer their prescription drug claims, and in the past they have used nationwide data because the PBM, their relationship with new and the PBM did not have access to claims data, but this year we've been really riding them pretty hard to try to get this included, and so this is the first filing where they did

incorporate -- the PBM did utilize MVP specific data to come up with trends.

Q. So you noted that I believe on page 5 of your report somewhere?

A. Yes. I believe.

Q. Next to last paragraph?

A. Next to last paragraph.

Q. What about did they use historic trend analysis?

A. They do provide historic experience and we review that as well. We recognize that there are some drawbacks to using historical trend information, but we still continue to analyze it because you can't ignore what's happened in the past. So they did provide the data and we looked at it, but it was -- it was very volatile which it has been in the past, and just using the PBM's sophisticated calculations -- using MVP's data is a superior method.

Q. Did you end up finding that their methodology and result then was reasonable about the pharmacy trend?

A. Yes.

Q. Do you remember what that trend was?

A. The trend was a paid trend of 12.2 percent.

Q. On the bottom of page 6 you talk about there's another factor and there's some adjustments. Did you make

a suggestion for MVP in that last sentence there? Did you suggest MVP do anything different in the future regarding that factor?

A. We just made a comment about insuring that MVP consider using a data driven age curve rather than just using HHS just to possibly improve the calculation and have them consider that going forward.

Q. Did you make any changes, though, on that?

A. No.

Q. What about to manual rating that's on page 7?

A. Yes. To manual rating they used a manual rate within the --

Q. Do you want to tell them what a manual rate is?

A. So typically in actuarial practice if you do not have enough experience within the current block of business that you're using, because that would be your best data to predict forward, if it's small or unreliable in some way you will use another population of data to balance out what you feel like you're missing in your current data set. So that's what a manual rate is. The manual is kind of the fixed control group that you bring into your current block of business. This is very common practice, however, they have been using this approach in the past, but their block has grown to a point where it is

sustainable on itself. When asked about it they did incorporate these other blocks because they are now eligible for -- to come into the population which we don't disagree with, however, we just think that the use of the manual rate is a little more complicated and that really they should be analyzing which group should be coming in and then incorporating them that way. So it's just more of a methodology difference, and given that it is so credible, the exchange population, and it will be more so going forward in future filings that we would like them to focus on their ACA compliant.

Q. So again that's a suggestion for the future without a change?

A. Correct.

Q. Let's get to the risk adjustment piece. You have been sitting here and listening to Matt's testimony about that and the questioning of the Board and myself and the HCA?

A. Yes.

Q. When you first received the filing did you ask about the risk adjustment at that time? What was the basis for their calculation at the time?

A. In the original filing the basis was using the 2014 results and they didn't want to rely too heavily on them during -- in the first submission so they used

two-thirds of the 2014 results as their starting point.

Q. At that time was the final CMS information available on which they could base their calculation?

A. No. There was an interim report, but there was not the final report at that time.

Q. Did you do your own calculation based on that interim report?

A. We did not.

Q. And when did the final report come out?

A. The final report came out on June 30th.

Q. When the final report came in did you do a calculation of the risk adjustment?

A. Yes, we did. We asked both carriers for their breakdown which is confidential. It's plan-by-plan risk scores including membership, and we took that data in conjunction with all of the other data that we had for them such as shifts in 2016, new populations that might move on to the exchange and other assumptions, and incorporated that into our calculation of the projected 2017 risk adjustment.

Q. When you say you used confidential information do you mean that each carrier it was their confidential that the other carrier did not have access to?

A. Correct. We had information from both carriers that was not to be shared with each side and we

-- for example, one carrier would make an assumption about the other that was maybe not fully accurate or accurate at all, and so we would modify based on responses or other information we had from the other carrier to refine the calculation.

Q. What was the decrease in rate that you recommended based on this calculation?

A. It was a 4.2 percent decrease in proposed rates.

Q. You have got -- you asked a question -- you talked about the back and forth and I think it came not from you, but from the primary reviewer Kevin. Did you ask about whether there would be a change based on the final reports from CMS? Did you ask MVP?

A. Yes. We asked MVP if they wanted to make any adjustments to their rates after the 6/30 report and they did not make any changes at that time.

Q. After you issued your actuarial memorandum did you receive something that said that they were going to in fact change their calculation?

A. Yes I did.

Q. I believe it's -- let's look at exhibit 11.

A. I'm there.

Q. On page 2 of that, that addresses the risk adjustment change. What was the response in general from

MVP on that? Could you just paraphrase what you understood?

A. Sure. They responded saying that in light of the new 6/30 report that they were going to modify their initial submission to use two-thirds of 2014 to incorporate the 2015 results and take two-thirds of the 2015 results and blend that with one-third of the 2014 results.

Q. Is that what you did in your calculation?

A. No.

Q. In the next to last paragraph a few lines up it says that they don't ignore the 2014 results as valid and real. Do you recall what they discussed with you for the 2016 filing about the 2014 data?

A. Yes.

Q. And I asked Mr. Lombardo about that a little bit. Do you believe that they used that as valid and real results for 2016 -- 2016 risk adjustment?

A. So are you asking if --

Q. Do you recall asking them whether they were going to change the risk adjustment last year for 2016 based on the 2014 data?

A. Yes. We asked that question.

Q. And do you remember them telling you that that was reliable data?

A. Yes. They said that 2014 was unreliable and did not want to incorporate any changes to the rates at that time.

Q. So I'm going to read something to you, "MVP does not believe that 2014 risk adjustment results should be used to indicate a carrier's relative risk position in 2016 for a number of reasons." Do you recall that?

A. Yes.

Q. You heard the testimony today about the risk adjustment. Do you have any understanding of how the one-third and two-thirds weighting was done? Were you given a calculation on that?

A. No.

Q. Did you do a detailed calculation as to risk adjustment with information that would not have been available to MVP?

A. Yes.

Q. Do you stand by your calculation that the 4.2 percent reduction is a valid calculation and is based on reasonable assumptions?

A. Yes.

Q. There was one other change that you recommended. Let's go to the last page of your report and that's go back to exhibit I believe it's 9. On page 10 you also talked about normalizing the AV and induced

utilization. What was that recommendation briefly?

A. Briefly that recommendation was their -- the actuarial value and induced demand or induced utilization factor do have some co-dependencies that were not captured in the initial calculation and exhibits presented by MVP. So we, throughout the course of our correspondence, agreed that this calculation should be changed to best reflect these particular assumptions and that result was a reduction in rates of .5 percent.

Q. Based on the two modifications that you recommend what was the resulting approximate rate increase that you determined was valid?

A. We recommended a 3.7 percent rate increase.

Q. And another thing I want to ask you, you heard talk about why this risk adjustment should not be based on your calculation and one of the arguments was volatility. Can you just tell me if a carrier wants to protect against volatility is it appropriate to put it within the risk adjustment?

A. There are times where in assumptions through -- you can put some margin within the assumption itself. However, in the State of Vermont that has not been a common practice and not something that we have done. So we have typically removed all margin. I mean, for instance, with trend if they think that it's going to be

the 2.8 or 2.5, they put 2.5 and they don't increase it to 3 just in case one of their contracts is incorrect or their assumptions is wrong. That's all been placed under the contribution to reserves. So --

Q. So each component needs to stand on its own?

A. Correct. We think each component should be the best estimate and that the -- any contribution to reserves or risk for volatility should be housed within the contribution to reserves.

Q. And on the contribution to reserves did you give any opinion whether the one percent that is requested is a reasonable request?

A. We felt it was reasonable.

Q. Just in closing, with the modifications that you're recommending which results in approximate 3.7 percent do you think that rate increase is not excessive?

A. Yes.

Q. And not inadequate?

A. Yes.

Q. These double negatives. I'm sorry.

A. That's how we say it too.

Q. That is your standard. That's how actuaries speak?

A. Yes.

Q. And not unfairly discriminatory?

A. Yes.

MS. HENKIN: That's it.

HEARING OFFICER HUDSON: Any questions from the Board at this time for this witness?

MS. RAMBUR: I have a question. Obviously reasonable people can look at the same information and come to different conclusions or processes. I just want to go a minute back to the one-third/two-thirds, and if I heard your testimony correctly, am I hearing that this is not a difference of opinion but your believing that you have additional data that makes you confident in using just the one year.

MS. LEE: Yes. We believe that it -- or I believe that there was additional data that could have been considered within the calculation. For instance, 2016 while we're still in the middle of it there were membership changes moving on to the exchange that could have been accounted for even within the projection of claims. There were assumptions that those other non-ACA compliant groups would be accounted for, but they weren't accounted for in the risk adjustment. Additionally, during our assessment and calculation we took into account the whole state, not just MVP themselves or Blue Cross

Blue Shield themselves. There was a consideration for the market since that has a huge impact on the final payment.

MS. RAMBUR: And one other quick question. You really touched on this in your written material, but I just want to flesh it out a little bit. I'm looking at exhibit 12 and obviously unless the market share changes dramatically Blue Cross Blue Shield's risk score is going to be very close to the state average.

MS. LEE: Correct.

MS. RAMBUR: So I'm wondering how we as regulator, as a non-actuary, how should we think about that?

MS. LEE: Well I think it is a concern that Blue Cross Blue Shield is going to be pretty stable going forward and that MVP could have volatile movement throughout their rates. However, I think you guys are challenged with something different on determining how to handle that year-to-year. I think that, as Matt testified to, that over time one way to establish credibility and smooth things out is to have more time. So we've tried to project forward on 2017. I think that it is a challenge that we're faced with in this small market.

MS. RAMBUR: Thank you.

MS. HOLMES: Just on the question about the differences in data availability that you have versus MVP just to clarify how much -- how important is it a factor that you had access to plan-by-plan risk scores versus what it sounded like there was sort of a summary measure that was obtained from the CMS web site backed out.

MS. LEE: What we were able to do is understand if we, let's say, were able to map a particular group, so 51 to 100, if we map them into a particular plan, we know exactly what the risk score is at that plan level rather than making a blanket assumption or just increasing it slightly because we don't really know what that risk score is. We know what the risk score was. So if we put more people in that risk score, we give more weight to that particular plan which changes the average plan level risk score which is what you see in the column off to the side on 12 -- exhibit 12. You will see the aggregate risk score. So if, for instance, we threw a whole bunch of people into a plan that had a high risk score, that's going to drive up the average, and we know that more specifically because we have the plan level data.

Now, as Matt indicated, there are commonalities. Bronze plans tend to have particular risk scores that they can make assumptions on and they are able to come to the aggregate so they can make some sophisticated assumptions, but we do have the plan level detail and can make very precise calculations to just make the estimate a little bit more refined.

MS. HOLMES: Great. Thank you. And then just one other question. In the report here where you -- we have -- we look through, you know, membership it just struck me as you were talking a little bit earlier the changes in the percent of membership as we go from 2016 to the proposed 2017 and then to the revised with the rate change.

MS. LEE: Yes.

MS. HOLMES: Can you walk me through a little bit about the assumptions behind how that membership would shift going from say 34 percent in bronze to 43 percent in bronze and what implications that might have --

MS. LEE: Sure.

MS. HOLMES: -- on utilization for cost?

MS. LEE: Sure. When we took these out of the filing either through the original filing or

correspondence MVP had mapped a lot of their small groups, 51 to 100's, to product that were most similar to what they currently had, and generally in the group market the plans are most similar to a gold type plan which is why you will see the gold jumping from 8.5 to 31 percent. So they are anticipating that these people as they are moving onto the exchange are going to try to buy plans that are most similar to what they are used to from a benefits perspective and so that's why the shifts.

To my knowledge there was no account for if there were a rate increase, rate decrease, how that would impact. It was more looking to benefits and mapping them that way.

MS. HOLMES: So this doesn't -- it's not adjusted for the changes within the metal?

MS. LEE: Not that I'm aware of, but probably a better question for them.

MS. HOLMES: Got it. Thank you.

DR. RAMSAY: I want to try to move away from this risk adjustment more towards what their exact total paid claims experience was over the 24 months, that's on page 5, over the 24 months that they used to develop their medical trend and their pharmacy trend knowing that their utilization was

zero. So the total paid claims for the 24 years (sic) of experience led MVP to request a 3.9 percent unit cost trend -- total trend, right?

MS. LEE: What page are you on?

DR. RAMSAY: Total allowed medical trend, total allowed pharmacy trend, medical was 2.5, pharmacy was 12.2. We know pharmacy is going to be high.

MS. LEE: Correct.

DR. RAMSAY: So they base their trend on total paid claims over 24 months.

MS. LEE: Okay.

DR. RAMSAY: Right. 2014, 2015. First sentence, "Total allowed medical trend combined all the allowed medical claims for the prior 24 months and modeled PMPM claims normalized for changes in demographics using an exponential regression."

MS. LEE: That is the process we did to determine if they were in the ball park.

DR. RAMSAY: And they were?

MS. LEE: Yes.

DR. RAMSAY: Okay. So that's exactly what they are trending that the claims that they are going to have to pay for this new 2017 premium, this 2017 premium, right?

MS. LEE: The 2.5 percent allowed.

DR. RAMSAY: On the medical?

MS. LEE: On the medical, correct.

MS. RAMBUR: And the pharmacy is?

MS. LEE: 11.6 allowed. So one thing to keep in mind is that when the company set the medical trend we were provided a list of their contracts by facility to evaluate that, but on top of that we like to -- you know we like to provide a range and make sure that we can assess the contracts aren't just completely different, and it's possible that they could be, but generally they don't change much year-to-year, and so we like to just have that as a backbone to make sure it's looking like what we expect.

DR. RAMSAY: Thank you.

HEARING OFFICER HUDSON: Hearing no further questions from the Board would MVP like to question this witness?

MR. KARNEDY: Yes please.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Hi Jackie, how are you?

A. Good. How are you doing?

Q. Sorry Ms. Novak isn't here today. I have to

ask questions just of you.

A. I know. I heard. It's unfortunate.

Q. Can you -- you have a good collaborative relationship with Matt and Eric at MVP as you work through these rate filings each year, correct?

A. That's correct.

Q. And they are good reasonable actuaries in your view, correct?

A. Yes. They are good to work with.

Q. If we could, I want to ask some questions -- I'm going to move this because it's not working -- about your memorandum. So if you can go to exhibit 9 for me please and go to page 10, I just want to frame where the differences are. So on page 10 there's two bullets at the bottom of page 10, the two recommendations from L&E, correct?

A. Correct.

Q. And on the first bullet the AV -- the normalization for AV issue is .5. We have agreement on that, correct?

A. That's correct.

Q. So the second bullet is where we have the dispute about the risk adjustment payment, correct?

A. That's correct.

Q. And as I understand it after this -- the date

of this is July the 11th and then MVP called you the next day on July the 12th. You talked over the risk adjustment payment and really couldn't come to an agreement on it, correct?

A. That's correct.

Q. And then MVP -- so that was a Monday you file, Tuesday conversation, and then Wednesday MVP filed their supplemental filing which is exhibit 11, correct?

A. I'll take your word for the days.

Q. Okay. But it was moving pretty quickly?

A. Correct. It was quick.

Q. And you have reviewed MVP's supplemental filing which is exhibit 11, right?

A. Yes. That's correct.

Q. And you heard Matt's testimony today, correct?

A. Yes.

Q. And you agree, and you have heard this before and we have heard it in these hearings before, that your approach and MVP's approach are both reasonable, they are different, both are actuarially reasonable, good minds can come to different conclusions. Is that fair?

A. It's fair that there are different ways to come about it. I don't feel that MVP used all the data that was available to them, so I don't think their approach is reasonable.

Q. Okay. They had valid -- valid actual methodology and assumptions. Just -- you just didn't agree with the data they used to come to those conclusions, correct?

A. They used a two-thirds/one-third split that I didn't use and didn't really agree with, but I don't think 2014 should have had a lot of value to it. We didn't use it last year. Didn't think it was appropriate to all of a sudden use it this year.

Q. So you -- in your opinions you relied only on the 2015 risk assumption data and you're not using -- you just said you're not using the 2014 risk assumption data in considering this issue, correct?

A. We used 2015 as a starting point.

Q. Let me ask the question again. You relied only on the 2015 risk assumption data not 2014, correct?

A. Did not rely on 2014. No.

Q. And you would agree with me that actuaries expressing actuarial opinions generally prefer to base their opinions on a range of information rather than one year pinpoint data, correct?

A. That's correct.

Q. And that's kind of a preferred practice for actuaries, wouldn't you agree?

A. Use as much data as possible. Correct.

Q. As it relates in quantity, larger amount of relevant data the better than having a small amount of relevant data, right?

A. That's correct.

Q. We can agree on that. You would also agree with me it's not uncommon -- you might disagree with the two third/one-third, but it's not uncommon for actuaries to weight data from different time periods to improve the results of their opinions, correct?

A. That happens in practice, yes.

Q. Happens often in practice, wouldn't you say?

A. Yes.

Q. So go to exhibit 9 please. You said that you were the peer reviewer on this, but you signed the document, right?

A. Yes. Yes. I'm highly involved in that.

Q. Highly involved?

A. In the filing.

Q. Go to page five please, and do you see the heading Total Allowed Medical Trend on page 5?

A. Yes. That's at the top of page 5.

Q. So I'm going to read to you the first sentence and then the last two sentences. Then I'm going to ask you a question to evaluate the reasonableness of the company's allowed medical trend development. "We combined

all of the allowed medical claims for the prior 24 months and modeled PMPM claims normalized for changes in demographics using exponential regression." And the last two sentences, "Our estimated allowed trend range based on regression analysis of the historical experience is 1.5 percent to 2.6 percent. Each of the numbers within our estimated range are not equally likely. That is, the trends on the low and high end are not as likely to occur as the trends in the middle of the range." Did I read that correctly?

A. Yes.

Q. So as it relates to the total allowed medical trend you used 24 months of data, correct?

A. That's correct.

Q. And you used a range, didn't you?

A. Yes we did. We presented a range.

Q. And you indicated and recognized that the numbers within the range aren't all equally likely, correct?

A. That's correct.

Q. And you felt that methodology, that allowed medical trend, was the best way to analyze that issue, correct, using multiple data points over 2 years?

A. We believe the best way to analyze medical trend is to use your contracted medical -- your contracted

rates which is what MVP did. That's the best way to analyze medical trend. We used this as a secondary method to confirm it.

Q. This is your language in this letter, correct?

A. Yes.

Q. You signed it and you don't disagree with the approach that was taken here, correct?

A. I don't agree -- I don't disagree with the fact that this is a way to evaluate it. That's not the basis of the assumption. We did not recommend 2.1 as our trend.

Q. Okay. So let's step back. You used 24 months of data, right?

A. Yes.

Q. And you used a range, right?

A. We presented a range. I didn't use a range.

Q. I'm sorry. I'm not artful in the language. I apologize and you indicated and recognize that the numbers within the range are equally likely, correct?

A. They are not equally likely.

Q. Not equally likely?

A. Yes.

Q. Let's go to page 5. You will see below on page 5 there's a pharmacy trend bullet. Do you see that just below?

A. Yes.

Q. So the pharmacy trend discussion pours over on to page 6, and at the top of page 6 I want to read you the first two complete sentences. "For comparison purposes we analyzed 24 months of MVP's historical pharmacy trend experience and found it to be volatile. Looking at rolling six-month averages the annual paid RX trend has consistently been about 35 percent over the last two years." Do you see that language?

A. Yes, I do.

Q. And you would agree with me here again you looked at multiple data points over 24 months, correct?

A. Yes we did.

Q. And you did in that context of this one particular issue reference volatility, didn't you?

A. Yes.

Q. And you felt using multiple data points over two years was the best way to analyze this issue, correct?

A. Yes. Again we were using -- we were basing our -- MVP based their assumption on data from the PBM. This was another way of analyzing it since we do not have access to the PBM.

Q. But you put the word volatile in here as it relates to this particular issue?

A. Yes. Correct.

Q. Not the overall?

A. Their pharmacy trends were volatile.

Q. So in your actuarial memorandum, exhibit 9, on multiple occasions you use more than one year of data for your analyses because that was the best methodology in your opinion, correct?

A. Sure. Yes.

Q. More than one data point, right?

A. Correct.

Q. And you would agree with me that in comparison to Blue Cross Blue Shield, MVP's smaller membership makes its risk adjustment much more volatile each year?

A. It has the potential to be much more volatile, yes.

Q. And that's because it's spread across fewer insureds, right?

A. Yes. There's less exposure.

Q. So you concluded that you did not use the 2014 results in any way, correct?

A. For risk adjustment?

Q. Yes.

A. No we did not use them.

Q. And was it your belief that it was because they were unreliable?

A. Yes, and in our testimony last year and the

order last year it wasn't used. So a year later being less relevant we didn't feel like it was appropriate to bring it back in to utilize as a data point.

Q. Because it was less relevant?

A. Correct.

Q. But reliability is a matter of degree, wouldn't you agree with me?

A. Yes, but I don't think it changes over time.

Q. It's not black and white it's gray, right?

A. It is gray. Yes.

Q. And would you agree with me that over 80 percent of the membership enrolled in 2014 was enrolled in 2015 roughly?

A. Yes roughly.

Q. And you would agree with me that the total membership was relatively unchanged between 2014 and 2015 roughly?

A. I don't really know the answer to that. I would have to look it up. I think it did change.

Q. You would agree with me, because you reviewed it, that MVP's amended filing recognized that the partial year data for 2014 can skew risk adjustment results so they used this weighted average, right?

A. That's what they said.

Q. Okay. They recognized the data wasn't as

credible as 2015 and they weighted an average to address that, correct?

A. Yes.

Q. And you would agree with me that MVP recognized volatility from 2014 to 2015 in part due to small market share, right?

A. Yes.

Q. So MVP gave 2014 one-third weight, 33.33 percent, right?

A. Correct.

Q. As you sit here today after considering the 2014 rate adjustment, and granted I understand you prefer 2015, you could have considered given the 2014 rate some weight, less than a third, but you could have had 20 percent, right?

A. I didn't, no.

Q. Or 15 or 10 percent? You refused to do that?

A. I don't think that -- I think that what it indicates is that MVP paid money, and that was something that Matt testified to earlier was that they were a payer. They were still a payer. So, therefore, they would be a payer. I think that was the conclusion that could be drawn.

Q. So in your view zero percent weight. You're not weighted at all. You didn't even consider it?

A. I didn't do that in the calculation. No.

Q. Would you agree with me, I think you just said it a moment ago, that the 2014 risk adjustment information, although less relevant, you said less relevant, is relevant to the 2017 risk adjustment, right?

A. Just as the 2016 population is relevant and the 2017 projection is relevant.

Q. Right, but as to kind of the dispute we have here is about 2014, you agree it's relevant, but you would just give it no weight, correct?

A. Correct. I would weight more recent information.

Q. And you were here yesterday and heard Donna Novak testify?

A. Yes.

Q. You were in the front row, and when she was asked about the risk adjustment program -- I wrote it down -- she said not comfortable making a comment on risk adjustment, a lot of moving parts. Do you remember her saying something to that effect?

A. I didn't hear that, no.

Q. But you do recall that she was not willing to simply agree with L&E on this issue?

A. She did not comment on risk adjustment as far as I knew.

Q. On the issue of solvency you have deferred to DFR on that, correct?

A. Yes. We defer to DFR.

Q. And don't disagree with what you heard today from DFR on that, correct?

A. No, we do not.

Q. Just a couple more. Matt was asked by my able counsel, the Health Care Advocate, about why he didn't consider the interim 2015 data, and as I heard your testimony you didn't consider it either. You waited for the final 2015 data, right?

A. That's correct.

Q. So Matt's approach on that was reasonable, correct?

A. That's correct.

Q. And you indicated we shouldn't consider volatility in any risk adjustment component, but you in fact did consider volatility as it relates to -- I forget whether it was the medical -- I think it was the medical trend, right? Remember we focused on that word volatility in the language?

A. Yes, we did.

Q. And then if you look at -- if you would look at exhibit 12 please, this is the risk adjustment program summary that we prepared, and do you see under volatility

for MVP 2014 shows a change of 20.1 percent. Do you see that?

A. Yes. I see that.

Q. So your opinion as it relates to risk adjustment program and how to deal with risk adjustment for 2017 is you ignore that, right?

A. Yes.

Q. But that is a significant amount of volatility, wouldn't you agree? I understand you're not considering it, but you would agree?

A. Yes.

Q. It's a big deal for MVP, isn't it?

A. Yes, it is.

Q. You talked about the -- you were asked about the difference in data that's available to L&E as the Board's actuary?

A. Yes.

Q. And when I heard that testimony I heard you also admit that MVP was able to come to the same aggregate answer, correct?

A. Yes.

Q. So the aggregate is really what we're talking about here, and you don't disagree with Matt's number on the aggregate, correct?

A. For 2015?

Q. Yes.

A. Yes.

Q. The risk score is specific to the members' utilization. So it's not a safe assumption that non-ACA data to a metal level is valid. Am I correct on that?

A. Can you repeat it one more time?

Q. The risk score is specific to the members' utilization. So it's not a safe assumption that non-ACA data mapped to a metal level is valid, correct?

A. Can you repeat it one more time?

Q. Let me do a followup that might help clear it up. There will be volatility in the risk score by metal level because they are specific to the members' utilization?

A. It is specific to the members' utilization, correct.

MR. KARNEDY: Thank you very much.

HEARING OFFICER HUDSON: Does the HCA have questions for this witness?

MS. KUIPER: I just have a couple quick questions.

CROSS EXAMINATION

BY MS. KUIPER:

Q. I would ask you to turn to exhibit 14 which MVP prepared.

A. Okay. Yes.

Q. Have you -- are you familiar with this exhibit?

A. Yes. I have seen it.

Q. This exhibit says, the second line down, that MVP used a weighted average and more data. Do you agree with that comment that they used more data than L&E?

A. No. I do not agree with that.

Q. Can you just explain that?

A. Sure. They used more of the risk adjustment reports than we did, but they did not use 2016 or 2017 actual or projected information.

Q. Thank you. And then a little further down it says L&E estimate of expected risk adjustment liability ignores 2014 data. Do you agree with that?

A. Yes, I do.

Q. And why did you not use -- that's more data that was available to you. Why did you choose not to use it?

A. We chose not to use 2014 data because the calculation or the data used in the calculation in the 2014 report had some unreliable -- unreliable issues with it, and so, for instance, they didn't have a full -- most members or a lot of members did not have a full year of data, and when there's partial year data that can

definitely skew results, and this was pretty widely known for this calculation, and then additionally last year that was the conclusion that we drew to say that it was unreliable at the time and why we did not make a recommendation last year, and so therefore we took the same position this year.

Q. Would you say it's true that 2014 had an unique enrollment period due to being the first year in the exchange?

A. Yes. There were some issues with enrollment in the Vermont Health Connect. So people were unable to enroll or were slow to understand that they needed to enroll, and it was definitely a very unique year because of it being the first year of the implementation of the Act.

MS. KUIPER: Thank you. That's all my questions.

HEARING OFFICER HUDSON: And are there any further questions from the Board?

MS. HENKIN: Can I just redirect a little bit?

REDIRECT EXAMINATION

BY MS. HENKIN:

Q. I just want to clarify, and it's going again to exhibit 14 where it says MVP weighted average more

data, let's just clarify here. Did you only use 2015 data to determine this calculation, the risk adjustment?

A. No.

Q. Did you use 2016 data?

A. Yes.

Q. Did you use data from other carriers that was not available to MVP?

A. Yes.

Q. Did you use 2014 data?

A. No.

Q. Was it used last year?

A. No it was not.

Q. Is it more consistent not to use it going forward?

A. Yes. We don't plan on using it next year.

Q. Do you remember last year when you asked MVP to discuss the impact of the risk adjustment transfer after it came out? I believe there was a correspondence between you and MVP, and specifically you received a response from Matt Lombardo on July 1st and you asked about what the impact of the final CMS report for 2016 was. Do you remember that?

A. Yes.

Q. What do you recall was the response about 2014 data? Was MVP going to use 2014 data?

A. They were not going to use 2014 data because it was not a good indicator of their risk.

MS. HENKIN: Thanks.

HEARING OFFICER HUDSON: Hearing no further questions for this witness, thank you very much. So that is the last witness we had on the agenda. If there are no further questions from the Board to any of the witnesses, then at this point we can move on to the closing of the evidence and move on to closing statements.

MR. KARNEDY: Thank you. I'll try to be brief. Just a couple of points. We believe the evidence has shown that the 6.3 percent rate increase is superior to the 3.7 rate increase proposed by L&E. MVP's proposed rate increase is superior. Two darts are better than one. I think you get the point. 2014 and 2015 weighted information is superior.

Now kind of the elephant in the room L&E's been the Board's own expert advisor for many years and does very good work for the Board, but in this case, this particular year on this particular issue, MVP's information is superior. Their opinion is superior, and this reminds me of when I was a kid in Barre playing on the Little League team and our coach was this terrific coach, but his son was on the

team and his son was a very good player but he was not the best player on the team, but his son got to pitch every game, every game they picked his son, and I was a kid, I had problems with that. That didn't seem fair. That didn't seem right to me, but now as an adult I understand, you know, it was his dad and I can understand what he did.

I say that because here in this case it's kind of delicate for us, you know. We're dealing with your actuary, but we're asking the Board to do something which is don't do what that coach did. You need to look at -- we believe statutorily you need to look at what is the best data, what is the best rate that we as a Board need to determine, and if that data happens to come from MVP rather than in this particular year from L&E so be it, but we believe that is your task.

Second, where is Donna Novak? She's come every year and the expert the HCA has had each year has come and it was their job to challenge the rates proposed by the carrier, and I mentioned the empty chair expert, and it is kind of odd. She came, she testified yesterday, then she got on a plane presumably and left, didn't stay today. Why didn't she stay today? Because she didn't have anything

that was going to help HCA's cause here which is to have a lower rate. There was no contrary evidence provided by HCA this year on solvency or on this risk assumption issue. She could have simply come and concurred with L&E on this risk adjustment program today, but she didn't. You heard her testimony yesterday about not being comfortable, a lot of moving parts. Well she decided not to come and here we are, and we think that the Board can certainly draw their own inferences about that and what is the better data this year.

I would also just point out that there was some linkage and I get it, you have to because this risk adjustment there's only two carriers involved, you got Blue Cross Blue Shield yesterday, MVP today, and there's a linkage on this issue, but the reality in the numbers is if you accept what L&E is proposing and don't go with the better data that we believe MVP has proposed, then MVP -- if you do it our way MVP's rate is 6.3 and you eliminate the bump that this Board is giving to Blue Cross Blue Shield this year up to 8.2. That's a reality. It's not really evidence here, but it's a reality the Board has to address.

So two darts are better than one. Don't

be like the coach, and the reality here we would hope that you would take our recommendation of 6.3 percent.

HEARING OFFICER HUDSON: Thank you. Does the HCA have a closing statement?

MS. KUIPER: Just briefly. As I stated at the beginning of the hearing, this rate review process is about developing rates that are both reasonable and affordable. Witnesses for the Board and for MVP today testified that the 2014 data was not reliable. MVP has the burden of proof in this case and they have not met this burden. We ask you to enforce L&E's recommendation to lower MVP's rates because it is the most sound method for developing MVP's rates and because it makes the rates more affordable for Vermonters. Thank you.

HEARING OFFICER HUDSON: Thank you all. Right now, as many of you may know, the Board will not be making a decision on this issue today. There is a public comment period that lasts through July 26th and our web site comment portal will be open until then to be taking any public comments, and as is customary and required by law there is also a public comment portion to this hearing which is the next item on the agenda and I usually turn that over

to the Chair and we begin that now.

CHAIRMAN GOBEILLE: Thank you. Nicholas Totten.

MR. TOTTEN: Should I sit here?

CHAIRMAN GOBEILLE: Absolutely. How are you?

MR. TOTTEN: How are you all?

CHAIRMAN GOBEILLE: Doing well.

MR. TOTTEN: I just have a statement I would like to read. My name is Nick Totten. I work in and around Johnson as an agricultural worker. I've lived in the state a couple years with my spouse and just recently signed up for health care. So I would like to say that I find that there are many inefficiencies in having private insurance companies attempting to work through VHC, and that includes time used up by individuals on the phone and on hold with both VHC and the respective insurance company.

My spouse and I have recently experienced this. Spending a total of about eight hours on the phone with VHC, MVP, and our pharmacy when we were signing up for an insurance plan through the marketplace. Having just signed up for a MVP insurance plan through VHC, it took three weeks to get the start date of our plan correct despite words

from both MVP and VHC that it should happen in a matter of a day or two of our call. Our doctors' visits and prescriptions in those weeks cannot be paid for. We had no access to our medications at that time unless we were to pay out-of-pocket. I cannot imagine that these rate hikes will see direct improvement of the customer service or of what the plan covers. Instead it seems the companies would like to buffer the executive pay grades as the already overly expensive health insurance plans cover no more services or prescriptions.

We simply cannot afford regular rate hikes when we still have to pay co-pays and co-insurance or out-of-pocket for services not covered. Moreover, if we have a big accident or get very sick, even our federally subsidized health insurance plan based on our projected income for the year would still require us to go into debt to pay medical bills. That is insolvent. I don't believe the rate hikes will see out-of-pocket limits and the like go down for consumers.

The insurance system is costly, inefficient, inadequate, and unfair, and we must change it as laid forth in the law. I believe that health care is a human right and we must move toward

a publicly financed equitable universal health care system that meets all of our health care needs. The Green Mountain Care Board must move our state toward, not away, from that goal. Allowing rate increases to make health care unaffordable and inaccessible to the people of Vermont is a step away from that goal. I urge you to say no to rate increases and move us toward our human right to health care.

CHAIRMAN GOBEILLE: Thank you, Nick. Is there anybody that did not sign up that would like to speak? Dale. Dale, you get to come to the big table this time. You don't have to stay --

MR. HACKETT: That's what they call this?

CHAIRMAN GOBEILLE: That's right.

MR. HACKETT: You know I actually can't see this with my glasses. I got to get the other ones.

From what I was hearing I just have a quick comment on we're using two different models to try to understand what the risk is going forward to make sure that we got our rates correct. They don't have a large enough population, if I understood correctly, to really calculate what that risk will be so they did something that is, and I'm trying to talk

in plain English here, they added a population to try to get a substantial enough sample to know that they are as accurate as possible in how they calculated their risk. However, if you are adding a population that reflects the population that you are insuring and it's a very small population, how do I know that I didn't add more risk than actually exists because I picked a population that maybe looks the same, but really doesn't have that actual risk in it that I modeled it to have. I don't know that and as I go forward with that I may be too high in my risk assessment. I may be too low.

What am I going to look at next? Are you solvent? If they are solvent, I'm not so concerned where I go with my rates if they have put into that rate a way to make sure they are solvent, and this came up as I heard it in the testimony, if they are solvent I've got more latitude in what I can do with the rates to keep them affordable. It would be a bigger issue if they weren't solvent, but if they are, then I can focus on affordability. Of course, that would be a consumer perspective.

CHAIRMAN GOBEILLE: Thank you, Dale. Is there anybody else that we missed with the clipboard? All right. Seeing none --

DR. RAMSAY: Can I make a comment?

CHAIRMAN GOBEILLE: Absolutely.

DR. RAMSAY: You know yesterday we heard a lot of -- we have heard a lot about relevancy in the last two days. Yesterday about the relevancy of projections and lots of numbers. Today the relevancy of using different data points, but the real linkage here is what we hear when we get these public comments and that's the most important data point for Vermonters is how much they are paying for their health care coverage, and I want -- I'm sure that the Board will put a lot of work into making sure that data point for Vermonters is well respected. Thank you.

CHAIRMAN GOBEILLE: Is there a motion to adjourn?

MS. RAMBUR: So moved.

MS. HOLMES: Second.

CHAIRMAN GOBEILLE: Nobody wants to second it, it's going to be a long day. All those in favor.

(Board Members respond aye.)

CHAIRMAN GOBEILLE: Thank you.

(Whereupon, the proceeding was adjourned at 11:40 a.m.)

C E R T I F I C A T E

I, JoAnn Q. Carson, do hereby certify that I recorded by stenographic means the hearing re: Docket Number GMCB-007-16RR at the 2nd Floor Conference Room of the Green Mountain Care Board, 89 Main Street, Montpelier, Vermont, on July 21, 2016, beginning at 9 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting, and the foregoing 119 pages are a transcript of the stenograph notes taken by me of the evidence and the proceedings, to the best of my ability.

I further certify that I am not related to any of the parties thereto or their Counsel, and I am in no way interested in the outcome of said cause.

Dated at Burlington, Vermont, this 25th day of July, 2016.

_____

JoAnn Q. Carson
Registered Merit Reporter
Certified Real Time Reporter