STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc.	)	
2018 Vermont Health Connect Rate Filing	)	GMCB-007-17rr
	)	
SERFF No. MVPH-131034103	)	
	)	

DECISION AND ORDER

Introduction

For the fourth consecutive year, the Board has reviewed major medical health insurance rates offered on Vermont Health Connect, the state's health benefit exchange. In this filing, MVP Health Plan, Inc. (MVP), one of the two carriers offering qualified health plans in Vermont, has proposed a 6.7% average annual rate increase, which it has subsequently reduced to 5.1%, for VHC plans with coverage beginning January 1, 2018. Based on our review of the record, the testimony, and evidence produced at hearing, we modify the rates as explained below, and then approve the filing.

Background

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

2. Vermont Health Connect (VHC) offers qualified health plans on Vermont's health benefit exchange to individuals, families and small employers with rates based on a single risk pool, or "merged market." *See* 33 V.S.A. §§ 1803, 1811. Beginning with plan year 2016, Vermont law expanded the definition of "small employer" to include employers with up to 100 employees. *See* 33 V.S.A. § 1811(a)(3).

3. Health insurance plans on VHC are offered to consumers in four "metal levels": bronze, silver, gold, and platinum.[1] *See* 42 U.S.C. § 18022(d)(1). Under the ACA, each metal level corresponds to an "actuarial value" (AV), an expected percentage of claims for essential health benefits that a health insurer will cover on average. For example, a bronze plan with a 60% AV is expected to cover, on average, 60% of an insured's claims. Bronze plans are the least "rich" of the four levels. Silver, gold and platinum plans respectively cover larger percentages of a beneficiary's claims.[2]

[1] In addition to the metal level plans, catastrophic coverage, which is characterized by low premiums and high deductibles, is available primarily to persons under thirty years of age. *See* 42 U.S.C. § 18022(e).
[2] This discussion is solely intended to be illustrative. More detail concerning 2018 payment parameters and actuarial values is available at https://www.federalregister.gov/documents/2016/12/22/2016-

4. There are several mechanisms to make health insurance plans offered on the exchange more affordable for individuals without employer-sponsored insurance. The ACA includes a provision for federal premium assistance for some individuals, depending on their household income. *See* 26 U.S.C. § 36B ("Refundable credit for coverage under a qualified health plan").

5. The ACA also requires insurers to reduce out-of-pocket costs through "cost sharing reductions" (CSRs) for enrollees with incomes between 100% and 250% of the federal poverty level. *See* 42 U.S.C. § 18071(a)(2). The federal government offsets the added cost of CSRs by making payments directly to insurers. *See* 42 U.S.C. § 18071(c)(3). It is currently uncertain whether the federal government intends to continue to make these offset payments to insurers.[3] This filing assumes cost sharing reductions will continue.

6. Vermont law provides additional health insurance premium assistance for eligible Vermonters purchasing coverage through VHC. 33 V.S.A. § 1812(a). In addition, the state provides cost-sharing assistance to further reduce enrollees' deductibles and copayments. 33 V.S.A. § 1812(b).

7. As of May 2017, approximately 83% of individuals enrolled through VHC qualify for some sort of financial assistance, whether premium assistance, cost-sharing reductions, or both. *See* Vermont Health Connect May 2017 Dashboard, *available at* http://info.healthconnect.vermont.gov/sites/hcexchange/files/Coverage%20Dashboard-May2017.pdf.

8. To help stabilize costs, the ACA includes a permanent risk adjustment program which applies to ACA-compliant plans in both the individual and small group markets. Under the risk adjustment program, insurers with an enrolled population with lower than average actuarial risk provide payments to insurers that have an enrolled population with higher than average actuarial risk. The program is intended to reduce incentives for insurers to structure plan offerings to make them most attractive to a healthy, low-risk population, while unattractive to a less healthy population more in need of insurance services.[4]

9. Section 9010 of the Affordable Care Act imposes a Health Insurance Providers Fee based on a covered entity's premium revenue in the previous year. *See* 26 C.F.R. Part 57. In

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30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018.

[3] In 2016, a federal district court concluded that the cost-sharing program is unconstitutional and enjoined further payments. *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016). The Obama Administration appealed the ruling, and CSR payments were permitted to continue during the pendency of the appeal. The case, now titled *U.S. House of Representatives v. Price*, is currently being held in abeyance. More recently, the President threatened, via Twitter, to discontinue the CSR payments to insurers. *See, e.g.*, Michelle Hackman et al., *Trump Threatens Insurance Payments to Push Congress on Health-Law Repeal*, WALL ST. J., July 31, 2017 (reports on the President's tweet: "[i]f ObamaCare is hurting people, & it is, why shouldn't it hurt the insurance companies.").

[4] Additional information about the program is available at http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.

2016, Congress imposed a moratorium on collection of the fee for plan year 2017. The fee is again in effect for plan year 2018.

Procedural History

10. On May 12, 2017, MVP filed its 2017 VHC Rate filing with the Green Mountain Care Board through the System for Electronic Rate and Form Filing (SERFF). The filing proposes an average annual rate increase of 6.74%, with actual increases ranging from 2.28% to 10.55%. Exhibit 1 at 3.[5]

11. On May 23, 2017, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care services and health insurance, entered a Notice of Appearance as an interested party to this proceeding.

12. On July 11, 2017, the Vermont Department of Financial Regulation (DFR) issued an opinion and analysis of the impact of MVP's rate filing on the company's solvency. Noting that MVP's Vermont book of business accounts for approximately 2.2% of its total premiums written, DFR opined that the rates as proposed would not materially impact the company's solvency. Exhibit 9 at 2.

13. Beginning on May 12, 2017, the Board's actuary, Lewis & Ellis (L&E), conducted an actuarial review of the filing. After a series of requests for information and clarification from the insurer, L&E on July 11, 2017 issued a memorandum summarizing its analysis and recommendations for modification of the filing. Exhibit 10.

14. On July 19, 2017, the Board held a hearing, open to the public, on the proposed rate increase. Gary F. Karnedy, Esq. of Primmer Piper Eggleston & Cramer, P.C. represented MVP and presented testimony from MVP's Director of Actuarial Services, Matthew Lombardo. Kaili Kuiper, Esq. appeared for the HCA. Jesse Lussier, Insurance Examiner for DFR, testified regarding DFR's solvency analysis and opinion. Actuary Jacqueline Lee testified concerning L&E's review and actuarial analysis. No members of the public offered comments at the public hearing.[6]

15. The Board accepted written public comments on the proposed rates from May 12, 2017 through August 8, 2017 to accommodate the more than 300 comments that arrived beyond the statutory July 28, 2017 close of the comment period. The Board received a total of more than 500 public comments, many of which reference both MVP and BCBSVT. The public comments

[5] The exhibits referred to in this decision were stipulated to by the parties. All documents, hearing transcript and public comments referenced in this Decision and Order are available at http://ratereview.vermont.gov/MVPH-131034103, and are described by their titles, rather than as numbered exhibits.

[6] The Board held an additional public comment session on the evening of July 27, 2017, at which members of the public in attendance referenced BCBSVT's proposed rate increase, or generally encouraged the Board to reject any insurance rate increases.

overwhelmingly address the issue of affordability for Vermonters and oppose any increase in premium rates.

Findings of Fact

Nature of the Filing

16. MVP Health Plan, Inc. is a non-profit health insurer domiciled in New York State and licensed as a health maintenance organization (HMO) in New York and Vermont. The company is a subsidiary of MVP Health Care, Inc., a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries. The company offers HMO products to individuals and employers in the small and large group markets in Vermont. Exhibit 1 at 155; Hearing Transcript (TR) at 16.

17. The rates in this filing will be used for MVP's Vermont Health Connect plan offerings for coverage beginning January 1, 2018 and ending December 31, 2018. Based on its February 2017 membership, there are 4,889 policyholders, 6,847 subscribers, and 10,305 members impacted by this filing. Exhibit 1 at 10.

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

18. To form a credible experience base for projecting its 2018 VHC rates, MVP used 2016 combined experience claims data from its ACA-compliant individual and small group books of business. MVP adjusted the data to reflect CSRs, incurred but not reported paid claims (IBNR) and pharmacy rebates, and replaced high-cost claims (in excess of $100,000, with an attachment point of $675,000) with a pooling charge. Exhibit 1 at 11-12.

19. MVP further adjusted the claims data to account for two items not captured in the experience period or that will not be applicable during the rating period. First, MVP adjusted the claims projection to reflect the impact of members who do not maintain coverage for a full year, assuming that unlike previous years, all small groups and individuals will be covered for a full twelve months. Second, MVP made a downward adjustment to the experience period claim expense to reflect that 2016 was a leap year and therefore had one more day than the rating period. *Id.* at 12.

20. MVP projected the experience period claims forward to the rating period using an average annual allowed medical trend factor of 4.7%.[7] MVP performed regression analysis on its historical data to arrive at a positive utilization trend of 0.7%. To calculate its allowed unit cost trend of 3.5%, MVP used known and expected contractual increases with providers in its network. Because MVP's 2018 hospital budget negotiations were not finalized and proposed hospital budgets had not been submitted to the Board at the time of filing, MVP assumed that 2018 hospital budget increases will match 2017 increases. Exhibit 10 at 4.

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

21. MVP's pharmacy benefit manager (PBM) provided the insurer with a pharmacy trend forecast of 11.9%, based on MVP's experience by drug class. The proposed trend is lower than recent trends experienced by MVP over the last few years. Exhibit 1 at 14.

22. MVP further adjusted the rate for paid claims surcharges, capitation, and non-fee-for-service (FFS) expenses, including $3.10 per member per month (PMPM) for the "billback" and costs to fund the HCA, for a total of $8.80 PMPM. *Id.*

23. MVP projects general administrative expenses of $38.10 PMPM. *Id.* at 16. Based on an analysis of its administrative expenses, the company estimates that 10% of the general administrative expense load is used to cover Quality Improvement/Cost Containment Programs. *Id.*

24. MVP has included a 1.0% load to premium to account for the return of the Health Insurance Providers Fee for plan year 2018. *Id.*

25. The company has included a 2.0% contribution to reserves (CTR) to meet New York statutory reserve requirements and to protect itself against unanticipated liabilities. *Id.* at 17.

26. Based on an interim report from the Centers for Medicare & Medicaid Services (CMS), MVP initially anticipated that it would make a 2018 risk adjustment payment of approximately $1.4 million. *Id.* at 15; Exhibit 10 at 7. MVP has updated its estimate based on the final risk adjustment report released on June 30, 2017, which estimated a risk adjustment payment of $1,382,986, reducing the carrier's proposed rate increase by 1.1%. Exhibit 10 at 10. MVP notes that its estimate reflects its assumption that 2018 enrollment will be approximately 50% higher than 2016 enrollment. *Id.* at 8.

27. On review, L&E recommends four modifications to the filing. First, L&E recommends that MVP modify its 2016 claims experience to reflect that some individuals will begin or terminate their coverage mid-year for a variety of reasons. This modification would decrease the overall rate increase by approximately 0.3%. *Id.* at 10.

28. Second, L&E recommends that MVP correct two errors in its unit cost trend calculation, which would reduce the paid medical trend to 3.9% and reduce the proposed overall rate increase by 0.5%. *Id.*

29. Third, L&E recommends that the Board consider the impact of the most recent 2018 hospital budget data on MVP's unit cost trend calculations. *Id.*

30. Finally, L&E recommends that the Board accept MVP's new best estimate assumption for its risk adjustment payment, which would reduce the overall rate increase by 1.1%. *Id.*

31. MVP stipulates to the recommended modifications to its unit cost trend and risk adjustment payments, which have the combined effect of lowering the proposed rate increase to

5.1%. The company disputes only L&E's recommendation that it modify its claims experience to account for those individual members that will not maintain coverage for a twelve-month period. TR at 11.

32. At hearing, MVP's actuary addressed the issue by explaining that for 2018, Vermonters purchasing health insurance through VHC must enroll by December 15th for plans beginning January 1st. Previously, members could enroll until January 31st, which allowed for some members to begin coverage as of February 1st. Assuming that this shortened enrollment period would result in all of its members maintaining twelve-month contracts—and therefore be more likely than those with partial-year coverage to have claims that exceed their deductibles—MVP adjusted its rates upward by 0.7%. *Id.* at 37-41.

33. In response, the Board's actuary, Jacqueline Lee, testified that even with a narrower enrollment window, MVP's assumption that all of its membership will maintain a full year of coverage is not reasonable for individual members. Lee explained that individuals may add or drop their coverage for a variety of changed circumstances during the course of the year; for example, individuals might obtain or lose employer-sponsored group coverage, or may find coverage too costly and allow their coverage to lapse. *Id.* at 143-144; 153-155. Taking these scenarios into account, Lee testified that an upward rate adjustment of 0.4%, rather than 0.7%, is reasonable and appropriate. *Id.* at 143-144.

34. MVP is domiciled in and regulated by New York State, which requires reserves of approximately 12.5% of premium. The carrier's 2.0% CTR request would allow it to meet its New York State solvency requirement without relying on the reserves of its New York lines of business. *Id.* at 55-56.

35. MVP's total share of VHC business has increased, from June 2016 to June 2017, from approximately 10% to 15%. TR at 16-18. Because its proposed rates are competitive, MVP expects to gain further market share in 2018. *Id.*

36. When asked how the growth in membership affects administrative costs, MVP offered testimony that it has considerably reduced its administrative costs over the last several years by automating processes, consolidating departments, and reviewing contracts on a regular basis. TR at 59. For 2018, MVP intends to increase its marketing budget to further increase its VHC market share. *Id.* at 109. While its VHC book of business is increasing, however, its large group lines of business in Vermont, and overall Vermont membership, has declined. *Id*. at 97.

37. Following the hearing, the Board requested clarification from MVP concerning, among other items, the effect on unit cost trend of the recent hospital budget submissions and adjustments for 2016 hospital budget overages, the breakdown of fixed and variable administrative expenses, and whether the company would remain in compliance with New York State solvency requirements if it were to reduce its CTR from 2.0% to 1.0%. GMCB Request for Supplemental Information (7/19/2017) at 1-2.

38. On July 24, 2017, MVP submitted a written response to each of the Board's questions. If it incorporates the FY 2018 hospital budget submissions into its unit cost trend,

MVP estimates that its overall rate increase could be reduced by 1.1%, and by a further 0.2% if 2016 budget overages were also taken into consideration. MVP cautions that reflecting hospital rate increases below what is ultimately approved by the Board would result in higher rate increases in future years to make up for the shortfall. MVP Response (7/24/2017) at 2-3; TR at 42 ("[w]e would just be concerned about making any changes to this rate filing until decisions are finally made.")

39. MVP provided a breakdown of its administrative expenses from 2014 to 2017 which indicates that from 59% to 63% of its administrative costs during this period were fixed. In addition, MVP confirmed that it "has budgeted increased costs to its VT Exchange business to account for expanded sales and marketing efforts which is one of the primary drivers of a forecasted higher administrative expense PMPM in [its] 2018 Exchange Rate Filing." MVP Response (7/24/2017) at 4.

40. Concerning its proposed CTR, MVP noted that it will need higher reserves to maintain its solvency as its VHC book of business grows. New York State regulators have advised MVP that each book of business within its corporate structure should be "self-supporting." If the company's Vermont book of business were to increase by 5,000 members in 2018, the company estimates that a 1.0% CTR would result in reserves far below the New York statutory minimum. *Id.* at 4-5.

41. At the Board's request, MVP also estimated how the impact would be absorbed by Vermont policyholders should federal CSR payments be discontinued. If the increase fell solely on silver plans, those premiums would increase by approximately 7.8%; if spread across all metal levels, premiums would increase by approximately 2.8%. *Id.* at 4.

42. Both MVP and the HCA filed post-hearing memoranda. MVP requests that no changes be made to its filing other than the ones to which it has stipulated, reducing the proposed rate change to approximately 5.1%. MVP Post Hearing Memo (7/27/2017) at 1. The HCA requests that the Board disapprove or modify MVP's proposed rate downward stating that it is not affordable, does not promote access to health care, and fails to "ensure the solvency of both MVP and Vermont households." HCA Post Hearing Memo (7/27/2017) at 10.

Standard of Review

With the passage of Act 48 (2011), the legislature conferred jurisdiction over major medical health insurance rates to the Board beginning January 1, 2012. 18 V.S.A. § 9375(b)(6). The Board reviews health insurance rate filings to ensure that rates are affordable, are not "excessive, inadequate, or unfairly discriminatory," promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. § 4062(a)(2), (3); GMCB Rule (Rule) 2.000, *Rate Review*, §§ 2.301(b), 2.401. In addition, the Board takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues in its discretion. 18 V.S.A. § 9375(b)(6). Although the first several terms—excessive, inadequate, or unfairly discriminatory—are defined actuarial standards, other standards by which the Board reviews rate filings are "general and

open-ended," the result of "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16.

As part of its review, the Board must consider DFR's analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2)(B),(3). The Board must also consider any public comments received on a rate filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id.* § 2.104(c).

Conclusions of Law

At the outset, MVP agrees to remedy errors in the calculation of its unit cost trend, and to incorporate into its rates its most current estimate of its 2018 risk adjustment payment. These changes will produce an approximate 1.6% reduction in the proposed rate increase.

I.

MVP does not agree with L&E's recommendation that it should alter its proposed 0.7% upward adjustment to account for partial-year enrollment. We conclude, however, that MVP has not met its burden to prove that its upward adjustment to the rate is either accurate or supported by the credible evidence. As explained by L&E's witness at hearing, it is reasonable to assume that all, or nearly all, of its small group members will begin coverage at the start of the year and maintain their enrollment for the duration of 2018. It is not similarly reasonable, however, to assume that the entirety of MVP's individual membership will remain enrolled for a full twelve-month period. MVP's assumption ignores the likelihood that some individuals will drop coverage mid-year, which might occur for any number of reasons—an individual may obtain employer-sponsored insurance mid-year, for example, or find the coverage unaffordable. Finding of Fact (Finding) ¶ 33. Likewise, new members may acquire coverage over the course of the year due to marriage, for example, or loss of coverage through an employer. We therefore agree with our actuary that MVP's 2016 claims experience must reflect the fact that not all individuals will have full-year coverage.

II.

We next address whether MVP must update its projected unit cost trend to reflect the hospital budget information submitted to the Board on July 1 of this year, as well as our orders to hospitals to reduce their rates due to 2016 budget overages. Although we recognize that it would have been impossible for MVP to incorporate newly-submitted information into its VHC rate development, the hospital budget and insurance rate processes should not be siloed, and the information before us at this time, prior to approving insurance rate increases, should be used to maximize consistency between the two processes going forward.

In ordering the carrier to utilize information in the hospital budget filings to inform its rates, we reject its argument that the proposed hospital budgets are too speculative at this juncture. Indeed, over the past several years, July 1 budget submissions have not deviated substantially from what we have approved. *See, e.g.*, PowerPoint Presentation, *Fiscal Year 2017*

Vermont Hospital System Final Budgets as Approved (January 2017) at slide 9 (comparing each hospitals' proposed to approved rates from 2013 to 2017). We further note that in addition to aligning hospital budgets and insurance rate filings, we reasonably expect that the insurers will vigorously negotiate rates with hospitals, including those outside our borders, in a way that promotes parity in reimbursements between academic medical centers, community hospitals and independent providers. Provider reimbursements should reflect actual costs of care rather than site of service. Despite the carrier's representation to the contrary, we remain unconvinced that the insurers are without sufficient bargaining power to influence commercial rate negotiations, or that the results of the hospital budget process inexorably mandate a predetermined contractual result.

Based on the insurer's calculations, this modification, inclusive of the Board's orders to several hospitals to correct 2016 overages, reduces the proposed rate by approximately 1.3%.

III.

With respect to administrative expenses, we accept our actuary's recommendation that MVP's assumed administrative expenses are reasonable and appropriate at this time. Notably, MVP has worked to reduce its administrative costs in recent years, notwithstanding the loss of members in Vermont's large group market. *See* Findings ¶¶ 23, 35, 36. Should MVP realize its projected VHC membership growth for 2018, however, we expect that MVP will further reduce its administrative expenses in next year's filing, as its administrative costs will be spread across a larger population and may reflect a reduction in the expanded sales and marketing efforts incorporated in the 2018 rate.

IV.

Finally, we conclude that the 2.0% CTR proposed by MVP is reasonable and appropriate at this time to maintain solvency while providing adequate margins for unidentifiable future risks and unexpectedly high claims. MVP has sufficiently demonstrated that it cannot rely solely on subsidization from its New York lines of business for its reserves to be considered adequate. In addition, while in past VHC filings from this carrier we have approved only minimal CTR—for example, in the 2016 filing we approved the requested 0.0%, which MVP submitted to ensure competitive rates—MVP's population in the Vermont exchange market has grown and is expected to continue to grow for 2018, necessitating additional reserves to cover the larger membership. *See* Finding ¶ 34. Given its relatively small share of the QHP market, we agree that the requested CTR in this filing is reasonable.

Conclusion and Order

The availability of affordable health insurance is again the subject of impassioned national debate. As we issue our decision today, we are mindful of the uncertainties surrounding provisions of the Affordable Care Act, and the difficulties that many Vermonters—particularly those who do not qualify for premium assistance or cost-sharing reductions—face as health insurance premiums continue to rise faster than other economic indicators. Today's decision

reflects our dual interests to approve rates as lean as possible, while ensuring that carriers remain solvent and therefore willing to continue to participate in our health insurance marketplace.

Accordingly, for the reasons set forth above, we modify, and then approve, MVP's 2018 Vermont Health Connect rate filing. Specifically, we order that MVP: 1) modify its unit cost trend as recommended by L&E, and as stipulated to by MVP, resulting in a 0.5% reduction to the rate; 2) incorporate its updated, best estimate of its 2018 risk adjustment payment, as recommended by L&E and as stipulated to by MVP, resulting in a 1.1% reduction; 3) modify its 2016 claims experience as recommended by L&E to account for individuals who are enrolled for less than a twelve-month period, resulting in a 0.3% reduction to the rate; and 4) modify its unit cost trend to align with recently submitted hospital budget data, as projected in its July 24, 2017 response, reducing the rate by an additional 1.3%.

As modified, the average annual rate increase is reduced from the proposed 6.7% to approximately 3.5%.

SO ORDERED.

Dated: August 9, 2017 at Montpelier, Vermont

s/ Cornelius Hogan)
)
s/ Jessica Holmes)
)
s/ Robin Lunge) GREEN MOUNTAIN
) CARE BOARD
s/ Kevin Mullin) OF VERMONT
)
s/ Maureen Usifer)

Filed: August 9, 2017

Attest: s/Erin Collier, Administrative Services Coordinator
Green Mountain Care Board

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

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