

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-008-18rr

IN RE: MVP Health Care 2019 Vermont
Health Connect Rate Filing

July 24, 2018
9 a.m.

115 State Street
Montpelier, Vermont

Rate Review Hearing held before the Green
Mountain Care Board, at the Vermont State House, Room 11,
115 State Street, Montpelier, Vermont, on July 24, 2018,
beginning at 9 a.m.

P R E S E N T

BOARD MEMBERS:

Kevin Mullin, Chair
Maureen Usifer
Jessica A. Holmes, Ph.D.
Robin Lunge, JD, MHCDS
Tom Pelham

STAFF:

Judy Henkin, Esq., Hearing Officer
Sebastian Arduengo, Staff Attorney
Agatha Kessler

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BURLINGTON, VERMONT 05402-0329
(802) 863-6067
Email: info@capitolcourtreporters.com

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A P P E A R A N C E S

MVP Health Care

PRIMMER, PIPER, EGGLESTON & CRAMER
150 S. Champlain Street, P.O. Box 1489
Burlington, VT 05402-1489
BY: GARY F. KARNEDY, ESQUIRE

Health Care Advocate

Jay Angoff, Esq.
Kaili Kuiper
Eric Schulteis
Tim Fisher

Vermont Department of Financial Regulation

GAVIN BOYLES, ESQUIRE
89 Main Street, 3rd Floor
Montpelier, VT 05620-3101

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1 (9:01 a.m.)

2 CHAIRMAN MULLIN: Good morning
3 everyone.

4 MR LOMBARDO: Good morning.

5 CHAIRMAN MULLIN: Going to call this
6 hearing to order. And the first order of business
7 will be to designate Judy Henkin as the Hearing
8 Officer for today's proceeding. With that, I'll turn
9 it over to you, Judy.

10 HEARING OFFICER HENKIN: Thank you,
11 Chair. Good morning everybody. It's July 24, 2018.
12 We are here in the matter of MVP rate filing. It is
13 Docket Number GMCB-008-18. And we have the parties
14 here. We have MVP. Representing MVP is Gary
15 Karnedy. And I don't know the other person at the
16 table.

17 MR. KARNEDY: My summer associate,
18 Michelle Bennett.

19 HEARING OFFICER HENKIN: Benny?

20 MR. KARNEDY: Bennett. She's going to
21 learn today.

22 HEARING OFFICER HENKIN: And you have
23 your witness at the table, Matt Lombardo from MVP.

24 MR. KARNEDY: Yes.

25 HEARING OFFICER HENKIN: The HCA is

1 here today. We have representing the Health Care
2 Advocate's office is Jay Angoff, Kaili Kuiper, Eric
3 Schultheis, and Chief Health Care Advocate Mike
4 Fisher is also at the table.

5 We have a court reporter for today's
6 hearing, so this will be -- it is being videotaped,
7 audiotaped, and is the tape on in fact? We have at
8 least videotaped. Audio tape. Not audio tape.
9 Transcribed by the court reporter. And I don't know
10 how to work simple recording instruments, otherwise
11 I'd do that. Robin is taking care of it.

12 The board has jurisdiction over this
13 matter under Title 18 of the Vermont Statutes
14 Annotated 9375(b)(6). Also Title 8 of the Vermont
15 Statutes Section 4062(a), and Title -- and that's it.
16 Sorry.

17 So I'm going to welcome all the members
18 of the public and the parties that are here today.
19 We do have a sign-in sheet, I believe, if you would
20 like to make public comment which will take -- be
21 taken at the end of today's evidence.

22 I will remind the board again, and I
23 will remind the parties that there may be
24 confidential information that has been submitted by
25 the carrier that is within the filing, and please

1 exercise caution in discussing anything that may have
2 been clearly marked as confidential because it cannot
3 be discussed in this open forum.

4 We have a lot more room today for
5 everyone, so you can stretch out a little bit. I
6 would like to have you swear in all the witnesses now
7 so we can take care of that. All the witnesses or
8 potential witnesses please rise and be sworn.

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1 Matt Lombardo

2 Mike Fisher

3 Jacqueline Lee

4 Jesse Lussier

5 Having been duly sworn, testified

6 as follows:

7 HEARING OFFICER HENKIN: Which reminds
8 me, we also have the Department of Financial
9 Regulation sitting right in front of me. They have a
10 witness here Jesse Lussier, and we have General
11 Counsel Gavin Boyles also in attendance.

12 Now that we have sworn in the
13 witnesses, we do have a stipulated set of exhibits
14 that the parties had worked on. There were -- there
15 was also a list of items that was submitted by the
16 Health Care Advocate. Some were stipulated to, some
17 were not, and those are items which they are
18 requesting that the board potentially, if used, take
19 some administrative notice of. We can address that
20 issue right now because I believe there was an
21 objection to several of the issues -- of the
22 submitted documents.

23 MR. KARNEDY: Do you want to start with
24 that before the motion in limine?

25 HEARING OFFICER HENKIN: Let's start

1 with that, get this out of the way.

2 MR. KARNEDY: So do you want to hear
3 the objection, or do you want to hear the proffer
4 first? Who do you want to hear from first, I guess?

5 HEARING OFFICER HENKIN: You filed an
6 objection. Why don't you please raise that first.

7 MR. KARNEDY: Fair enough. So the
8 Health Care Advocate provided well over a dozen
9 documents by email to us asking if we would take
10 judicial notice of those. We agreed to all of them
11 save two. I'm going to talk about those two
12 documents.

13 The first document, as I understand it,
14 and I think I'll talk about both of them at the same
15 time because it's related, is the Commonwealth Fund.
16 This is a document, a 20-page paper, from May of
17 2015. There are four authors to this document who
18 are not here today for me to cross examine. The HCA
19 could have brought any one of them as an expert
20 witness, disclosed them pursuant to our procedure.
21 This document cites to other papers that haven't been
22 provided, so there is a lack of foundation. This
23 article is not like Grey's Anatomy or Black's Law
24 Dictionary or some other learned treatise to get
25 around the hearsay issue. This is hearsay. It's not

1 a public record. No exception on that. And the
2 document, I think, acknowledges bias. It's admitted
3 in the document by the Commonwealth Fund, whatever
4 that is, that the paper only has views presented by
5 the authors, not necessarily those of the
6 Commonwealth Fund. So I can't test that bias without
7 having these witnesses here. And what we are talking
8 here is about judicial notice, and that standard
9 appears to be higher than the APA standard where, you
10 know, there is just a question of reliability. Here
11 we have got a question of whether this document is
12 not subject to reasonable dispute. I would say that
13 it is. Difficult for me to dispute without witnesses
14 here, so I would say that that should not be
15 referenced in briefs or used in this case.

16 The second document is really for the
17 same arguments. This is represented as a market
18 decision's document, a comprehensive report prepared
19 for DFR in 2015. It's a 101-page report. It's
20 written by a Brian Robertson, a PhD, director of
21 research. He's up in Portland, Maine. Again, they
22 could have disclosed him as an expert and brought him
23 here. Portland is not too far away.

24 Expert disclosures provide the other
25 side an opportunity to prepare. We haven't had that

1 opportunity. I don't think it's a deliberate attempt
2 to subvert that, but the reality is if this goes in,
3 there is hearsay issues. There is a lack of
4 foundation. This isn't relied upon anyone testifying
5 as an expert in this case. And the public records
6 exception specifically excludes investigative reports
7 prepared for a government entity. So both of these
8 documents shouldn't be referenced in any brief or
9 here in the case, and we don't think that they should
10 be considered by the board for the reasons I stated.

11 MR. ANGOFF: Yeah. We think the
12 objection with respect to the Commonwealth Fund
13 report is at least in part well taken, and we
14 withdraw it. The Commonwealth Fund is not a
15 governmental entity. It has a certain point of view,
16 and though I don't agree with everything counsel
17 says, I think he has some good points. We withdraw
18 it.

19 On the other hand, the other report is
20 not done by a foundation. It's done by a
21 governmental entity, the Vermont Department of
22 Regulation, Insurance Division. And therefore, we
23 think this ought to be admitted, that it does fall
24 into the category of judicial record, and this body
25 should certainly take official notice of it.

1 BOARD MEMBER LUNGE: And before --
2 Judy, before you rule, I should just disclose that
3 while I was working for the executive branch I was
4 actually responsible for the production of the
5 household insurance survey. I -- in March of '15 I
6 was in the Agency of Administration, but because I
7 was in charge of health care reform, I worked closely
8 with the staff at DFR and with that consultant for
9 the production of the report.

10 MR. KARNEDY: The only thing I would
11 add is it sounds like Board Member Lunge is very well
12 versed on these issues. And she doesn't need this
13 report to come into evidence to deliberate on the
14 matters before us here today. And Mr. Robertson
15 isn't here for me to cross examine.

16 HEARING OFFICER HENKIN: The report is
17 produced by a governmental agency that was a
18 contractor. It is a report that I believe is again
19 being prepared. This one was from 2015. It was the
20 last available report on this.

21 It is not being offered into evidence.
22 It is being -- they are requesting that the board
23 take notice, if, in fact, it is to be administrative
24 notice for the purposes of hearing and for their
25 briefing, if it is to be used at all, it is the type

1 that a reasonably prudent jurist may consider, in
2 fact, and we find it's reliable for the reasons
3 discussed that it is a regularly produced report. It
4 was produced by the Department of Financial
5 Regulation which I believe then might have been
6 BISHCA. I can't remember. And it will be given
7 appropriate weight in our consideration.

8 So that does not mean it will be taken
9 into evidence as fact. But if, in fact, it is used
10 by the parties, it will be weighted accordingly by
11 the board. So we will take notice of that document.

12 Moving on, we have another motion
13 before the board which was filed by the party -- by
14 MVP. And there was a written response on this
15 motion. Would you like to present your motion
16 quickly please?

17 MR. KARNEDY: Yes, please. We stand by
18 our briefs. The law is clear that the report by Mr.
19 Fisher should be stricken, and he should not be
20 allowed to testify. First, we start with the
21 proposition that was unopposed, the frame of his
22 testimony was set forth in the four corners of that
23 report. The subject matter is restricted to what he
24 discussed in his expert report, and he was not
25 disclosed as a fact witness. So they made the choice

1 to have him talk solely about this.

2 And then that relates to the second
3 issue. His report and related testimony amount to
4 inadmissible legal conclusions about legislative
5 history. The case law is clear on this. See our
6 brief. Expert testimony on legislative history is
7 stricken. We are not allowed. This is a subject for
8 the board to consider if it chooses in its briefing.
9 It's not a testimonial expert that's needed. The
10 board and their counsel can review, cite case law,
11 legislative history, whatever you want to do. This
12 hearing should not devolve into debates about what
13 happened and what was said leading up to the passage
14 of Act 48.

15 And Mr. Fisher's, respectfully, cherry
16 picking on what he recalls back then. Since this
17 report and the testimony are inadmissible, and he was
18 not disclosed to talk about anything else, he should
19 be prohibited from testifying.

20 I would also note that I understand
21 that the board ruled on a similar motion yesterday to
22 prohibit his testimony. We would ask that you do the
23 same here.

24 HEARING OFFICER HENKIN: Mr. Angoff.

25 MR. ANGOFF: Yes. We are aware that

1 the board ruled yesterday -- and therefore -- on this
2 motion. Therefore, we withdraw Mr. Fisher's -- Mr.
3 Fisher as an expert, and instead we would like to
4 rely on Section 4062(e)(1)(B) which says that the
5 board shall provide an opportunity for testimony from
6 the insurer, the office of the Health Care Advocate
7 and members of the public. So we withdraw Mr. Fisher
8 as an expert and simple rely on the statutory mandate
9 that the Health Care Advocate be prepared to testify.

10 HEARING OFFICER HENKIN: Do you have a
11 response?

12 MR. KARNEDY: I do. We had several
13 prehearing meetings, prehearing orders, and a path to
14 which there was a fair disclosure and transparent
15 process here leading up to this hearing.

16 One thing we were supposed to do, the
17 parties were supposed to do, was to disclose fact
18 witnesses, to disclose our witnesses, whether they be
19 expert or fact. He was not disclosed as a fact
20 witness. And now I'm hearing he is going to be
21 testifying as a fact witness. That's inconsistent
22 with your ruling yesterday. And we would ask that he
23 not be allowed to testify on that.

24 HEARING OFFICER HENKIN: I believe my
25 ruling yesterday was that he could not provide

1 testimony as to the legislative history, his
2 recollection of the legislative history, and his
3 interpretation of the intent. This sounds like this
4 may be different. But I would like to just clarify a
5 few things.

6 Have you reviewed the board's
7 scheduling order that was agreed to by the parties
8 and signed by the board?

9 MR. ANGOFF: Yes, I have.

10 HEARING OFFICER HENKIN: And there is
11 -- there was a date, in fact, for disclosure of
12 witnesses so the parties would have an opportunity to
13 be fairly apprised of the testimony.

14 MR. ANGOFF: Yes.

15 HEARING OFFICER HENKIN: And was Mr.
16 Fisher disclosed on that?

17 MR. ANGOFF: Mr. Fisher was disclosed
18 as an expert. We believe that Mr. Fisher qualified
19 as an expert. And therefore, there was no need to
20 disclose him as a fact witness. In fact, that would
21 be -- contradict our proposal that he testify as an
22 expert witness. We believe that he's qualified. The
23 ruling as an expert -- the ruling was that he's not
24 qualified which we accept obviously. But the
25 statutory mandate that the board shall allow the

1 public advocate to testify, I understand he wouldn't
2 be testifying about -- he can't testify about
3 anything that seems like -- testimony about
4 legislative intent or what the legislature meant, but
5 he can still testify as to -- under the statute as
6 the Health Care Advocate.

7 HEARING OFFICER HENKIN: Was this a
8 strategy decision, however, to not offer him as a
9 fact witness and just instead offer him to discuss
10 the intent of the legislation?

11 MR. ANGOFF: No. We are not that
12 smart. We believe that -- we believed that he would
13 be allowed to testify as an expert, and we were
14 wrong. It's not the first time.

15 HEARING OFFICER HENKIN: But we should
16 reward you for your ignorance.

17 MR. ANGOFF: Ignorance. It's been done
18 before.

19 HEARING OFFICER HENKIN: It has been
20 done before. Sometimes they come out ahead.

21 I would like to consider this because
22 there is no -- I think that some of you may have seen
23 that the board has barred testimony. There was a
24 fair opportunity for Mr. Fisher to come in, and in
25 fact, I think what was disclosed to the board and to

1 the other party was that there would be two
2 witnesses, one of whom was someone from your
3 Burlington office who presumably would be discussing
4 facts about filings and about phone calls and so
5 forth, and what goes on through that office relative
6 to these filings.

7 This was not what transpired whether by
8 default or ignorance or whatever you would like to
9 say, and the testimony, yes, you can see that the
10 legislative testimony is not going to be admissible.
11 And thank you for conceding that. That's very
12 gracious. However, we don't have notice of what Mr.
13 Fisher would be testifying to for the other party,
14 and we did have this discussion, and the opportunity
15 was there for the Health Care Advocate to discuss
16 this at that time.

17 What can be allowed is Mr. Fisher can
18 appear as a rebuttal witness on the matters that are
19 already out there before the board. However, I'm not
20 going to allow him to come in with unknown testimony
21 as an undisclosed witness at this time. So as you
22 strategize, instead of letting things happen for
23 today, you may think of how you wish to do that,
24 because I think that is quite allowable and would
25 give fair notice to MVP the content of what you're

1 going to testify about because it will be limited to
2 what is discussed at hearing in that matter.

3 The other piece of this is I also want
4 to make clear, and again I thank you that the HCA is
5 not barred from this hearing. In fact, it's
6 represented here, and you have the opportunity to
7 cross witnesses and to ask as many questions as you
8 need to of Mr. Lombardo or of the Department of
9 Financial Regulation. So this is not an effort to
10 bar you from the hearing.

11 However, agreed upon and by prior
12 ruling with adequate notice and in the interest of
13 fairness to all parties, the HCA is a very good
14 partner. We are not opposing parties on this. We
15 are all here to try to ensure that Vermonters get the
16 best rates possible and the slimmest possible rates,
17 and that they are in line with all the statutory
18 requirements.

19 So there is a very important role, and
20 the HCA has been participating, has submitted or
21 suggested questions for the actuaries to present.
22 Those have been answered. The information has been
23 provided to the HCA's office. You still have
24 opportunities for comment as provided for in 4062.
25 And you have an opportunity to fully participate in

1 today's hearing. And I want to make it very clear
2 that this is not intended to quash your participation
3 in any way, but it will have to be within the set
4 bounds of the prior order and the agreement of the
5 party and standard procedure in the cases.

6 So with that, I will let us proceed,
7 and if you have a question, Mr. Angoff.

8 MR. ANGOFF: Yes. Just for scheduling
9 purposes then, so Mr. Fisher can testify as a
10 rebuttal expert -- a rebuttal witness, and then he's
11 not an expert.

12 HEARING OFFICER HENKIN: He is not an
13 expert.

14 MR. ANGOFF: He can testify as a
15 rebuttal witness. Just for scheduling purposes, when
16 would that be?

17 HEARING OFFICER HENKIN: That would be
18 at the end. We will discuss that. That will be
19 after we take all the testimony today. So we will --
20 we will proceed with allowing MVP to present their
21 case first as we always do. We will allow DFR to
22 then proceed. L&E can proceed, and we will take any
23 testimony offered from Mr. Fisher at the end of the
24 day.

25 MR. ANGOFF: Very good. Thank you.

1 HEARING OFFICER HENKIN: Is that
2 understood?

3 MR. KARNEDY: And then we could
4 obviously rebut whatever he says?

5 HEARING OFFICER HENKIN: You can cross.
6 And rebut. Hopefully time will allow today.
7 Yesterday was a little bit crunch of a time. I think
8 today with only one witness here we should be able to
9 get through everything.

10 I am going to also caution everyone to
11 be mindful of the time in their testimony and in
12 their questioning. I don't want to cut anyone off.
13 But I do want to make sure that everyone gets heard.

14 CHAIRMAN MULLIN: Before we proceed,
15 there is one thing I should have announced at the
16 beginning. If there are any members of the public,
17 there is a public comment period tonight from 4:30 to
18 6:30 at Montpelier City Hall, but at the end of the
19 proceeding today we will also listen to those who
20 cannot be at Montpelier City Hall. And Agatha, if
21 you could stand up.

22 (MS. Kessler standing.)

23 CHAIRMAN MULLIN: If anybody from the
24 public wishes to make a comment, please make sure you
25 sign in with Agatha. Thank you.

1 HEARING OFFICER HENKIN: Okay. To
2 start today, I'll let you each present an opening,
3 and then we will move right on into the witnesses, if
4 there is no other matters.

5 MR. ANGOFF: Madam Hearing Examiner,
6 stipulated documents.

7 HEARING OFFICER HENKIN: The stipulated
8 documents are admitted into evidence. It's --
9 exhibit list is -- there is Exhibits 1 through 14.
10 And we will enter those into evidence now.

11 (Exhibits marked 1-14 were admitted
12 into the record.)

13 MR. KARNEDY: Thank you very much.

14 MR. ANGOFF: I'm sorry. 1 through 14
15 what?

16 HEARING OFFICER HENKIN: Will be
17 entered into evidence now. Oh wait, yeah. Is 1
18 through 14, and there is three that are not
19 stipulated.

20 MR. ANGOFF: Correct.

21 HEARING OFFICER HENKIN: Let's go to
22 those now. Sorry.

23 MR. KARNEDY: Do you want to deal with
24 those now or at the time --

25 HEARING OFFICER HENKIN: I was going to

1 wait until they were offered. So would that work for
2 you also?

3 MR. ANGOFF: To wait?

4 HEARING OFFICER HENKIN: Yes. Until
5 the time they are offered.

6 MR. ANGOFF: Yes, it would.

7 HEARING OFFICER HENKIN: And then we
8 can have some discussion as to whether they should or
9 shouldn't be admitted.

10 MR. ANGOFF: Yes.

11 HEARING OFFICER HENKIN: Again, the
12 Exhibits 1 through 14 are admitted into evidence.

13 MR. KARNEDY: Thank you very much.

14 Good morning. My name's Gary Karnedy
15 from Primmer & Piper. I once again represent MVP in
16 this 2019 rate hearing. I have with me Matt Lombardo
17 who was introduced a moment ago, director of
18 actuarial services at MVP who will be testifying
19 again this year.

20 I also want to say welcome to Board
21 Member Pelham to our fun and frolic here today. The
22 evidence presented today will show that MVP's
23 original increase, the average request, was 6.4
24 percent. That is the amount that will be felt by
25 Vermonters to use a phrase coined by L&E.

1 I wanted to provide the board with a
2 road map on our presentation with this opening
3 statement. First of all, after conferring with L&E
4 the evidence will show that we have reduced the
5 request we are making today from 6.4 percent to 4.6
6 percent. MVP has made three changes to its original
7 proposal on May 10th. The evidence will show that
8 the first change was an actuarial adjustment
9 suggested by L&E relating to silver loading, 6.4 to
10 6.1. So that's the first change.

11 The evidence will also show that there
12 is three initial issues of disagreement that were
13 laid out by L&E in their report. We continue to have
14 a respectful disagreement, respectful, over the first
15 issue of mid-year enrollment. That amounts to a .3
16 difference.

17 We have agreed on the second issue that
18 they have raised. A reduction for the risk
19 adjustment of 1.9 percent. So that's the second
20 issue, and that's the second change MVP is making to
21 today's rate filing.

22 The third issue raised by L&E relates
23 to hospital budget increases. In its May 10 rate
24 filing MVP simply plugged in last year's budget
25 increases for the hospitals which was the best data

1 they had back in May at the time. The evidence will
2 show that in its July 10th recommendations L&E
3 recommended that any more recent information we get
4 regarding the hospital budget increases, that may
5 arise after their July 10th letter, should be
6 considered by the board.

7 This recommendation is consistent with
8 the board's ruling in our MVP case last year when it
9 ruled that it would consider the hospital budget
10 filings even though it had not yet had the hearings
11 to finally approve those budget proposals.

12 This year you will hear evidence on how
13 the hospitals recently filed proposed budgets with
14 the board, and that MVP is making an adjustment, an
15 increase of .5 percent to recognize the recent
16 proposed increases of the hospitals. So this is the
17 third change that MVP is proposing.

18 The bottom line is that MVP has reduced
19 its original rate proposal from an average of 6.4
20 percent to 4.6 percent felt by Vermonters. The HCA
21 has not disclosed any actuarial expert to testify
22 this year, so the only two qualified expert actuaries
23 here will be Jackie Lee and Matt Lombardo.

24 As we have done every year, MVP will
25 submit evidence that may apply to some or all of the

1 actuarial or non-actuarial criteria. In a case both
2 MVP and the Green Mountain Care Board are familiar
3 with, which we took to the Vermont Supreme Court and
4 argued, the Supreme Court ruled these statutory non-
5 actuarial terms such as affordability are broad and
6 largely undefined leaving you, the board, with broad
7 discretion to consider the evidence that may bear on
8 each of the statutory criteria.

9 We believe that the evidence that's
10 been submitted and will be submitted as it has in
11 prior years will have broad application to some or
12 all of the statutory criteria. One piece of evidence
13 may relate to many of the statutory criteria rather
14 than falling into only one bucket. This is for the
15 board to determine. For example, in exercising its
16 broad discretion the board may find that the
17 telemedicine benefit that's in the rate filing
18 relates not just to access to care, but also to
19 affordability and the adequacy of the rate and the
20 non-discriminatory way the benefit is offered. Said
21 another way, you don't have to be an expert to define
22 non-actuarial terms. You just have to sit on the
23 Green Mountain Care Board.

24 By the end of the hearing, the evidence
25 including the testimony, multiple exhibits, multiple

1 objection letters, and the explanation and
2 description of the benefits offered in MVP's 90-page
3 rate filing will be sufficient for the board to make
4 findings on each and every statutory criteria.

5 Thank you very much.

6 HEARING OFFICER HENKIN: Mr. Angoff.

7 MR. ANGOFF: Thank you. We believe
8 that the rate increase is not fully actuarially
9 justified, and we will demonstrate that through our
10 questioning. In addition though, the three issues
11 which I think the board -- which we have got
12 questions about, and which we are actually somewhat
13 agnostic about, and which we will be questioning.
14 One is on the affordability issue, which as you know,
15 is the first standard in the statute, MVP submitted
16 Exhibit 13 entitled "What is Affordability?" And we
17 would like to go through that carefully and determine
18 how that's relevant to the affordability of this rate
19 to see if it has any relevance.

20 Second issue is it's clear that the MVP
21 RBC ratio is substantially lower than that of Blue
22 Cross. Whether that's a good thing or a bad thing, I
23 think can be discussed, and how that affects the need
24 for profit or what the companies here call a
25 contribution to reserves. I think that's also an

1 issue that's unclear. So they have got a lower RBC
2 ratio. Is that good or bad? And does that mean they
3 should get a higher or a lower profit factor or CTR?

4 Third issue. MVP underwent a
5 reorganization recently. There is nothing insidious
6 about that at all, but they underwent a
7 reorganization that allows them to save state premium
8 taxes. And I think it's important that the board
9 understand exactly what they did. I don't think it's
10 important that the board understand exactly what they
11 did and how, if at all, they factor the savings on
12 premium taxes into their rate filing, specifically
13 into their actuarial memorandum.

14 And similarly, under the Trump tax bill
15 -- the tax jobs -- the what is it? The whatever they
16 call it. The Jobs Act. Tax Cuts and Jobs Act, MVP,
17 like Blue Cross, does get some benefit, but it's
18 unclear exactly what that benefit is, how much it is,
19 and again, how, if at all, that's factored in the
20 rate filing and particularly into the actuarial
21 memorandum. So we will press about actual elements
22 of the actuarial memorandum, but those are three
23 issues that I think are particularly important for
24 the board to take notice of. Thank you.

25 HEARING OFFICER HENKIN: You may call

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your first witness.

MR. KARNEDY: Call Matt Lombardo.

1 MATTHEW LOMBARDO

2 Having been duly sworn, testified
3 as follows:

4 DIRECT EXAMINATION

5 BY MR. KARNEDY:

6 Q. Matt, I believe you're already sworn in.

7 A. Yup.

8 Q. So I'm going to ask you questions, so try to
9 look at the board, but also listen to the questions.
10 Okay?

11 A. Yup.

12 Q. Could you state your name for the board,
13 please?

14 A. Matthew Lombardo.

15 Q. And where are you employed, Matt?

16 A. MVP Health Care.

17 Q. Okay. And who is the filer of this rate
18 filing, please?

19 A. MVP Health Plan, Inc. It's a non-profit HMO
20 subsidiary of MVP Health Care.

21 Q. And what is your position at MVP?

22 A. Director of actuarial services.

23 Q. And Matt, do you have any professional
24 certifications or memberships, please?

25 A. Yes. I'm a fellow in the Society of

1 Actuaries. I'm a member of the American Academy of
2 Actuaries.

3 Q. How long have you worked in the health care
4 insurance industry?

5 A. Worked in health care for 12, 12 and-a-half,
6 13 years. 10 years with MVP.

7 Q. Okay. And have you had involvement working on
8 the Vermont rate filing for MVP over the years?

9 A. Yes. I have been involved in every one of the
10 Vermont Health Connect rate filings since 2014, so I'm
11 familiar with them.

12 Q. And how many times have you been in the hot
13 seat testifying?

14 A. This is my third or fourth time that I've
15 actually testified.

16 Q. So what are some of your job duties as a
17 director of actuarial services, please?

18 A. In addition to setting premium rates, it's
19 also corporate forecasting, understanding some market
20 intelligence about our competitive premium position. And
21 we also analyze value-based contracts for our New York
22 Medicaid business, in addition to a number of other items.

23 Q. Do you review cost drivers?

24 A. Yes. I mean that's always part of our rate
25 calculation. We are analyzing how we experience period

1 data and anticipate the change, you know, from 2017 in
2 this case to 2019.

3 Q. Okay Matt, you have a binder in front of you
4 which the stipulated exhibits are in evidence. Do you see
5 that list of exhibits, it says "Stipulated Exhibit List."

6 A. Yes.

7 Q. So we will be referring to that today. And if
8 you would look just at that list, and you see Exhibit 1 is
9 the rate filing and then Exhibits 2 through 9 are all of
10 the objection responses. Do you see that?

11 A. Yes.

12 Q. And you're familiar with the rate filing,
13 those objection responses?

14 A. Yes.

15 Q. And you adopt them as your testimony in this
16 case?

17 A. Yes.

18 Q. And then Exhibit 10, do you see that? That's
19 the DFR solvency analysis letter?

20 A. Yes.

21 Q. And you've reviewed that and familiar with it?

22 A. Yes.

23 Q. And then Exhibit 11 on the list is the L&E
24 actuarial opinion. Do you see that?

25 A. Yes.

1 Q. And have you reviewed that, and are you
2 familiar with that report?

3 A. Yes, I am.

4 Q. Okay. And then Exhibit 12 is your CV. Did
5 you prepare that?

6 A. Yes.

7 Q. Okay. Then Matt, if you look, for example, at
8 Exhibit 1 behind the number one binder, do you see the
9 little red numbers in the bottom right-hand corner?

10 A. Yes.

11 Q. So I'll try to refer to those. They are not
12 on every exhibit, but they are on a lot of them, so I'll
13 try to refer to those so we can follow one another and the
14 board can follow what you're talking about. Okay?

15 A. Sounds good.

16 Q. With that in mind, let's start at a high level
17 on the numbers, Matt. So would you go to page 32 of
18 Exhibit 1, please.

19 A. Okay.

20 Q. Would you read the last two sentences of that
21 first paragraph at the top, please?

22 A. "Assuming all members purchasing Cost Sharing
23 Reduction subsidy plans stay on the exchange while all
24 other members purchasing silver plans move to the
25 reflective plans, the proposed rates reflect an average

1 rate adjustment to prior rates of 10.9 percent ranging
2 from 4.2 percent to 30.7 percent. The average rate
3 adjustment absent any loading to silver plans for CSR
4 defunding would be 6.4 percent with increases ranging from
5 4.2 percent to 10.6 percent."

6 Q. Okay, great. Could you go, please, briefly to
7 Exhibit 11 which is the L&E report to page 12. There is a
8 table there. Do you see that?

9 A. Yes.

10 Q. You see where L&E uses the language
11 "Recommended Rate Change Felt by Vermonters." Do you see
12 that?

13 A. Yes.

14 Q. Okay. So let's go back then, please, to
15 Exhibit 1. Those two sentences that you just read. Can
16 you explain how those two sentences relate to this issue
17 of help by Vermonters?

18 A. Yes. So MVP worked with various stakeholders
19 including DVHA and Green Mountain Care Board and Health
20 Care Advocate in creating silver reflective plans which
21 are helping to mitigate the impact of Cost Sharing
22 Reduction subsidy elimination by the federal government.
23 With the change, it's going to increase the overall
24 premium rates which is coming in at 10.9 percent, but
25 offsetting that is an increase to the premium subsidies

1 that eligible members will feel.

2 And the increase felt by Vermonters is taking
3 into account the increase in premium subsidy.

4 Q. Okay. Thank you. So originally if you look
5 at that second sentence on page 32 in that first heading,
6 we were at 6.4 percent absent the silver loading; correct?

7 A. Correct.

8 Q. Okay. So going back to the L&E report which
9 is Exhibit 11, please.

10 A. Okay.

11 Q. This year is it fair to say that L&E and MVP
12 agree on most everything?

13 A. Yes.

14 Q. Okay. So if you would go, please, to page 11?

15 A. Okay.

16 Q. You'll see the document has three bulleted
17 recommendations and then a sentence after that. Do you
18 see that?

19 A. Yes.

20 Q. Okay. So read the sentence at the end there,
21 the "after the modifications," please.

22 A. "After the modifications, the anticipated
23 overall rate increase will reduce from 10.9 percent to
24 approximately 8.5 percent, and the rate increase felt by
25 Vermonters will reduce from 6.1 percent to 3.8 percent."

1 Q. Okay. So a moment ago we pointed out that we
2 started out at 6.4. Do you remember that testimony?

3 A. Yes.

4 Q. And L&E is saying 6.1 here is the starting
5 point. Do you see that?

6 A. Yes.

7 Q. Can you explain why the numbers are different
8 and how MVP reacted to that?

9 A. Sure. MVP is -- for the members that are in
10 the silver loaded plans, MVP is mapping them to the most
11 similar silver reflective plan, and when that's taken into
12 consideration, you arrive at 6.4 percent increase. L&E's
13 calculation is excluding the silver loaded members from
14 the calculation which is driving the 6.1 percent increase.
15 They are both reasonable calculations. Just a little bit
16 different way of looking at it.

17 Q. So are we agreeing then to their 6.1 percent
18 as a starting point?

19 A. Yes.

20 Q. So then if you look on this same page, do you
21 see the three bullets under recommendations?

22 A. Yes.

23 Q. Okay. The second bullet, again just high
24 level, just identifying for the numbers, the second bullet
25 relates to changes to the risk adjustment. Do you see

1 that?

2 A. Yes.

3 Q. And they are proposing a 1.9 percent decrease;
4 correct?

5 A. That's correct.

6 Q. And we have agreed to that as we sit here
7 today?

8 A. Yes, we agree with that adjustment.

9 Q. The first bullet, that relates to mid-year
10 enrollment; correct?

11 A. Correct.

12 Q. And that's the one we -- well let me ask you.
13 Do we respectfully agree or do we respectfully disagree on
14 that one?

15 A. We respectfully disagree on this adjustment.

16 Q. And then the third bullet, is that what
17 relates to the hospital budgets?

18 A. Yes.

19 Q. And you'll be explaining this later. But we
20 are looking for a .5 percent increase on that issue;
21 correct?

22 A. That's correct.

23 Q. Okay. So adding all of that up if my math is
24 correct, we are at 4.6, and L&E is at 3.8; is that
25 correct?

1 A. That's correct.

2 Q. Okay. So let's walk through the rate filing,
3 Matt.

4 A. Okay.

5 Q. Again going back to Exhibit 1. And I'll try
6 to do this in the order of the pages. Let's start with
7 page one. What was the date of the submission?

8 A. May 11, 2018.

9 Q. Okay. And then go to page three, please.

10 A. Okay.

11 Q. On May 11 what was the overall rate increase
12 we were looking for?

13 A. 10.88 percent.

14 Q. Okay. And what's the increase in premium we
15 were looking for?

16 A. \$15,734,195.

17 Q. And the number of policyholders?

18 A. 8,929.

19 Q. And the written premium?

20 A. \$144,599,214.

21 Q. And the maximum and the minimum change?

22 A. 30.69 percent down to 4.24 percent.

23 Q. Thank you. And would you go back to page 32
24 of the exhibit.

25 A. Okay.

1 Q. Okay. The first paragraph, I had you read
2 some of it a moment ago, but it makes reference to a CSR
3 subsidy plan. Do you see that?

4 A. Yes.

5 Q. I think you started to explain that. But
6 explain, please, what the CSR subsidy plan is.

7 A. CSR was a function of the Affordable Care Act
8 to help low-income individuals with out-of-pocket expenses
9 like copays, deductibles. The fourth quarter of 2017 the
10 federal government ceased making those payments to
11 carriers, but it's important to note that the second
12 lowest-cost silver plan in any market also drives premium
13 subsidies. So with various stakeholders throughout
14 Vermont we worked together to come up with a solution
15 where members that are in Cost Sharing Reduction plans, we
16 have loaded up the rates to reflect the shortfall funding
17 from the federal government, which at the same time is
18 increasing premium subsidies. That's what's creating the
19 disconnect between the 10.9 percent and the 6.4 percent
20 and the 6.1 percent we had referenced.

21 And then members of silver plans that aren't
22 impacted by the cost sharing reductions can purchase a
23 very similar plan off the exchange which doesn't include
24 the loading for the CSR funding.

25 Q. Great. Would you go to page 41, please?

1 A. Okay.

2 Q. And you see where there is a heading that
3 says: "Silver CSR Loading." Do you see that?

4 A. Yes.

5 Q. Okay. You just spoke about this some just a
6 moment ago; didn't you?

7 A. Yes.

8 Q. Would you go to the third paragraph, please,
9 which starts: Increasing the second lowest cost silver
10 plan?

11 A. Okay.

12 Q. Do you see that paragraph?

13 A. Yes.

14 Q. So there is a reference to the silver plan and
15 the bronze plan as well. Would you explain how this rate
16 filing and the CSR subsidies relates to those two metal
17 levels?

18 A. Yes. So just to go through the CSR levels
19 there is a 73 percent CSR, 77 percent CSR, and 87 percent
20 CSR, and a 94 percent CSR. A normal silver plan is about
21 70 percent actuarial value which means the carrier will
22 pay on average 70 percent of the cost. The member will
23 pay 30 percent of the cost.

24 Because of the amount of the funding, the CSR
25 loading that's built into the rates, the 73 and 77 percent

1 benefits will actually be more expensive than a richer
2 gold plan. So gold plan is approximately 80 percent
3 actuarial value, so you can purchase -- if you're an
4 eligible member, the 80 percent actuarial value for less
5 money than the 73 and 77 percent plans which have that
6 benefit.

7 Additionally, because the APC is increasing
8 you can purchase a bronze plan for a relatively low
9 premium, so it is a leaner benefit, but it will help make
10 the premium rate more affordable for Vermonters that are
11 eligible.

12 Q. And you said Vermonters that are eligible.
13 Can you explain the APTC credit and how that lines up with
14 particular Vermonters?

15 A. Yeah. The APTC is available to individuals
16 that are between -- that are below 400 percent of the
17 federal poverty limit, and it's based on a maximum out-of-
18 pocket or maximum percentage of your income actually go
19 towards premium.

20 Q. How about the folks who don't receive the APTC
21 subsidies? Is their premium increasing because of the CSR
22 issue?

23 A. There are members in those plans right now.
24 But that's what the silver reflective plans are going to
25 be used for, and we are working with -- I know that we are

1 working with DVHA externally as well as other stakeholders
2 and internally actuarial is working with our marketing and
3 communications team at MVP to help guide members towards
4 the right purchasing decision that's in their best
5 interest.

6 Q. Have you heard this called the silver
7 solution? Have you heard that before?

8 A. Yes.

9 Q. And the State of Vermont has been a
10 stakeholder in that?

11 A. Yes.

12 Q. Green Mountain Care Board as well?

13 A. Yes.

14 Q. Okay. Roughly -- we talked about the APTC
15 issue. Roughly how many of our members in 2017 were
16 eligible for APTC?

17 A. Well I know the numbers as of current in 2018.
18 And it's about 8,500 members. So that's about a third of
19 our overall population. And it's actually over 75 percent
20 of our individual population.

21 Q. Thank you. Let's go back to page 32, please,
22 Matt.

23 A. All right.

24 Q. There is a heading "Market Benefits." Do you
25 see that?

1 A. Yes.

2 Q. And then the fourth paragraph down it says:
3 All essential health benefits are covered. Do you see
4 that sentence?

5 A. Yes.

6 Q. You agree with that statement?

7 A. Yes.

8 Q. Okay. The fifth paragraph talks about non-
9 standard plans. Do you see that?

10 A. Yes.

11 Q. Could you explain to the board about standard
12 versus non-standard and DVHA's involvement in approval, et
13 cetera?

14 A. Sure. Standard plans -- so one of the
15 features of the Affordable Care Act was to make purchasing
16 decisions easier to understand for consumers, a set of
17 standard plans, same benefits have to be offered by all
18 carriers that are offering plans on the exchange.

19 So the state, DVHA, determines what those
20 standard plans are. Those go through approval. Both MVP
21 and Blue Cross Blue Shield offer those benefits so that a
22 Vermonter can go on to the exchange and compare two of the
23 same benefits to understand, okay, I'm really just -- the
24 only difference to this benefit is premium, maybe a
25 network difference, and just maybe the carrier on the ID

1 card.

2 The non-standard plans allow carriers to come
3 up with plan designs that are still within the metal level
4 requirements of the Affordable Care Act, but it gives us a
5 little bit of flexibility to offer something unique or
6 different than the other carrier is offering that we may
7 think is a selling point that can differentiate us from
8 our competitors.

9 Q. Thank you. Matt, the last paragraph on that
10 page references book of business. Do you see that?

11 A. Yes.

12 Q. Would you please walk the board through what
13 it says there.

14 A. Sure. So the book of business, I'll just read
15 the statement to start. "Book of business affected by
16 this rate filing is 8,929 policyholders, 16,360
17 subscribers, and 25,223 members as of February 2018."

18 A policyholder in this instance, if it's an
19 individual, it's the subscriber, so if you were family --
20 if you purchase a family contract for your spouse and
21 children, then the subscriber would be the policyholder in
22 that case, and then the members are your dependents,
23 whether it be your spouse or your children.

24 And in a small group the policyholder is
25 actually the employer group. So the reason why that

1 continues to get larger is because small groups are mixed
2 into the policyholder calculation. So if it were
3 individual -- if this were all individuals, policyholders
4 would equal subscribers, and members are subscribers plus
5 dependents.

6 Q. Thank you. Now would you please go to page 35
7 of Exhibit 1.

8 A. Okay.

9 Q. There is a heading that says "Market-wide
10 Adjustments to Experience Period Claims." Do you see
11 that?

12 A. Yes.

13 Q. And then there is three sub headings that go
14 on to page 36. Do you see that?

15 A. Yes.

16 Q. Okay. So as to the first heading, does that
17 relate to the mid-year enrollment issue that you're going
18 to be talking about later?

19 A. Yes, it does.

20 Q. So we have a disagreement on that?

21 A. Correct.

22 Q. The second heading relating to -- on page 36,
23 "Adjustment for Pharmacy Benefit Mandate." Do you see
24 that?

25 A. Yes.

1 Q. Do we have any dispute with L&E on that?

2 A. No. We do not.

3 Q. Okay. And then the third matter, "Adjustment
4 for Individual Mandate Penalty set to \$0. Do you see
5 that?

6 A. Yes.

7 Q. Okay. Do we have a dispute on that with L&E?

8 A. No. The Green Mountain Care Board consulted
9 with L&E to provide an estimate of the overall impact of
10 the individual mandate penalty being set to zero. So just
11 to get a little bit of background, the individual mandate
12 -- there is a mandate to have coverage under the
13 Affordable Care Act or else you would be assessed a
14 penalty when you file your taxes in the next year.

15 In December of 2017, the Trump administration
16 set the penalty to zero which effectively doesn't have any
17 teeth, so it almost -- it effectively repeals the mandate.
18 L&E did a comprehensive analysis based on Vermont's market
19 of what will happen to the market when the penalty is set
20 to zero.

21 Generally speaking, health care members that
22 were paying more in premium than they may have been
23 valuing the benefits they were utilizing will likely drop,
24 which overall will raise the level of cost in the market.

25 And MVP did a similar analysis. It wasn't

1 quite as robust as L&E's, but we did a similar calculation
2 where we were assuming that health care members would exit
3 the market. And we came up with a comparable figure.
4 Because L&E's figure was a little bit more detailed, we
5 just adopted their best estimate.

6 Q. And that's a two percent -- that impact is a
7 two percent of premium; is that right?

8 A. That's correct.

9 Q. Would you please go to page 39 now. Page 39.

10 A. Okay.

11 Q. The second to last paragraph is entitled
12 "General Administrative Expense Load Including QI
13 Component." Do you see that?

14 A. Yes.

15 Q. So would you explain what this is about,
16 please?

17 A. Carriers have to meet a minimum loss ratio
18 requirement. We have to file a federal MLR filing with
19 the NAIC annually, and that calculation is guaranteeing
20 that a certain percentage of our premium dollar is being
21 spent towards medical expenses. So in the small and
22 individual market that's 80 percent.

23 They do allow a little bit of flexibility in
24 the calculation. They allow us to remove premium taxes
25 and assessments from the calculation just because they

1 don't want to penalize carriers for that, for those
2 premium costs.

3 And they also allow carriers to increase -- to
4 adjust admin expenses for quality improvement into a
5 medical expense, because these quality improvement
6 expenses are spelled out by the NAIC, and what it actually
7 has -- the costs are associated with reducing inpatient
8 readmissions. Inpatient stay's around 4 to \$5,000 per
9 night. So they -- the federal government doesn't want to
10 stop carriers from putting expenses towards helping reduce
11 costs, making more affordable rates.

12 Other items like reducing medical errors.
13 Health and wellness initiatives. Those are all items that
14 are included in the quality improvement expense.

15 Q. Does it also consider chronic care?

16 A. Yes. Some services associated with case
17 management and utilization management which help -- which
18 are utilized to help a member with a chronic condition
19 like diabetes navigate through the health care system. So
20 MVP nurses will contact the members that are in these care
21 management programs regularly to make sure that they are
22 on top of their meds, going to their PCP, and helping
23 reduce further costs. Because if you're not following
24 those kinds of best -- those medical guidelines, you may
25 end up with a higher cost procedure and inpatient

1 admission, a more severe case.

2 Q. Thank you. Would you read the second sentence
3 under that heading, please, under "General Administrative
4 Expense Load." The second sentence?

5 A. "Based on an analysis of MVP's 2017 expenses,
6 10 percent of MVP's total administrative expense was spent
7 on QI."

8 Q. So 10 percent, correct?

9 A. Yes.

10 Q. Okay. Thank you, Matt. So let's turn -- I
11 want to go through these three bulleted issues raised by
12 L&E. If you go back to Exhibit 11, please.

13 A. Okay.

14 Q. The first issue is one where we have a delta
15 .3. A difference of .3; correct?

16 A. Correct.

17 Q. And that relates to mid-year enrollment;
18 correct?

19 A. Correct.

20 Q. Would you please explain to the board our
21 position on that issue?

22 A. Sure. The benefits being offered on the
23 Vermont exchange are calendar-year benefits, and what
24 that means is that deductibles and out-of-pocket maximums
25 are reset on January 1st of every year. In MVP's

1 experience period of 2017 we see members enroll through
2 the year, so if you were to enroll on July 1 and your
3 deductible was \$3,000, then you really only have six
4 months to fulfill that deductible. The following year MVP
5 is assuming that that member will enroll on January 1st,
6 and we will cover them for a full 12 months. And
7 therefore, they are more likely to reach their deductible
8 which will raise their costs. So MVP's calculation is
9 assuming that all members will be enrolled for a full 12
10 months going forward.

11 Q. Okay. And then if you would please -- so it
12 relates to claim exposure and deductibles, getting through
13 your deductible; right?

14 A. That's correct.

15 Q. Go to Exhibit 11, page three to four of the
16 same exhibit. So on page three there is a paragraph down
17 at the bottom. The number one next to it. It says "2017
18 Actual Projected Claims Experience." Do you see that?

19 A. Yes.

20 Q. So this -- and it spills into page four. This
21 is L&E's explanation of their position on this issue;
22 correct?

23 A. That's correct.

24 Q. So would you please say what their position is
25 and why you disagree?

1 A. L&E's position is that -- they recommend that
2 the open enrollment period was shortened from 2017 to
3 2018. So some members -- our experience period of data
4 may be more skewed towards later enrollments. They
5 adjusted for that impact, but then they still said that
6 there is going to be some members through special
7 enrollment periods that will enroll. I believe that was
8 somewhere in the range of nine percent of members, and
9 they enroll throughout the year.

10 Q. So if you had to pick between the two on which
11 is more conservative, which one would you pick and why?

12 A. MVP's is more conservative because we are
13 mitigating our exposure for members enrolling for a full
14 year. If we adopt L&E's opinion then we would be exposed
15 if members don't follow the enrollment pattern that they
16 have projected.

17 Q. So if you follow L&E's proposal, you might
18 have to catch up next year; is that right?

19 A. That's correct.

20 Q. And in your view is it more conservative not
21 to kick the can down the road, but to deal with it this
22 year?

23 A. I would rather deal with it this year than
24 kick the can down the road as you put it.

25 Q. Let's talk about the second bullet then. If

1 you go back to our bullet page which is page 11.

2 A. Okay.

3 Q. "Changes to Risk Adjustment." Do you see
4 that?

5 A. Yes.

6 Q. So I understand we have agreement with L&E on
7 that?

8 A. That's correct.

9 Q. Would you explain what that's all about?

10 A. Risk adjustment, it's another feature of the
11 Affordable Care Act. The concept is to level the playing
12 field, so if a carrier has higher morbidity risk than
13 another carrier, that their rates aren't arbitrarily
14 increased. So if, for example, MVP's morbidity actually
15 is much healthier based on risk adjustment results than
16 Blue Cross's, our claim cost is actually lower. Risk
17 adjustment when you account for that levels out the risk
18 to put into the market-wide average. And MVP believes in
19 the risk adjustment program. And that's why we are
20 adopting this adjustment.

21 Q. Okay. Go to page eight, please, of the
22 exhibit. Let me know when you're there.

23 A. Okay.

24 Q. And you see that there is a box on the right
25 which says "Future of Risk Adjustment." Do you see that?

1 A. Yes.

2 Q. Well first let me ask you chronologically, why
3 didn't you reduce by 1.9 at the time of the rate filing
4 and only did it after L&E recommended it? Could you
5 explain why chronologically?

6 A. Yeah. We submit our rates on May 11 which
7 uses 2017 experience period claims. At that time the only
8 information that we have from the federal government for
9 risk adjustment is an interim risk adjustment result which
10 differs from our final results. The final results were
11 issued in early July of this year. And the 1.9 percent
12 adjustment reflects the difference between our interim
13 results and our final results as a percentage of our claim
14 costs.

15 Q. So L&E had more recent data; is that correct?

16 A. That's correct.

17 Q. So okay -- I kind of interrupted our flow
18 there. But this box, what's this talking about? Please
19 explain it to the board.

20 A. In this past winter, federal court, District
21 Court in New Mexico, their opinion was that the risk
22 adjustment transfer calculation wasn't clear enough for
23 years 2014 through 2018. In 2019 the notice of benefit
24 payment parameters actually included more clarifying
25 language which spelled out exactly what the formula was

1 doing, and we are confident based on our understanding
2 that this won't be an issue in 2019, and risk adjustment
3 will be in play. So we still should be adjusting our
4 rates for the risk adjustment mechanism.

5 Q. Thank you. Let's go back to our bullets map,
6 please, on page 11. And there is a third bullet that we
7 have identified as relating to hospital budgets. Correct?

8 A. Correct.

9 Q. So I'm going to have you turn one more time to
10 Exhibit 9, please, Exhibit 9 which is in evidence. And
11 would you just identify this for the board first, please?

12 A. Yes. This was an interrogatory response that
13 we submitted on July 17, 2018. The question from L&E to
14 MVP was to address whether the recent information
15 regarding hospital unit cost increases for 2019 were
16 anticipated to have an impact on the proposed rates.

17 Q. So Matt, in honor of Kim, I'm going to ask you
18 to speak more slowly. Okay?

19 A. No, okay. No problem.

20 Q. She is trying to type every word. Okay. So
21 L&E asked us a question about the hospital budgets on July
22 the 16th; correct?

23 A. That's correct.

24 Q. Okay. And do you know when those hospital
25 budgets were posted?

1 A. It's at the bottom of the page. July 13, at
2 11 a.m.

3 Q. Okay. So and when did L&E respond to this
4 July -- excuse me -- when did MVP respond to L&E's July 16
5 request?

6 A. The question was asked on July 16, and we
7 responded the next day. July 17th.

8 Q. And didn't they actually give us additional
9 time beyond that to respond?

10 A. Yes. I believe it was three or four days, and
11 we responded the next day.

12 Q. Would your mother be proud of you that you
13 were prompt in responding?

14 A. I suppose that would be something that she
15 would be very proud of me for.

16 Q. Okay. Let's go back to Exhibit 11, the third
17 bullet. And I want you to read what it says in the third
18 bullet, please, from L&E?

19 A. "If updated information regarding unit cost
20 trends are known at the time of the board order, L&E
21 recommends considering this updated information in the
22 development of the unit cost in the 2019 premium rate
23 calculations."

24 Q. So L&E's recommending that this information be
25 considered; correct?

1 A. Correct.

2 Q. And this information is more recent
3 information that we received after our rate filing;
4 correct?

5 A. Correct.

6 Q. And after L&E's report; correct?

7 A. Correct.

8 Q. And what did the board do last year on this
9 issue when we had the budget proposals but no hearings had
10 been held yet for the hospitals?

11 A. If I recall, it was taken into consideration
12 in the final rate decisions.

13 Q. Thank you. So what is your -- you can look at
14 objection 6 if you need to, but what is your calculation
15 of the impact this year?

16 A. The proposed hospital budgets will increase
17 the proposed premium rates by .5 percent.

18 Q. And that's all laid out in Exhibit 6; correct?

19 A. Objection 6, I believe. Was it --

20 Q. Yes, I'm sorry. Objection 6 which is Exhibit
21 9.

22 A. Exhibit 9. Yes.

23 Q. And what's your understanding of where L&E is
24 at since they got our response on objection 6 on this
25 issue?

1 A. Based on correspondence that we had with L&E
2 last night, they are still reviewing the impact.

3 Q. Okay, Matt. I want to ask you about Vermont
4 market share and competition. Okay?

5 A. Okay.

6 Q. So would you explain to the board how our
7 market share has changed over the last year or so?

8 A. Last year when we were sitting here we had
9 somewhere in the 11 to 12,000 member -- we were somewhere
10 in that range for 13 percent of the market. We have grown
11 considerably since then up to 25,200 members. And that's
12 because of the improvement in our premium position.

13 We have been doing everything under our power
14 to try to promote the most affordable rate, and that's
15 actually why the spread between MVP and Blue Cross in
16 terms of the premium position. And we attribute that to
17 our growth.

18 Q. Do you also attribute it to the product being
19 affordable?

20 A. Yes. Well by trying to promote the most
21 affordable rate possible, that's how we are able to expand
22 the premium position that we have against Blue Cross Blue
23 Shield.

24 Q. Thank you. Next I want to ask you about
25 reserves and solvency. Would you please go to Exhibit 1,

1 page 40. Do you see the first paragraph which references
2 "Contributions to Reserves/Risk Charge." Do you see that?

3 A. Yes.

4 Q. And what's the contribution we are requesting
5 this year?

6 A. We are building in two percent of premium into
7 our 2019 rates. That's consistent with those filed and
8 approved for 2018.

9 Q. I didn't hear that last part. Can you say
10 that again?

11 A. That's consistent with what was filed and
12 approved in the 2018 rates.

13 Q. So I get confused. You mean last year we did
14 two percent, is that what you're saying?

15 A. That's correct.

16 Q. And that was approved?

17 A. Yes.

18 Q. Okay. Why two percent?

19 A. Good question. As we have grown, we actually
20 should be -- to maintain our solvency we should actually
21 be charging somewhere in the range of eight and-a-half
22 percent to meet our minimum solvency requirements. But
23 that wouldn't make much sense to us because as I was just
24 talking about, we are promoting an affordable rate
25 relative to Blue Cross. And that's what's helped us gain

1 our membership over the last year. So now we're around 30
2 percent, 33 percent membership. And if we were to build
3 in eight and-a-half percent into newer rates, then our
4 competitive position would go away. Then all the efforts
5 that we put towards growing our membership would probably
6 walk out the back door.

7 So it didn't make much sense for us. We would
8 rather step into this, and this is a long-term play for
9 us. So we felt like two percent was a reasonable number.
10 It's the number that was approved. It's the figure that
11 was approved last year. We recognize that it's not
12 sustainable for -- in a one-year time period, but over
13 time that we will get to our minimum reserve requirements
14 with that figure.

15 Q. And MVP's picked up members; correct? From
16 last year?

17 A. Yeah. We have grown by over a hundred
18 percent.

19 Q. So how does that growth relate to what you
20 need to set aside for surplus?

21 A. New York State is -- the solvency, they govern
22 MVP's solvency. That's where we are domiciled. Solvency
23 in New York State is determined based on percentage of
24 premium. So as our premium has grown substantially, it
25 grew by over 100 percent, we more than double our premium.

1 Effectively that means that two percent of our premium
2 that we are attributing isn't actually enough to catch up
3 to the minimum solvency requirement which is about 12
4 and-a-half percent. MVP targets somewhere between 16 to
5 20 percent, and that's based on New York State's
6 recommendations.

7 They have an Enterprise Risk Management
8 program that actually analyzes not just premium risk but
9 also regulatory risks and a number of other risks. And
10 their recommendation is 16 to 20 percent of premium.

11 Q. When a carrier increases market share,
12 increases membership, I should say, does that line up with
13 a need to increase contributions to reserves?

14 A. Yeah. As I referenced, to meet our minimum
15 reserve requirements for 2019 we would need to build into
16 somewhere closer to eight and-a-half percent to nine
17 percent of premium because of the increase in premium, and
18 that would measure from a solvency perspective on
19 percentage of premium basis.

20 Q. If you have more claims, do you need more
21 reserves?

22 A. Yes. And so not just membership needs to be
23 taken into consideration but the fact that claims are
24 increasing, claims are approximately 90 percent of every
25 dollar that's in the premium rates. So as our claims are

1 increasing, we need to also increase the premium rate.

2 Q. Would you agree there is a fair amount of
3 uncertainty at the federal level on these issues on health
4 care in general?

5 A. Yeah. It's hard to get your finger on the
6 pulse of exactly what's going to happen at the federal
7 level. Last year it was all about individual mandate
8 repeal and Cost Sharing Reduction removal. Both of those
9 actually came through. This year, in addition to a number
10 of other items, association health plans are a concern
11 that we have which could adversely impact the market.

12 Q. Okay. Let's go to L&E Exhibit 11 again,
13 please. Page nine, paragraph nine. Page nine, paragraph
14 nine. And the heading is "Changes in Contribution to
15 Reserves." Let me know when you're there.

16 A. I'm there.

17 Q. So what did L&E say about our proposed two
18 percent?

19 A. "The contribution to reserves assumption
20 appears to be reasonable and appropriate. While L&E does
21 not recommend any changes to the CTR, the results of the
22 Department of Financial Regulation solvency analysis
23 should also be considered."

24 Q. And do you agree with that that DFR's input
25 should be considered?

1 A. Yes.

2 Q. And read the first two sentences in the first
3 paragraph, please. I think you read the second paragraph.
4 Read the first one. It says: The proposed two percent.

5 A. "The proposed two percent contribution to
6 reserves is consistent with the assumptions found in MVP's
7 other recent filings."

8 Q. And read the next sentence.

9 A. "The projected federal loss ratio using the
10 CTR is 90.2 percent which greatly exceeds the statutory
11 minimum of 80 percent and is reasonably consistent with
12 the other carrier in this market."

13 Q. Do you agree with those statements?

14 A. Yes.

15 Q. Okay. Go to Exhibit 10, please, which is the
16 DFR solvency letter, please.

17 A. Okay.

18 Q. And I think you testified you've reviewed this
19 and are familiar with it; right?

20 A. That's correct.

21 Q. Okay. Would you read under the heading:
22 "Summary of MVP Solvency Opinion." Which is -- strike
23 that, Matt. I don't want to confuse you.

24 Read the summary of opinion sentence on the
25 first page.

1 A. Okay. "MVPHP currently meets Vermont's
2 financial licensing requirements for a foreign insurer,
3 and DFR believes the proposed rate will sustain MVPHP
4 solvency."

5 Q. You agree with that; correct?

6 A. That's correct.

7 Q. And then go to the second page, please.

8 A. Okay.

9 Q. Okay. There is a heading that says: "MVPHP
10 Solvency Opinion." Do you see that?

11 A. Yes.

12 Q. And would you read from the sentence that
13 starts: "Finally" to the end of that paragraph, please.

14 A. "Finally, in 2017 all of MVP's Holding
15 Company's operations in Vermont accounted for
16 approximately 2.9 percent of its total premiums written.
17 Thus DFR has determined that MVPHP's Vermont operations
18 pose little risk to its solvency. Nonetheless, adequacy
19 of rates and contribution to surplus are necessary for all
20 health insurers in order to maintain strength of capital
21 that keeps pace with claims trends."

22 Q. So do you agree with what the department is
23 saying here about that 2.9 percent for business?

24 A. That's an accurate statement, yes.

25 Q. So it's a small part of the overall business.

1 What are they saying, or what do you believe that small
2 percentage means in terms of being prudent and considering
3 solvency?

4 A. Although it is a small percentage of our
5 overall revenue for MVP Health Plan, we are of the opinion
6 that we should be setting our rates for every block of
7 business to be self sustaining and self supportable. If
8 we fail to do so, and we have grown one block, and we
9 shrink another block, that could actually -- it may be 2.9
10 percent in 2017, but that could really shift with growth
11 in reductions in membership in our other blocks of
12 business.

13 So we feel it's important that when we analyze
14 our premium rates for the Vermont exchange, we are focused
15 on the Vermont exchange block of business and to make sure
16 that's a self-supporting block.

17 Q. Then there is a final heading just below that
18 it says: "Impact of the Filing on Solvency." Do you see
19 that?

20 A. Yes.

21 Q. Would you please read that sentence
22 underneath, please?

23 A. "Based on the entity-wide assessment above,
24 and contingent upon GMCB's actuary's findings that the
25 proposed rate is not inadequate, DFR's opinion is that the

1 proposed rate will likely have the impact of sustaining
2 MVPHP's current level of solvency."

3 Q. Do you agree with that?

4 A. Yes.

5 Q. In your opinion will the reduction from our
6 original filing number of 6.4 percent down to the 4.6
7 percent that we are talking about today for a rate
8 increase, will that adversely impact the solvency of MVP
9 Health Care?

10 A. No. Because all the adjustments that are
11 built into that 4.6 percent are actuarially sound and
12 reasonable.

13 Q. Thank you. Now Matt, I want to ask you a
14 little bit about lowering costs and promoting quality care
15 and access. If you would go please to the L&E report
16 which is Exhibit 11.

17 A. Okay.

18 Q. And go to page nine, please. Page nine. And
19 there you're going to find a paragraph numbered eight at
20 the top that says: "Changes in Administrative Costs." Do
21 you see that?

22 A. Yes.

23 Q. Okay. So what conclusion is drawn by L&E
24 about our administrative costs? If you look at the --
25 I'll cut to the chase. Look at the last sentence of that

1 paragraph.

2 A. Okay. "In light of the steps taken by MVP in
3 reducing administrative costs over the recent years, the
4 assumed administrative 2019 costs appear to be reasonable
5 and appropriate."

6 Q. Okay. And they talk a little bit about New
7 York in there. Do you see that?

8 A. Yes.

9 Q. So would you explain to the board how
10 administrative costs work at MVP as it relates to New York
11 work and Vermont work and overall administrative costs?

12 A. Yeah. So we analyze our costs on an
13 enterprise-wide level. There aren't -- there are a number
14 of functions that are actually housed in our New York
15 offices that still are utilized by MVP in Vermont. So for
16 example, our claims operating system is sitting in our
17 Schenectady headquarters. Those claims that are
18 processed, although it's physically located in New York,
19 we have to allocate the cost associated with running that
20 operating system into our overall book of business premium
21 rates. And even though we have grown significantly in the
22 MVP Vermont market, our overall corporate-wide membership
23 has actually been reduced, which is resulting in us
24 spreading fixed costs over a small membership base, and
25 therefore it's increasing our per member per month

1 proposed in these rates.

2 Q. So that last point you made, Matt, Board
3 Member Usifer asked you last year if we grow market share,
4 can't we spread the costs out over more people and lower
5 our costs. I want you to answer that question again,
6 related to what you just said.

7 A. Yeah. Again, it's based on the fact that we
8 were -- at that time I think the assumption that was
9 implicit is that we would be growing everywhere not just
10 in Vermont. We were hoping to grow in our New York
11 business as well. The net change in our membership has
12 actually decreased by tens of thousands of members
13 recently. And that's actually the reason why we have to
14 increase our costs.

15 So I think the statement I made last year was
16 -- pertained to just Vermont growth and assuming that we
17 would be growing everywhere, but we are not, so the growth
18 in Vermont is being offset by a larger reduction in New
19 York membership.

20 Q. Thank you. Is it a goal of MVP to lower
21 costs?

22 A. Yeah. We have a number of competitive bidding
23 processes with outside vendors, so if we are using an
24 outside consultant or a vendor for a service, we have
25 competitive bidding processes where you have to take in a

1 number of RFPs to make sure we are trying to keep our
2 administrative costs down. At the end of the day, we are
3 really operating as lean as possible so we can promote an
4 affordable rate and have -- while we are promoting a
5 quality product at the same time.

6 So our goal is to analyze our admin costs
7 annually continuously, but it's definitely a very focused
8 annual effort. How are we managing our admin costs.
9 Where are we putting our expenses. Because we understand
10 wherever those expenses are changing that's going to have
11 an impact on the premium rate and the affordability of
12 premium rates we are offering.

13 Q. Matt, what is the company doing around
14 pharmacy contracts or rebates?

15 A. Our pharmacy team does a great job. They
16 contract with our PBM. They are continuously
17 renegotiating unit cost discounts on drugs. So as new
18 drugs are coming out, a lot of times they are very
19 expensive. Our pharmacy team is working with our PBM to
20 try to manage those costs down as much as possible whether
21 it's through unit cost reduction or an increase in a
22 rebate that we are going to receive.

23 And we are expecting an increase in our
24 rebates, and we are reflecting that in the premium rates
25 that we are proposing for 2019. Also analyzing

1 formularies. So to the extent that a new drug comes out
2 or a drug is coming off a patent and there is a lower cost
3 generic available, we analyze the formulary. And we will
4 say, okay, well the higher cost brand drug, that is going
5 to move to a higher tier which will make it a higher cost
6 share, and we will incent members to go to the lower cost
7 generic. Those are all ways that we are trying to analyze
8 our costs and again keep our rates affordable.

9 We are proud of our growth in Vermont. And
10 you know, our goal is to keep working on these items so
11 that we can get our costs down and get the premium rate
12 advantage against Blue Cross.

13 Q. What is MVP doing around online price
14 comparisons for members?

15 A. We have a tool available where you can enter
16 your location and the procedure -- suppose you need to
17 have a knee surgery performed. You can enter your
18 location, whether it's where you live or where you work,
19 and we will actually tell you the cost, our contractual
20 arrangement with providers within a certain service area,
21 within a certain radius of where you're located. So if
22 you are a member with a deductible, suppose you have a
23 plan that's a silver plan with a two or three thousand
24 dollar deductible, you go -- you can go online and see
25 that there is doctor A versus doctor B, and doctor B is 10

1 percent lower cost. That will help mitigate our
2 out-of-pocket costs if you go to that lower-cost doctor.

3 And all of the providers in our service area
4 are all -- that we contract with are all quality
5 providers. We are currently looking for NCQA
6 accreditation to make sure we are promoting the most
7 quality care possible.

8 Q. So what you just described helps to keep costs
9 down; correct?

10 A. Yes.

11 Q. Helps for access for care to the medical care
12 provider the member wants; correct?

13 A. Correct.

14 Q. Promotes qualities of care as well for the
15 reasons you described; correct?

16 A. Correct.

17 Q. Would you please tell the board about our
18 telemedicine benefit?

19 A. Recently MVP rolled out a telemedicine
20 benefit. It's actually pretty cool. I've used it a few
21 times where you can use --

22 Q. Sorry, Matt. Did you say pretty cool?

23 A. Yes.

24 Q. Go ahead.

25 A. That's on the record. Use your Smartphone or

1 your tablet or computer, and you can meet with a doctor
2 24/7 and any day of the year and have a conversation, and
3 they can fill a prescription for you. It's really --
4 there is a number of uses.

5 But we have seen that the highest use is a
6 replacement for urgent care. So the cost of -- the cost
7 of telemedicine visit is somewhere in the range of \$40
8 where urgent care visit is somewhere actually between 150
9 to \$300. So that's definitely something that we are
10 really trying to promote and push members towards
11 utilizing that benefit.

12 It's part of a member welcome packet. When
13 you start off with MVP, you know, we try to -- we
14 understand the health care system is complex, and we try
15 to engage members and help them understand the benefits
16 they're receiving with MVP. So we are really optimistic
17 about that program. We are hoping that we can see an
18 uptick in utilization as we go forward, because we think
19 it will reduce costs as we move ahead.

20 Q. So Matt, have I ever taken you up to my
21 brother's hunting camp up in Victory?

22 A. No.

23 Q. Okay. That's up in the Northeast Kingdom.
24 Have you heard of the Northeast Kingdom before?

25 A. I'm familiar with that.

1 Q. Okay. So if you're a person living up in
2 Victory, I'll represent to you you've got to drive about
3 an hour to get to the hospital down to St. J or over to
4 Newport. So for somebody like that, the telemedicine
5 benefit is something that it sounds like it would be
6 cheaper for them; correct?

7 A. Yes. It's cheaper, and not only that, it's
8 also just more efficient and it's easier access. You
9 know, it's -- somebody who lives in the northeast, another
10 good example is if you have a foot of snow and you get
11 snowed into your house, you can still access a provider
12 without having to leave your house. So it's a nice
13 benefit.

14 Q. It's also the cost of gas; right? To drive
15 somewhere, right?

16 A. That's correct.

17 Q. Matt, would you explain to the board, and I
18 know there is not a bright line, but the difference
19 between costs that we have direct control over and more
20 indirect control over, and how that all relates to
21 affordability?

22 A. Yeah. So as I was mentioning earlier, about
23 90 cents of every premium dollar are going towards health
24 care expenses. We have less control over those costs. We
25 do go through, you know, I was talking about pharmacy cost

1 management. We do try to manage those costs as much as
2 possible through contractual arrangements, whether it's
3 with doctors, hospitals, or our pharmacy benefit manager.

4 But we can more directly manage our admin and
5 overhead costs, and those are the items that I think,
6 Gary, you're referring to is direct costs that we can
7 manage. And again, we go through continuous -- a
8 continuous process of analyzing where our expenses are
9 going, what improvements can we make, and it's a very IT
10 intensive business, health insurance. So we are
11 constantly reviewing how up to date our IT systems are and
12 making updates as needed.

13 Q. Okay. And I apologize if you said this in
14 your answer, and I wasn't listening properly. Out of
15 every dollar, how much do we have direct control over
16 versus indirect control?

17 A. Direct meaning the overhead and admin is about
18 10 cents of every premium dollar. The indirect costs are
19 90 cents for every premium dollar.

20 Q. I want to talk to you a little bit about
21 promoting quality care and activities that MVP is doing.
22 One thing you already talked about is the online health
23 and ability to go in and choose and compare care
24 providers; correct?

25 A. That's correct.

1 Q. Are there also online health and wellness
2 tools?

3 A. Yeah. We also offer health and wellness tools
4 that will help members navigate through quitting smoke or
5 working on -- if they want to take a personal health
6 assessment, they can do that through MVP's online health
7 and wellness tools. And that will give them an output at
8 the end that gives them different ways, the mechanisms
9 that they can try to help improve their health whether
10 that's through eating more healthy, again tobacco
11 cessation programs. Those are all benefits that are
12 available to members.

13 Q. And is there a member Welcome Package that's
14 provided to members?

15 A. Yes. As I was mentioning earlier, there is a
16 lot of different information included in our member
17 Welcome Package. Again, we recognize that health care is
18 not the easiest to understand concept. And our goal is to
19 engage a member and help them navigate through the health
20 care system. These are complex decisions they have to
21 make, and if we can help make it simple, help simplify the
22 decision making process, we think that is a really
23 valuable piece of information to provide to members.

24 Q. Okay. What is -- what efforts is MVP making
25 as it relates to physicians at hospitals versus

1 community-care docs?

2 A. Recently our contracts with, in particular
3 UVMMC, we were made aware that the physician fee schedules
4 were misaligned between our Community Health Care doctors
5 and our hospital-owned physicians. So recent changes to
6 our contracts are fee schedule increases, or changes, I
7 should say, have actually been decreases to the
8 physician's fee schedule at the hospital-owned practices,
9 and increases on the facility side to end up at a net
10 figure that either matches or beats the Green Mountain
11 Care Board approved budget.

12 And we are working towards getting those two
13 fee schedules, a community-based fee schedule and the
14 hospital and physician fee schedules more appropriately
15 aligned over time.

16 Q. And do those efforts promote quality care?

17 A. Yes.

18 Q. Why?

19 A. We are of the opinion that if we can increase
20 access to physicians, PCPs that are in the community, your
21 PCP is generally, I think Medical Home through the Vermont
22 Blueprint and other items such as that, it will help --
23 they understand your health care better than a doctor that
24 -- a specialist or somebody like that. So if we can
25 direct more care through the PCP, we are of the opinion

1 that it will help not only improve the member's health
2 care or health, but we can also help reduce costs because
3 PCPs are generally lower cost than specialists.

4 Q. I think you talked a little bit about MVP's
5 health and care management program a little bit a moment
6 ago. Didn't you or did you?

7 A. I don't recall. Do you remember anything
8 particular, Gary?

9 Q. I'm older than you, so I'm asking you. Well
10 let me ask you then a question.

11 A. Okay.

12 Q. MVP has health and care management programs;
13 correct?

14 A. That's correct.

15 Q. So why don't you describe those briefly?

16 A. Yeah. So we did discuss this earlier. We
17 have chronic -- we hire nurses and medical doctors that
18 will help members with chronic conditions navigate through
19 the health care system, make sure that they are seeing
20 their doctor regularly, and they are taking the
21 prescriptions and getting refilled in a timely fashion.
22 That helps avoid higher cost hospital admits, and that's
23 another way that we are hoping to promote not only access
24 to care and higher quality care but also affordability at
25 the same time.

1 Q. Do part of our administrative costs include
2 credentialing?

3 A. Yes. As I mentioned earlier, all the
4 providers that are in our network are -- have to meet
5 standards of, you know, based on HEDIS measures as well as
6 we are going through an NCQA accreditation right now for
7 MVP Health Plan Vermont. We have accreditation right now
8 in New York. I think we are getting close to getting
9 accreditation in Vermont.

10 Q. And does MVP link into a national network of
11 providers?

12 A. Yeah. It's a benefit feature we added to our
13 2018 premium rates, and it's access to any provider that's
14 contracted with Cigna who is a national carrier. The nice
15 feature about the Cigna network is if you are on vacation
16 in Florida in the winter, and you have MVP coverage
17 through the Vermont Health Connect, then you'll actually
18 be able to access a number of providers in Florida. So
19 rather than having it pay higher out of network fees, you
20 can have -- you'll have your lower in-network cost share
21 applied at a lower discounted rate.

22 Q. Thank you. I want to go through the statutory
23 criteria with you. So based on the rate filing, the other
24 evidence submitted, and your testimony today, do the MVP
25 rates meet the standard of affordability?

1 A. Yes.

2 Q. Based on the rate filing, other evidence
3 submitted today, and your testimony, do the rates promote
4 quality of care and access to health care?

5 A. Yes.

6 Q. Based on the rate filing, other evidence
7 submitted today, and your testimony, are the rates not --
8 double negatives. The rates are not unjust, unfair,
9 inequitable, misleading or contrary to law; correct?

10 A. That's correct.

11 Q. Are the rates reasonable based on the data we
12 have?

13 A. Yes.

14 Q. And are they actuarially sound and fair
15 charging a premium for the services covered?

16 A. Yes.

17 Q. Next I want to ask you about whether the rates
18 are excessive, inadequate or unfairly discriminatory. Are
19 you familiar with the ASOP 8?

20 A. Yes.

21 Q. What is that?

22 A. There is actuarial standard practice number 8.
23 Actuaries have to follow a certain set of criteria that --
24 to make sure we are in compliance with the best standards
25 of practice. And ASOP 8 is -- requires actuaries to

1 attest that the rates they are promoting are not unfairly
2 discriminatory against any parties and that they are
3 adequate and not excessive.

4 Q. Thank you. So do the rates provide for
5 payments of claims, administrative expense, taxes and
6 regulatory fees and have reasonable contingency for profit
7 margins?

8 A. Yes.

9 Q. So it's your opinion they are adequate;
10 correct?

11 A. That's correct.

12 Q. Do the rates exceed the rate needed to provide
13 for payment of claims, administrative expenses, taxes,
14 regulatory fees, and reasonable contingency and profit
15 margin?

16 A. Yes.

17 Q. Do the rates exceed?

18 A. No.

19 Q. Okay. So they are not excessive?

20 A. They are not excessive.

21 Q. Thank you. Do the rates result in premium
22 differences among insureds within similar risk categories?

23 A. No. Where rates are assuming that any
24 Vermonter that's eligible to purchase care can purchase
25 the same set of benefits. Nothing is discriminatory in

1 our rate setting.

2 Q. So they do not -- so they do reasonably
3 correspond to expected costs; right?

4 A. Yes.

5 Q. And to the extent there is any differences,
6 those are reasonable differences; correct?

7 A. Yeah. The premium differences reflected in
8 rates purely reflect the benefit differences being offered
9 between our products.

10 Q. One last issue I wanted to touch on with you,
11 Matt, which is the associated health plans. Are you
12 familiar with that issue?

13 A. Yes.

14 Q. So would you explain to the board your
15 understanding of the issue?

16 A. When the Affordable Care Act rolled out in
17 2014, association health plans and -- I'll back up. An
18 association is -- it's people with similar jobs that can
19 band together for purposes of having more purchasing power
20 for an item such as health insurance. Under the
21 Affordable Care Act small employers were not permitted to
22 purchase coverage outside the exchange is my
23 understanding. They had to purchase it through an ACA-
24 qualified plan in the small employer market. And if you
25 were a sole proprietor, then you would have to purchase an

1 individual plan being offered.

2 Recently there's been some federal legislation
3 that came out between the time when the rates were
4 submitted on May 11 and today that association health
5 plans can purchase coverage outside of the exchange. MVP
6 is aware of this, and we are working with various
7 stakeholders in the State of Vermont to gain a better
8 understanding of what the risks are that those -- that
9 some of our membership base in the Vermont exchange exits
10 the market.

11 The general concept is that the associations
12 are going to seek out a premium rate from MVP, Blue Cross,
13 or any of our competitors, and if their premium rate for a
14 comparable benefit is better than the rate offered on the
15 Vermont Health Connect or the reflective plans, then they
16 are going to purchase that product. Implicitly because
17 they have a lower premium rate, that would mean that they
18 are actually a lower morbidity population. As those
19 members leave, similar to the individual mandate, the
20 overall morbidity of the pool will actually increase.

21 At this time we are engaged in these
22 conversations. I know Susan Gretkowski is helping MVP
23 navigate through these conversations. We don't have
24 enough data at this point to actually put a number to how
25 much this is going to impact our rates. It's just

1 something that we are well aware of, and we think that
2 there is definitely a risk, and the premium rates that we
3 have put forth -- if the association health plans can take
4 off before the 2020 year. So in 2019, if the association
5 is there, there is definitely premium risk in our rates.

6 Q. So the 4.6 MVP is proposing at this hearing
7 doesn't include a reduction as it relates to the
8 association health plans or an increase related to the
9 association health plans; correct?

10 A. That's correct. We haven't made an
11 adjustment. We don't have enough data at our fingertips.
12 We are still evaluating what the risks are. We are just
13 aware that this is definitely a risk in our premium rates.

14 Q. It's a concern of MVP's; correct?

15 A. That's correct.

16 Q. Thank you very much, Matt.

17 HEARING OFFICER HENKIN: At this time
18 we will take a 10-minute break. So we will come
19 right back and start off with the HCA, but I wanted
20 to give people 10 minutes to get up, stretch, and do
21 whatever.

22 (Recess was taken.)

23 HEARING OFFICER HENKIN: Everybody back
24 here. Everybody's here. Great. Attorney Angoff,
25 you can proceed.

CROSS EXAMINATION

1
2 BY MR. ANGOFF:

3 Q. Good morning, Mr. Lombardo.

4 A. Good morning.

5 Q. You weren't the guy who prepared the rate
6 filing; are you?

7 A. I work closely, and he works for me.

8 Q. You're his boss?

9 A. Correct.

10 Q. And so is it okay if I ask you questions about
11 the rate filing he prepared? You vouch for everything in
12 there?

13 A. Yes. That's fine.

14 Q. So what's your position?

15 A. Director of actuarial services.

16 Q. And is that just for Vermont, or is that for
17 New York too?

18 A. That's New York as well.

19 Q. So and are you a fellow of the Society of
20 Actuaries?

21 A. Yeah. Yes, I'm a fellow of the Society of
22 Actuaries and a member of the American Academy of
23 Actuaries.

24 Q. How many actuaries do you supervise?

25 A. A handful. 1, 2, 3. Two credentialed

1 actuaries and indirectly four students that are taking
2 exams.

3 Q. Okay. And the person who prepared this is
4 Eric Bachner?

5 A. That's correct.

6 Q. And is he a credentialed actuary?

7 A. Yes.

8 Q. He's not a fellow; right?

9 A. He's close, but no, he's not yet.

10 Q. What's the difference between a fellow and a
11 non-fellow?

12 A. There is two levels of credentialing that you
13 go to. The first is ASA which is an associate in
14 Society of Actuaries. The second level is fellow in
15 Society of Actuaries. Eric is very close to becoming a
16 fellow, so I'm confident -- Eric has done a great job.
17 He's one of our brightest employees at MVP.

18 Q. Does he have to take one more test, is that
19 it?

20 A. Yes. One more test. So hopefully he'll pass
21 it next sitting and will be a fellow next year.

22 Q. So you've -- you supervise both Vermont and
23 New York. Have you testified here before, right?

24 A. Yes.

25 Q. For how long?

1 A. This is my third year being the primary person
2 testifying on behalf of MVP. I believe I testified a word
3 or two, three or four years.

4 Q. So you're familiar with the rate -- you're
5 familiar with the rate proceedings for the last several
6 years in Vermont?

7 A. Yes.

8 Q. Okay. And is that the case for New York too?

9 A. There aren't rate hearings in New York. Prior
10 to when I was an actuary, they did have rate hearings, but
11 there aren't any more in the State of New York.

12 Q. Sorry. I stand corrected. Are you familiar
13 -- there being no hearings in New York.

14 Are you familiar with the rate filings that
15 are submitted in New York?

16 A. Yes.

17 Q. And then the insurance department's decision
18 on those filings?

19 A. That is correct.

20 Q. We have talked a lot about all the percentage
21 increases are based on various elements, various
22 components of the rate filing. But can you tell us what
23 the actual rate is that you're charging -- you're
24 proposing -- or let's start with current, please.

25 Can you tell us what the actual rate is that

1 you currently have for standard plans?

2 A. Off the top of my head, no. But I could -- we
3 may have that somewhere in the filing.

4 Q. Yeah. Could you look it up. But I should
5 have asked you this first. How many standard plans are
6 there?

7 A. One platinum, two at silver, well two at
8 silver. Six to seven.

9 Q. That's among all metal levels, right?

10 A. Yes. That's excluding the American Indian,
11 Alaska native plans. Catastrophic. I wasn't taking into
12 consideration because that's questionable.

13 Q. And do you know how your rates compare to Blue
14 Cross's rates?

15 A. Yes. On a high level. We have a more
16 competitive premium rate than Blue Cross.

17 Q. Meaning your rates are lower?

18 A. Yes.

19 Q. Without taking too much time, can you give us
20 an example of what your rates are for standard plans?

21 MR. KARNEDY: Object. Just as to --
22 what time, Jay?

23 MR. ANGOFF: Today. Your current
24 rates.

25 MR. KARNEDY: Current rates. Thank

1 you.

2 THE WITNESS: When you say a standard
3 plan, there is standard plans every metal level. So
4 --

5 BY MR. ANGOFF:

6 Q. Yeah. Your most popular standard silver plan.

7 A. I can look that up for you. I don't know it
8 off the top of my head. So to the dollar amount I don't
9 know exactly what it is. But it's somewhere in the range
10 of \$480 to \$520 for a single rate.

11 Q. Between 480 and 520?

12 A. Somewhere around \$500 I would estimate for a
13 single plan.

14 Q. For your standard silver?

15 A. Yes.

16 Q. And what page is that of the --

17 A. I'm looking at page 77, Exhibit 1, and I'm
18 just kind of backing into it based on what the proposed
19 rate increase is.

20 Q. Okay. All right. And that would be -- would
21 that be your most popular plan?

22 A. I haven't memorized where all of our
23 enrollment lies, but I mean we have exhibits that I could
24 easily pull up if that's something you would like to share
25 with you.

1 Q. Can you tell from what you're looking at what
2 your standard gold plan rate is?

3 MR. KARNEDY: Just so the record's
4 clear, Exhibit 77 it's very small type. Can you read
5 it?

6 THE WITNESS: It's challenging.

7 CHAIRMAN MULLIN: I'm envious of his
8 eyesight.

9 THE WITNESS: Would be approximately 6
10 hundred dollars per -- on a single contract basis.

11 BY MR. ANGOFF:

12 Q. And you believe that those rates are lower
13 than Blue Cross's rates?

14 A. Yes.

15 Q. Do you know that?

16 A. I'm aware that we have more affordable, lower
17 rates than Blue Cross in 2018.

18 Q. Could you explain your methodology in
19 estimating the effect of the individual mandate repeal on
20 your proposed rates for this year?

21 A. Yeah. MVP adopted L&E's recommendation which
22 was a two percent impact on the morbidity of the risk
23 pool. MVP did some independent analysis where we analyzed
24 -- we were assuming certain percentage of our healthier
25 members would drop coverage and how that would impact our

1 rates. L&E estimated two percent. MVP had 2.2 percent.
2 So that we adopted L&E's recommendation because the
3 recommendation was taking into account more items such as
4 federal poverty level and metal level and contract tier.

5 Q. And you also use a 3.7 percent figure; right?
6 In connection with that estimate?

7 A. Yeah. That was the impact on the individual
8 members only. So this is a merged market. If we were
9 proposing a premium rate that was just for individuals, so
10 if there was a separate individual versus a small group
11 market, the individual rates would have gone up by an
12 additional 3.7 percent for the individual mandate penalty
13 being set to zero. But because it's a merged market, we
14 blend the impact together and you arrive at two percent.

15 Q. So the increase that you asked for based on
16 the repeal of the individual mandate is two percent, not
17 3.7 percent; correct?

18 A. On the premium rates it's a two percent
19 adjustment.

20 Q. And that's the same -- because it's a merged
21 market it's two percent for both individuals and small
22 groups; correct?

23 A. That's correct.

24 Q. Okay. And the underlying philosophy of that
25 increase is that the people you insure next year are going

1 to be as a group less healthy than the people you insure
2 this year; right?

3 A. Not necessarily MVP's enrollment, but the
4 entire market will be higher morbidity because risk
5 adjustment normalizes your claim cost to the market-wide
6 average.

7 So risk adjustment has normalized our claims
8 to the 2017 market. In 2019 with the individual mandate
9 being set to zero, we expect the overall risk of the
10 market to actually raise up by two percent. And that's
11 what that additional two percent represents.

12 Q. Okay. But I mean you're not projecting that
13 your own book is going to be -- have worse health status
14 -- you're not projecting that your own book is going to
15 have worse health status in 2019 than it did in 2018?

16 A. The concept of the Affordable Care Act is that
17 you set your premium rates to the market-wide average risk.
18 When you adjust your rates for the experience period data
19 for risk adjustment, the risk adjustment received in the
20 experience period or payment, then that gets you to the
21 market-wide average risk.

22 Q. I don't know if I got an answer to that. I
23 think it's a simple question. Are you projecting that the
24 people you insure in 2019 are going to have worse health
25 status than the people you insure in 2018?

1 A. We are projecting the market morbidity will
2 deteriorate by two percent, which is the way that you
3 should set your rates when risk adjustment is in play.

4 Q. So what effect does that have on the people
5 you're going to insure?

6 A. It's unknown at this point what the members
7 that we are going to enroll in 2019 will -- their
8 morbidity or their utilization of health care services
9 will look like relative to our 2018 book of business.

10 Q. So it's possible that the people that you
11 insure in 2019 will not have worse health status than the
12 people you insure in 2018?

13 A. It's a possibility.

14 Q. Do you also increase your rates for overall
15 morbidity in addition to the amount that you decrease your
16 rates based on the repeal of the individual mandate?

17 A. Not -- no.

18 Q. Let me ask you --

19 CHAIRMAN MULLIN: Just to be clear,
20 you've done it a few times, and I've let it go. It's
21 not a repeal of the individual mandate. It's the
22 repeal of the penalty.

23 MR. ANGOFF: Pardon me. I stand
24 corrected.

25 BY MR. ANGOFF:

1 Q. When the individual mandate was enacted, did
2 MVP reduce its rates based on the effect that it projected
3 the individual mandate would have?

4 A. At that time there wasn't much of an
5 individual market. MVP didn't participate in the
6 individual market in 2013 prior to the Affordable Care Act
7 being rolled out. So the basis of our 2014 rates which is
8 prior to the Affordable Care Act, use small group claim
9 experience. We did anticipate that the individuals
10 enrolling would be higher cost. But now we are using
11 actual data. We are using our actual exchange enrollment
12 to set our premium rates. So this is, in effect, the
13 market-wide average when we adjust for a risk adjustment.

14 Q. When the individual -- when there was a
15 penalty for the individual mandate, do you remember what
16 it was?

17 A. It was a function of your federal poverty
18 level or your income. And it was similar to how your ATC
19 would be determined, so it was up to a certain amount.

20 Q. And was it \$95 in the first year, 2014; 325 in
21 2015; and 695 in 2016?

22 A. I don't -- I will assume that you're correct
23 in those figures. But my understanding was that it would
24 raise up based on your FPL.

25 Q. Did MVP think that the penalty for not having

1 individual coverage was strong enough to really have an
2 effect when it was in effect?

3 A. There is definitely concern at this point
4 after we have done more analysis on our claims that
5 healthier members are going to drop coverage.

6 Q. That wasn't my question though. When the
7 individual mandate was in effect, did MVP have a concern
8 that it wasn't strong enough to really incentivize people
9 to buy coverage?

10 A. There may have been times in the past where we
11 were concerned at \$95 penalty as you referenced earlier
12 may not have much teeth, but our understanding was over
13 time the penalty was increasing. And that became a
14 significant portion of your income at one point, and that
15 would actually incent members to stay enrolled.

16 Q. And did MVP ever do any research to determine
17 what the effect of the individual mandate was? I'm sorry.
18 Did MVP ever do any research to determine what the effect
19 of the penalty for not having individual coverage was?

20 MR. KARNEDY: Object. Vague. Answer
21 it if you can.

22 HEARING OFFICER HENKIN: Can you repeat
23 the question also, so you can clarify that for me?

24 BY MR. ANGOFF:

25 Q. Did MVP do any research to determine what the

1 effect on coverage of the penalty for not having
2 individual coverage was?

3 A. When the mandate was in place, it didn't seem
4 necessary to do an analysis of the impact of it because
5 our assumption was that with the mandate in place, then it
6 would be business as usual and be continuing forward.
7 Once it was -- the penalty was set to zero, that's when
8 our concern, and we started doing our analysis which the
9 Green Mountain Care Board also hired L&E to do a similar
10 analysis.

11 Q. So that's a no.

12 A. We did not do an analysis while the mandate
13 was in place, while there was a penalty attached to the
14 mandate, because it didn't seem necessary at the time.

15 Q. And has MVP ever done any research as to the
16 extent to which residents of Vermont are currently aware
17 of the repeal of the penalty for not having individual
18 coverage?

19 A. MVP's participating in any kind of stakeholder
20 groups that are in place, and we are very focused on
21 trying to retain our membership to make sure that members
22 don't lapse coverage. Our understanding is that Vermont
23 is working towards trying to institute a penalty again in
24 2020, but it won't be in place in 2019. So we are hoping
25 is that in 2000 -- in the 2019 open enrollment year our

1 work with all various stakeholders in Vermont and
2 internally with our marketing communications teams we can
3 enroll as many members as possible and continue coverage.

4 Q. But has MVP ever done any research on the
5 extent to which people living in Vermont are aware that
6 there is no longer a penalty for not buying individual
7 coverage?

8 A. No.

9 Q. Let me ask about administrative expenses. And
10 you can -- if you want to refer to the issue, you can look
11 at page nine of your rate filing and page 39 of PDF
12 Exhibit 1. Your administrative expenses for -- in this
13 rate filing are 39.80 per member per month; correct?

14 A. Correct.

15 Q. Okay. And last year your administrative
16 expenses were less; right? They were \$38.10?

17 A. Yes.

18 Q. And you're aware that last year the board said
19 that we expect MVP to reduce administrative expenses
20 because it's enrolling more Vermont members; correct?

21 A. Correct.

22 Q. And this year your administrative expenses
23 aren't less than they were last year. They are more than
24 they were last year because of your overall loss of
25 business in New York; correct? Which outweighs your

1 Vermont gain in business?

2 A. Yes.

3 Q. Okay. And aren't you -- by charging Vermont
4 policyholders for the New York reduction in business,
5 aren't you forcing Vermont policyholders to subsidize New
6 York policyholders to a certain extent?

7 A. I don't agree with that. It's because our
8 fixed expenses are, you know, I was using an example of
9 our claims operating system. It's physically housed in
10 our New York offices, but it's being utilized by Vermont
11 members. So the cost of running that claims operating
12 system is something that we need to account for in all of
13 our premium rates, not just Vermont or New York
14 specifically.

15 Q. But you agree in principle the business should
16 stand on its own; right? Vermont people should pay for
17 Vermont coverage. New York people should pay for New York
18 coverage; correct?

19 A. And our rates reflect that.

20 Q. Okay. So for example, your contribution to
21 reserves should be the same in Vermont as in New York,
22 right?

23 A. There is reasons why you could differentiate
24 those two figures.

25 Q. Okay. What are those reasons?

1 A. So in the individual market in New York, for
2 2019 we are proposing a 1.5 percent contribution to
3 reserves. That's because with the individual mandate
4 repeal we are anticipating membership decline in that
5 market. And similar to earlier we were speaking about if
6 we grow membership, we would actually need to charge more
7 to maintain our minimum solvency level. If you lose
8 membership, you can charge less to maintain your minimum
9 solvency levels.

10 So with individual mandate repeal we are
11 projecting to insure fewer individuals in New York which
12 is it why we are promoting a lower contribution to reserve
13 for 2019. We don't think it's a long-term sustainable way
14 of preserving solvency, and in the future we plan to
15 monitor what the impact of the individual mandate repeal
16 has had on membership. And then we are going to reassess
17 going forward.

18 Q. So for 2019 you filed for a two percent
19 contribution to reserves in Vermont, and 1.5 in New York;
20 right?

21 A. In our individual market in New York 1.5
22 percent. In our small group market which we don't expect
23 to be impacted by the individual mandate being set --
24 being set to zero we are still charging two percent on the
25 reserves.

1 Q. So and in 2018 when the board awarded you,
2 when this board awarded you a two percent CTR for Vermont,
3 New York only allowed you a 1.5 percent CTR for the
4 individual market; correct?

5 A. Yes.

6 Q. And in 2017 do you remember what your CTR was
7 in New York? Or as they would say, profit.

8 A. I don't recall.

9 Q. Turning to the AHP issue. Does MVP plan to
10 participate in the AHP market?

11 A. To the extent that a group or association
12 requests a quote, we wouldn't decline to quote them. I
13 believe that's actually regulatorily we have to quote the
14 group if they are allowed to purchase coverage in Vermont.

15 Q. Is MVP actively soliciting that AHP business
16 in Vermont?

17 A. Not that I'm aware of at this point.

18 Q. Okay. Could you tell the board a little bit
19 about the reorganization that MVP undertook recently that
20 had the effect of saving -- eliminating or at least
21 reducing premium taxes?

22 A. Yeah. MVP prior to third quarter of 2018
23 offered our large group and small group grandfathered
24 business on our health insurance company which is an
25 Article 42 license, and we were charging premium tax. We

1 recognize as a non profit we shouldn't be offering
2 coverage on the for-profit entity, which it helped promote
3 a more affordable rate.

4 Our goal was to remove the premium tax that
5 was built into our rates of approximately two percent so
6 that we would have a more affordable rate and promote a
7 more competitive premium against our competitors for a
8 large group market.

9 Q. So how much did MVP save in the Vermont
10 premium tax as a result of the reorganization?

11 A. Well whatever savings, I don't know the number
12 off the top of my head, but whatever savings MVP will
13 achieve is being passed through into the premium rates,
14 because we are not charging premium tax any more.

15 Q. Could you show the board in the rate filing
16 where that premium tax savings is reflected?

17 A. This filing is offered on MVP Health Plan. We
18 have always offered our Vermont exchange business on MVP
19 Health Plan which is the legal entity where premium taxes
20 are -- have always been zero.

21 So again, we rate our blocks to be self
22 supporting. So the blocks that are going to receive the
23 benefit of the premium tax being set to zero are the large
24 group block as well as the small group grandfathered block
25 where they transition from paying a premium rate that

1 reflected the premium tax to a premium rate that reflects
2 the premium tax.

3 Q. Are you saying then the elimination of the
4 premium tax has no effect on individual policyholders, on
5 the rates that individual policyholders pay?

6 A. We have never charged a premium tax on the
7 Vermont Health Connect business. So as a result, we are
8 still charging zero percent. So there is no impact on the
9 rate increase that we are proposing this year.

10 Q. The elimination of the premium tax has an
11 effect on small group business?

12 MR. KARNEDY: I'm going to object.

13 This has been asked and answered.

14 MR. ANGOFF: No. It's not clear.

15 BY MR. ANGOFF:

16 Q. Has the elimination of the state premium tax
17 had an effect on the rates that small group policyholders
18 in Vermont pay?

19 A. If you were a small group policyholder in our
20 grandfathered block of business, then yes.

21 Q. Okay. Has the elimination of the state
22 premium tax had an effect on the rates that large
23 policyholders in Vermont pay?

24 A. Yes.

25 Q. And am I correct then in understanding that

1 the elimination of the premium tax, state premium tax, has
2 not had an effect on the rate that individual
3 policyholders in Vermont pay?

4 A. That's an accurate statement.

5 Q. Could you explain what the effect, if any, of
6 the Tax Cuts and Jobs Act has been on the taxes that MVP
7 will pay in 2019?

8 A. That's outside my area of expertise. I have
9 had conversations with our finance team. And they have
10 indicated that they don't anticipate an impact due to the
11 Tax and Jobs Act.

12 Q. They have indicated that the Tax Cuts and Jobs
13 Act will have no effect on --

14 A. That's my understanding.

15 Q. But you don't know that?

16 A. I'm not the subject matter expert on the Tax
17 Cut and Jobs Act. I would have to defer to our accounting
18 team who is not here.

19 Q. Okay. So you don't know then whether any
20 effect that the Tax Cuts and Jobs Act has been factored
21 into the rate filing?

22 MR. KARNEDY: Object. This has been
23 asked and answered.

24 HEARING OFFICER HENKIN: This has been
25 asked several times, and we can continue on. And we

1 have a limited amount of time, and I don't want to
2 cut the questioning short. So please move ahead.

3 BY MR. ANGOFF:

4 Q. Does MVP have a target RBC ratio?

5 A. As I testified earlier, New York State
6 Department of Financial Services governs MVP's solvency.
7 It's not on an RBC basis. It's on a percentage of premium
8 basis. We translate that to an approximate RBC
9 percentage. The target -- what I'm more comfortable with
10 is the percentage of premium, the minimum solvency
11 requirement is 12 and-a-half percent of premium. We
12 target at MVP 16 to 20 percent. That's also been
13 suggested through the Enterprise Risk Management program
14 that New York State Department of Financial Services has
15 put forth as well.

16 Q. So does MVP have a target RBC ratio?

17 A. We -- again, we target a percent of premium to
18 hold, and that's something that I can work with someone to
19 translate that to an RBC percentage for you. But it's 16
20 to 20 percent of premium.

21 Q. Would MVP have any concerns if its RBC ratio
22 fell below 300?

23 A. I would have to know what that translates to
24 on a percentage premium basis. If that's below 12
25 and-a-half percent, we would be concerned.

1 Q. Thank you. Could you turn please to page --
2 to tab 14 which is the MVP Annual Statement.

3 A. Okay.

4 Q. And could you turn please to page 46, start
5 with that page of that statement.

6 A. Okay.

7 Q. Can you look down at lines 14 and 15 there
8 under "Risk-based Capital Analysis."

9 A. Okay.

10 Q. Okay. And the RBC ratio is simply line 16,
11 I'm sorry. Line 14 total adjusted capital divided by line
12 15, authorized control level capital; right?

13 A. That sounds familiar. Yeah. That sounds
14 appropriate.

15 Q. Okay. So if you were to do the division and
16 come up with the RBC ratio, does that level of RBC cause
17 you any concern?

18 MR. KARNEDY: I'm going to object and
19 just caution to the line of questioning around the
20 RBC issues. We have a confidentiality statute here
21 in Vermont. And I just want to be careful that we
22 are not asking the witness to testify to something
23 that would be deemed confidential.

24 MR. ANGOFF: The Annual Statement is
25 public. I'm asking the witness simply to testify as

1 to whether the quotient of two numbers would cause
2 him any concern.

3 MR. KARNEDY: He's asking the witness
4 to testify and do math relating to the RBC. And if
5 he testifies as to the mathematical, then we might be
6 getting into confidential information. That's my
7 point.

8 HEARING OFFICER HENKIN: He did not ask
9 for a specific number. He's asking if he had done
10 the math, would it give him a concern. And I'll
11 allow it for now.

12 MR. KARNEDY: Thank you.

13 THE WITNESS: Back to what I was saying
14 earlier, I'm more comfortable weighing in on the
15 percentage of premium that we are holding in
16 reserves. So I haven't done the calculation. I
17 didn't prepare this income statement. That's
18 something that I can calculate or I could do.

19 MR. ANGOFF: Madam Hearing Examiner,
20 may I approach the witness with a calculator?

21 MR. KARNEDY: This goes to my
22 objection.

23 HEARING OFFICER HENKIN: At this point
24 I will allow it. You can do the math and ask your
25 question, but this line of questioning I think we

1 have already had the answer already, they do not use
2 the standard. But you can get the math and have that
3 one question, and we will move forward.

4 Go ahead. I think there is many people
5 right now looking at their phones and doing the
6 calculation. And the question was when you get the
7 answer to this equation whether that RBC would be of
8 concern; is that correct? Mr. Angoff, is that the
9 correct question?

10 MR. ANGOFF: I'm sorry?

11 HEARING OFFICER HENKIN: We will move
12 forward and let him do his math, and I believe your
13 question was whether the resulting number would be of
14 concern to the company.

15 MR. ANGOFF: Exactly right.

16 THE WITNESS: On a percentage of
17 premium basis, we are above the minimum threshold.
18 We are not quite to the target that we want. Our
19 target is 16 percent to 20 percent based on our
20 recommended solvency concerns that our hearing
21 process has put forth in the process management, and
22 right now we are at 15.4 percent of premium.

23 BY MR. ANGOFF:

24 Q. The number that you just got with my very high
25 tech calculator, does that cause you any concern?

1 A. As premiums increase, so we are below the
2 threshold as -- our target threshold as it is. So we
3 would like to get up to 16 percent at a minimum. Right
4 now I'm calculating 15.4 percent.

5 Q. I think I'm entitled to an answer to my
6 question. I'm asking him about one number, and he's
7 giving me an answer that does not apply to that number.

8 MR. KARNEDY: Objection. I know it's
9 cross-examination, but it's argumentative. He's
10 answered the question.

11 MR. ANGOFF: He didn't answer the
12 question.

13 HEARING OFFICER HENKIN: You were
14 asking him to do one equation and whether the
15 resulting number would be a concern.

16 MR. ANGOFF: Exactly right.

17 HEARING OFFICER HENKIN: And is that
18 the equation you did?

19 THE WITNESS: I did that equation.

20 BY MR. ANGOFF:

21 Q. And does that cause you any concern?

22 A. I guess could you define what you mean by
23 concern?

24 Q. Do you think that that -- the number that you
25 got, the quotient of those two numbers, does that make you

1 concerned at all about MVP's financial condition?

2 A. Based on recommendations as I understand from
3 New York State Department of Financial Services, we should
4 be increasing that figure, so there is concern since we
5 are not meeting that threshold. We are above the minimum.
6 So we are in between the minimum that New York State has
7 dictated and the target.

8 Q. Could you please turn to Exhibit 13.

9 A. Okay.

10 Q. Are you familiar with that exhibit?

11 A. This is not an exhibit that I prepared.

12 Q. That's fine. If you're not -- I don't want to
13 ask you a question about an exhibit you're not familiar
14 with.

15 A. I'm not aware -- no, not. This is the first
16 time I've looked at this exhibit actually so --

17 Q. MVP has not implemented alternative payment
18 methodologies in Vermont, has it?

19 A. As of today, no. We have not.

20 Q. And by implementing alternative payment
21 methodologies you could drive hospital costs and other
22 provider costs down, couldn't you?

23 A. We are participating in alternative payment
24 methodologies in New York. And it's too early to actually
25 assess whether or not it is impacting hospital costs down.

1 That's about all I can say at this point.

2 Q. And why haven't you implemented them in
3 Vermont?

4 A. Previously we didn't have what we felt was a
5 large enough footprint in our -- in membership. There is
6 also no desire from our contracting team to have more
7 information about regional price analysis of hospitals and
8 delivering costs on a unit-cost basis in Vermont. That's
9 about all I'm familiar with outside of the fact that I
10 know there are still conversations taking place between
11 MVP and One Care.

12 Q. You're a fellow of the Society of Actuaries;
13 correct?

14 A. Yes.

15 Q. And as a fellow of the Society of Actuaries
16 you're certainly qualified to render an opinion as to
17 whether or not a rate is excessive; correct?

18 A. Correct.

19 Q. Or inadequate; correct?

20 A. Correct.

21 Q. Or unfairly discriminatory; correct?

22 A. Correct.

23 Q. Okay. But there is no actuarial standard that
24 qualifies you to render an opinion as to whether a rate is
25 affordable; correct?

1 A. That is -- that's correct. That's not an
2 actuarial opinion. I know it's in Vermont statute. My
3 understanding is that's for the board to determine.

4 Q. But I believe -- but I believe that you
5 answered to counsel that this proposed rate was
6 affordable, right?

7 MR. KARNEDY: Objection. That's not
8 exactly what he said. Go ahead. So I would object
9 to the question as it's phrased.

10 THE WITNESS: Could you please re-ask
11 the question?

12 MR. ANGOFF: Sure.

13 BY MR. ANGOFF:

14 Q. I'll ask it this way. You are not qualified
15 as an actuary to render an opinion, are you, as to whether
16 this proposed rate is affordable?

17 A. That is a non-actuarial topic, but as an
18 actuary our job is to analyze our costs and project what
19 we think those costs will be in the future. Approximately
20 90 cents on every premium dollar are going towards health
21 care costs. And I'm not going to try to dispute that
22 health care is expensive in the State of Vermont. But 90
23 percent of every premium dollar is going toward health
24 care costs.

25 The remaining amount we are managing as

1 directly and as efficiently as possible to make the rate
2 as affordable as possible.

3 Q. Let's assume that every word that you said was
4 correct, nevertheless in analyzing those costs you don't
5 determine whether or not people can actually have the
6 money to actually pay for those costs; are you?

7 A. That is not taken into consideration in the
8 development of our rates. Our rates --

9 Q. Sorry. Go ahead.

10 A. Our rates are determined to promote an
11 actuarially sound rate which is reviewed extensively by
12 L&E, and they have three actuaries sign off that the rate
13 is not excessive, inadequate, and it's reasonable relative
14 to the benefits being offered.

15 Q. Sure. And as an actuary, you're not qualified
16 to render an opinion as to whether the rate that you find
17 to be not excessive, inadequate or unfairly discriminatory
18 promotes quality of care.

19 A. That's not part of our actuarial opinion. But
20 the testimony we have adopted earlier was discussing
21 quality of care, access to care, affordability, and a
22 number of other items.

23 Q. But as an actuary, you don't have any
24 particular qualification to determine whether this
25 proposed rate promotes quality of care; correct?

1 A. That is not part of the actuarial statement.

2 MR. ANGOFF: Okay. I have no further
3 questions.

4 HEARING OFFICER HENKIN: Board members.
5 I think that our chair is ready to go.

6 CHAIRMAN MULLIN: So I think I'll start
7 with the individual mandate. You made reference to a
8 report, and you said that it was a Green Mountain
9 Care Board report. Are you referring to the joint
10 effort of the Green Mountain Care Board and DFR
11 commissioning an outside consultant, L&E, to come
12 back with a report in February?

13 THE WITNESS: Yes.

14 CHAIRMAN MULLIN: And since that report
15 came back, legislation was passed in the State of
16 Vermont, was it not?

17 THE WITNESS: My understanding is that
18 that is not for the 2019 plan year.

19 CHAIRMAN MULLIN: Okay. Legislation
20 did pass though; correct?

21 THE WITNESS: That's my understanding.
22 Correct.

23 CHAIRMAN MULLIN: And there's been
24 quite a bit of publicity in Vermont that Vermont has
25 taken that action, followed suit with other places

1 like New Jersey, Washington, Massachusetts had an
2 individual mandate prior to the Affordable Care Act.
3 It appears in your filing that you believe that the
4 legislation that was passed by the Vermont
5 legislature will have no impact on mitigating the
6 effects of the removal of the penalty for your
7 premium year 2019; is that correct?

8 THE WITNESS: That's correct.

9 CHAIRMAN MULLIN: And what leads you to
10 that assumption?

11 THE WITNESS: The benefits that are
12 offered are calendar year benefits. If there were
13 benefits that were running into the next year, that
14 would be something that we would have to take into
15 consideration. But because the benefits will reset
16 on January 1, 2020, our assumption is that the
17 calendar year '19 rates are not impacted by the
18 individual mandate or -- individual mandate penalty
19 set to zero.

20 CHAIRMAN MULLIN: So you don't believe
21 that the knowledge that there would be some type of
22 penalty in 2020, and the fact that this would only be
23 a one-year decision mitigates it at all?

24 THE WITNESS: We did not reflect that
25 in our rates. We are working with our marketing

1 communications team to try to enroll as many members
2 as possible, so that continuous coverage. But if
3 you're a purchaser, it's a calendar year, one-year
4 snapshot. So you do -- if you feel healthy, and you
5 feel like you have been paying too much in premium
6 rate, our assumption is that they will likely walk
7 away from coverage for one year.

8 CHAIRMAN MULLIN: How in depth is your
9 analysis of the actuarial study that was done in
10 February?

11 THE WITNESS: I read through the slide
12 deck, and then we also did our own analysis
13 afterwards.

14 CHAIRMAN MULLIN: Okay. On the
15 association health plans, you have chosen not to
16 include any request for a rate increase in this year.
17 Can you tell us why?

18 THE WITNESS: We simply don't have
19 enough data at this point to understand what we think
20 the impact is going to be to adequately assess the
21 impact. We would want to know who the members were
22 that were most likely affiliated -- that were
23 affiliated with an association would be most likely
24 to exit the market, and then understand how their
25 health care utilization compares to the market-wide

1 average.

2 CHAIRMAN MULLIN: Have you had any
3 internal discussions about how many lives might be
4 lost by MVP?

5 THE WITNESS: Those aren't
6 conversations I was participating in. I know that we
7 are in a multi-stakeholder conversation about the
8 impact of association health plans. But that's not
9 part of my job responsibilities at this point.

10 CHAIRMAN MULLIN: Okay. So no one has
11 come to you and asked you about changes in morbidity
12 or anything when it comes to that particular topic?

13 THE WITNESS: No. I think that
14 question will come if -- once we have an
15 understanding of who the potential groups or
16 associations that will exit, that request is going to
17 come our way. We just haven't had any of that
18 information asked of us at this point.

19 CHAIRMAN MULLIN: Do you have any
20 knowledge of any of those groups coming to MVP to try
21 to do business with another one of your plans to meet
22 --

23 THE WITNESS: We -- I'm not aware of
24 which groups -- I think the question was are there
25 groups that used to be in associations that are now

1 with MVP. Is that -- I'm not aware of which groups
2 those are.

3 CHAIRMAN MULLIN: Well the question is,
4 if MVP has been approached by any association to have
5 an association plan piggybacking on an existing MVP
6 plan.

7 THE WITNESS: That is not something
8 that -- that hasn't come across my desk at this
9 point.

10 CHAIRMAN MULLIN: Okay. You talked a
11 lot about trying to create transparency for the
12 consumer as far as what they would spend for medical
13 expense. And you talked about your members can go
14 online and see what the net effect of the rates are.
15 And that is what their out of pocket would be, not a
16 hospital charge list; correct?

17 THE WITNESS: For a given procedure,
18 yes. That's what they would be able to compare is
19 the cost of a given procedure at -- for doctor A
20 versus doctor B or facility one versus facility two.

21 CHAIRMAN MULLIN: Have you had any
22 discussions as a company trying to create a similar
23 data base for members so that they could see that if
24 they have been prescribed drug A, that at Walgreens
25 it's \$107 and CVS it's \$50 or anything like that?

1 THE WITNESS: I'm not familiar enough
2 with our contracts to know if those costs do vary at
3 Walgreens versus CVS in your example.

4 CHAIRMAN MULLIN: I think there have
5 been several articles in the press, so it should be
6 common knowledge if you're a member of whatever the
7 group is called, certain drugs are cheaper. We all
8 know what Walmart has available. So that hasn't
9 risen to the level where you think there is a
10 sufficient amount of return like providing your
11 members with that information?

12 THE WITNESS: No. That sounds, you
13 know, assuming that's true, I think that would be
14 valuable information. I just don't know if that's
15 something that MVP has undertaken. That's not
16 necessarily something that we would be asked to
17 quantify. If it is in place, that would be something
18 we would want to quantify and to understand the cost,
19 the savings associated with directed care to a lower
20 cost pharmacy.

21 CHAIRMAN MULLIN: Okay. Are you at all
22 involved with negotiations with providers and
23 hospitals for the setting of rates?

24 THE WITNESS: I'm not physically or I'm
25 not personally a person that's doing the

1 negotiations. To the extent we work with our
2 informatics and contracting team to understand how
3 much our rates are changing, our unit costs are
4 changing by facility or by physician group. But
5 outside of that, I'm not actually the person that's
6 doing the negotiating of the contracts.

7 CHAIRMAN MULLIN: Okay. During your
8 testimony I just want to applaud you. You talked
9 about your movement of trying to equalize payment
10 schedules for physicians. But I almost am afraid
11 that I heard something that you followed that with
12 that you shifted those dollars to hospital fee
13 schedules. Is that facility fees, or did I just
14 mishear you?

15 THE WITNESS: I think the concept is if
16 the approved -- if the contractual increase at a
17 facility such as UVMMC which employs physicians was
18 two percent, we were -- there is a facility
19 component, and there is a physician fee schedule
20 component. We are arriving at two percent in
21 aggregate, and that's a hypothetical number. But we
22 are basically doing the calculation to arrive at two
23 percent aggregate which is a reduction to the
24 physician fee schedule and offsetting increase to the
25 facility cost to arrive at two percent aggregate.

1 CHAIRMAN MULLIN: If I went to the deli
2 and bought a sandwich and it's \$4, and I decided that
3 they were charging too much for the bread, did I
4 benefit any if there was a change so I'm paying \$2
5 for the bread and \$2 for the meat?

6 THE WITNESS: No.

7 CHAIRMAN MULLIN: Okay. Getting back
8 to that, you seem to understand as a company to have
9 a -- what I'm hearing from you is that you're -- you
10 want to try to provide parity. And do you know if
11 there is variation in payments made for like
12 procedures to similar providers?

13 THE WITNESS: In the past it was a
14 wider spread. And we are working towards closing
15 that gap to get them more aligned. I haven't -- I
16 don't analyze the fee schedules in detail. But I
17 know that we are still anticipating some reductions
18 to physician fee schedules which would imply that we
19 are still working towards getting them more aligned.

20 CHAIRMAN MULLIN: And what about
21 procedures?

22 THE WITNESS: I'm sorry?

23 CHAIRMAN MULLIN: What about
24 procedures? Is there a variation in procedures? So
25 let's pick one. Colonoscopy. Nobody wants to go get

1 it done, but we are all told we have to.

2 THE WITNESS: Yup.

3 CHAIRMAN MULLIN: Do you have an
4 acceptable level of variation between hospitals?

5 THE WITNESS: I'm not involved enough
6 in the negotiations to answer that. That would be
7 something that our contracting team would have to
8 weigh in and reflect in our response.

9 CHAIRMAN MULLIN: Okay. You're a
10 numbers guy. You received several questions from
11 Attorney Angoff about your reserves. When you go to
12 work in the morning do you worry about the health --
13 financial health of your company because it's not
14 being monitored with an RBC?

15 THE WITNESS: It doesn't bother me that
16 we are not being monitored by RBC.

17 CHAIRMAN MULLIN: Okay. Thank you.

18 HEARING OFFICER HENKIN: Member Holmes.

19 BOARD MEMBER HOLMES: Okay. Thank you.
20 So I think I'm going to throw a little bit along Mr.
21 Mullin's lines too.

22 You talked a little bit about having
23 little direct control over about 90 percent of the
24 premium in respect to the health care expenditures.
25 So I want to talk a little bit about the incentives

1 that MVP has to contain costs and to try and bring
2 that number down.

3 In your filing you proposed a 3.2
4 percent unit cost increase. And it was -- that unit
5 cost increase was about 1.7 percent for providers
6 that are subject to Green Mountain Care oversight.
7 And it was five percent for all other providers that
8 the Green Mountain Care Board has no oversight for.

9 So I want to hear a little bit about
10 what room you have from an effective bargaining over
11 that five percent that we have no regulatory
12 authority over. And what leverage you have in
13 bargaining, what obstacles you face in that
14 bargaining, and how that number could be more aligned
15 with the 1.7 percent that we have more regulatory
16 authority over.

17 THE WITNESS: Yeah. Our providers
18 outside of Vermont aren't governed by Green Mountain
19 Care Board for what premiums are acceptable. So our
20 contracting team does a rigorous negotiating process
21 where we go back and forth. We have contracts that
22 we have negotiations for a year and-a-half to two
23 years to try to keep costs affordable as possible.
24 Unfortunately, without regulatory oversight it's
25 challenging to actually keep those costs as low as

1 they are in Vermont. If we were to -- unfortunately
2 if we want to provide access to our New York
3 facilities, New York doctors, and our national
4 providers with Cigna, those increases are going to
5 have to be passed on into the rates, to the extent
6 that the utilization of Vermonters is reflected.

7 I just want to make it clear that if
8 Vermonters utilize 100 percent of costs that were
9 governed by the Green Mountain Care Board, the trend
10 increase would be the 1.7 percent that you
11 referenced. It's because Vermonters are seeking care
12 outside of Vermont which is driving up the cost. But
13 we do have a rigorous contracting and negotiating --

14 BOARD MEMBER HOLMES: Do you create any
15 incentives for your members to remain in Vermont to
16 seek the care where it's been negotiated at a lower
17 cost?

18 THE WITNESS: I'm not aware exactly of
19 any specific initiatives. I do know that we set our
20 benefit designs to have a lower PCP cost than your
21 specialist visit. That's a strategic decision to try
22 to direct care to PCPs, and generally people's PCPs
23 are in the state where they live, unless you live
24 right on the border. So the vast majority of that
25 care is delivered by Vermont physicians.

1 Our benefit design, that's the way I
2 would say that I'm familiar with. If there is other
3 efforts to try to direct care, I'm not familiar with
4 those.

5 BOARD MEMBER HOLMES: Okay. In the
6 past week there have been recent announcements by
7 several pharmaceutical companies to hold down price
8 increases that had been planned; Pfizer, Merck,
9 Novartis, Bayer, Roche. They have all said that they
10 are going to clamp down on some pharmaceutical
11 planned increases.

12 Does that -- I'm assuming that does not
13 obviously factor into the filing. Would that cause
14 you to make an adjustment downwards of the pharmacy
15 trend, this idea that there are pharmacy
16 manufacturers that are planning to keep costs stable?

17 THE WITNESS: Yeah. We periodically
18 receive projected trend information from our pharmacy
19 benefit manager. And those trend projections reflect
20 that kind of information. The information that we
21 have reflected in our premium rates was current as
22 of, I believe it was March of this year. So to the
23 extent that our pharmacy team was able to negotiate
24 better discounts in December of 2017, that is
25 reflected in our rates. And any information that's

1 been passed on in updates, that wouldn't be reflected
2 in our rates because we don't have that information
3 at this point.

4 We do have conversations with our
5 pharmacy team. I'm not aware of a material change in
6 some -- in any pricing in contracts that MVP is
7 experiencing, but to the extent that manufacturers
8 are reducing their unit costs, I'm sure we are going
9 to work that into our pricing at some point.

10 So hopefully it will be felt through
11 lower trends in the future filings.

12 BOARD MEMBER HOLMES: Okay. So what is
13 MVP's commitment to reducing excess and unnecessary
14 costs, which there are some estimates out there that,
15 you know, as much as 25 percent of expenditures do
16 nothing for health outcomes of individuals. What is
17 MVP's cost containment strategies particularly
18 related to reducing that sort of wasteful,
19 inefficient, unnecessary spending?

20 THE WITNESS: Our -- we have a number
21 of different items in place like the care management
22 programs that we had discussed earlier. Or we have
23 other programs in place. Our goal is really to try
24 to improve wellness, improve our members' health, and
25 we do that. For example, if you have a newborn

1 child, then you receive a letter in the mail that
2 tells you here are the appointments that you should
3 be having for your child. So we are not really -- I
4 think your question was to the extent of what are we
5 doing to reduce costs. I think our goal is to put
6 forth best practice guidelines into our materials
7 that would help you understand in the example of like
8 a newborn here are the steps that you should take to
9 make sure that they are healthy so you can monitor
10 their health.

11 BOARD MEMBER HOLMES: So that's an
12 example that you provided of providing people with
13 best practice information. And you mentioned earlier
14 in your testimony a website that talks about
15 wellness. Has the company done any assessment of
16 whether that works, whether, for example, mothers are
17 reading those new information -- those Welcome
18 Packages and actually acting on it? Whether people
19 are going on the website and downloading the
20 information on health and wellness. How does MVP
21 know that those strategies are actually working and
22 changing behaviors to improve health outcomes and
23 lower costs?

24 THE WITNESS: That's something that I
25 haven't been intimately involved in if there is that

1 kind of analysis taking place. I think right now I
2 know we have a number of initiatives in place such as
3 we have a total medical expense team, a TMA team, and
4 their job is to analyze costs.

5 Are there programs that we have in
6 place, something like this newborn campaign. Is it
7 actually effectively helping reduce costs, or is it
8 helping guide members to utilize benefits. Because
9 it may reduce costs, but if it's not actually making
10 them healthier, that's not necessarily a good thing.
11 Are they adhering to these policies we are putting in
12 place. I'm not familiar with any of those analyses.

13 But I do know that that is a huge
14 effort that MVP medical management team has
15 undertaken to try to understand whether or not there
16 is a positive ROI on some of these programs.

17 BOARD MEMBER HOLMES: So from your
18 actuarial knowledge there is no new cost containment
19 strategy that you're aware of that MVP undertook for
20 this upcoming year that would have translated into a
21 rate reduction that you were asked to say what would
22 be the impact on lowering rates because of this new
23 cost containment strategy that's being undertaken.
24 There is nothing in there.

25 THE WITNESS: I know we are in

1 conversations to put forth a musculoskeletal program
2 to help mitigate costs for items such as like a
3 shoulder surgery. Rather than having a shoulder
4 surgery, having physical therapy and trying to work
5 through that. Those direct costs are hopefully going
6 to play out in our data as time goes on. But we will
7 wait until like the contract was signed and that we
8 actually had some data to analyze the effect, because
9 everything that we would have other than that would
10 just be information that was provided by the vendor.
11 So we would want to look at what's the impact on our
12 overall cost.

13 BOARD MEMBER HOLMES: My hope is that
14 when you all come next year that there are specific
15 cost containment strategies that are going to
16 translate into lower rates that will reduce some of
17 the wasteful spending that we have in here. That is
18 true in all expenditures.

19 One of the things related to that, MVP
20 in Exhibit 7 states that the company does not
21 directly incent providers to provide generics or non-
22 specific alternative specialty drugs. Why not incent
23 providers to redirect towards more lower cost drugs
24 specifically?

25 THE WITNESS: I'm not part of that

1 campaign. I know that we provided that response.
2 But I'm not part of those marketing efforts or those
3 contracting efforts, I should say. I'm not even
4 familiar if there is a law that would prohibit that.
5 So I can't really weigh in with confidence in why we
6 are not doing that or why we do that.

7 I know that generic drug utilization is
8 90 percent of our utilization, so if you look at our
9 rate filing, 9 out of 10 of the prescriptions that
10 are filled are generics. And then it's about 9
11 percent brand drugs and less than one percent are
12 specialty drugs which are the highest cost drugs.

13 So we are seeing an increase in generic
14 dispensing rate, and that is something, but I'm not
15 aware of any kind of contract talks for promoting or
16 incenting providers offering generics.

17 BOARD MEMBER HOLMES: Okay. Let's talk
18 about incenting consumers and informing consumers.
19 You spoke a little bit about your website, that you
20 have a price transparency and website. What
21 percentage of your members visit that website,
22 actually use the website?

23 THE WITNESS: I know those figures are
24 maintained by our marketing and communications team.
25 But I don't know those off the top of my head.

1 BOARD MEMBER HOLMES: Would you maybe
2 follow up and we can get that back? My sense is that
3 many of those web sites if there is not real strong
4 efforts to drive traffic to those websites don't get
5 much usage. So I would also wonder if maybe you can
6 follow up what are the policies and incentives to
7 encourage people to actually use the website or
8 actively seek lower cost alternatives. I would like
9 to hear about what those --

10 THE WITNESS: Yeah. So I think I had
11 referenced earlier, but when we have a member -- when
12 somebody enrolls through MVP, you do get a member
13 activation kit. And we do try to guide members
14 towards tools such as this so they understand, you
15 know, the benefits available to them.

16 BOARD MEMBER HOLMES: Do you know how
17 many people actually go on and activate with the
18 activation kit?

19 THE WITNESS: So everybody receives it.
20 And then I think that should be activated.

21 BOARD MEMBER HOLMES: Mean you don't do
22 anything with it.

23 THE WITNESS: It's to the members,
24 yeah.

25 BOARD MEMBER HOLMES: Any information

1 you can provide on that, I think would be helpful.

2 THE WITNESS: Okay.

3 BOARD MEMBER HOLMES: My next area. I
4 will let that go. I'll see where my theme was. It's
5 a concern of mine.

6 I have to say I'm very, very surprised
7 other than through the HCA's questioning not to hear
8 any mentioning of the all-payer model and One Care in
9 any of your testimony earlier. So let me ask you
10 this. What role do you think the all-payer model
11 plays in improving health and lowering costs for
12 Vermonters?

13 THE WITNESS: So I'm not that familiar
14 with the all-payer model. That's something that once
15 we further our negotiations, if we do enter into an
16 arrangement with One Care, then my team would be
17 tasked with analyzing some of the costs that we think
18 are associated with that, with that program. I know
19 that we do participate in value-based arrangements in
20 our New York Medicaid population and even some of our
21 commercial population.

22 And at this point we haven't seen -- we
23 don't have enough data to basically thoroughly
24 evaluate exactly what the impact is. In theory, I
25 understand what should happen. But we don't have

1 enough data at this point to actually confidently
2 assess whether or not it's driving costs down.

3 BOARD MEMBER HOLMES: So how likely do
4 you think MVP is to, you know, enter into an
5 agreement with One Care and facilitate the success of
6 the all-payer model through that?

7 THE WITNESS: I would have to follow up
8 with somebody who is involved in those negotiations.

9 BOARD MEMBER HOLMES: That would be
10 very helpful, and I know has there been a sharing --
11 you know, any kind of sharing of data with One Care
12 to help them design or understand a workable
13 contract. That's another question that I would like
14 to understand a little bit more about.

15 What is MVP's plans with respect to One
16 Care? What's their plan with respect to helping the
17 state reach scale targets for the all-payer model and
18 other lines of business? And a little bit more about
19 reimbursements, fee for service versus prospective
20 payment. What is MVP's plan here? Because I think
21 it all relates to our cost containment strategy. I
22 also think it relates to Vermont's decision to enter
23 into this health reform effort, and having our
24 carriers involved is very important to the success of
25 that program. So information about that would be

1 helpful.

2 THE WITNESS: Okay. Thank you.

3 BOARD MEMBER HOLMES: Related to that,
4 I think I'm almost done. In the -- you've talked
5 about directing more care to the primary care
6 practices --

7 THE WITNESS: Yeah.

8 BOARD MEMBER HOLMES: -- as a cost
9 containment strategy. I noticed in the filing that
10 the percent of medical claims dedicated to primary
11 care literally have not changed the percentage of
12 your expenditures at least in the data that you
13 provided since 2014. So again, related to our
14 statewide efforts at reform and increasing primary
15 prevention, what is MVP's plan here with trying to
16 increase access to primary care?

17 THE WITNESS: Yeah. You know, we are
18 definitely -- we understand the value of primary care
19 in the health care system and how they can actually
20 lower costs overall. It's just been challenging to
21 get members to move in that direction. So I do know
22 we have initiatives under way to help guide members
23 towards the PCP, but I do recognize that hasn't been
24 shown in the data and the experience.

25 BOARD MEMBER HOLMES: Okay. What

1 percentage of your claims would you say are deemed
2 fraudulent and therefore recoverable?

3 THE WITNESS: That is not a number I
4 could quote. I know we have a special investigation
5 -- investigation unit team. And they monitor
6 irregular prescribing patterns or regular practices
7 patterns regularly. And they do when something --
8 when a provider is doing something that doesn't kind
9 of pass the sniff test, then we start to work towards
10 either suspending payment to them until it's
11 resolved, or even taking this -- taking information
12 to -- up the regulatory authority chain whether
13 that's insurance department in New York or actual
14 authorities such as police. That is part of the
15 goal.

16 I don't know the exact number. But
17 that is definitely -- we have an entire unit that
18 that's our goal, and I know that there are
19 recoverables every year as a result. I just don't
20 know that figure.

21 BOARD MEMBER HOLMES: And any efforts
22 made to increase those recoverables would actually
23 translate into lower premium growth; right? To the
24 extent that that's --

25 THE WITNESS: Yeah, it would be money

1 taken out of claim expense. That's correct.

2 BOARD MEMBER HOLMES: Any information
3 about, you know, that, would be helpful. And I guess
4 the last thing this is related to the Health Care
5 Advocate's questions and your testimony around the
6 fixed costs associated with the admin costs. And the
7 New York business and the Vermont business. And the
8 idea that despite the fact that MVP experienced 145
9 percent increase in membership in 2017 on this
10 Qualified Health Plan, the members don't seem to be
11 benefiting proportionately in the reduction of
12 administrative costs associated with that growth
13 because MVP as a whole experienced membership decline
14 in New York.

15 So I would love to see the numbers of
16 actually that per member per month admin cost could
17 be allocated differently. You know the -- such that
18 it's reflecting the fact that the Vermont membership
19 has increased and New York has decreased. What would
20 be the per member per month in that but for world if
21 it had been calculated accounting for the fact that
22 Vermont membership went up and New York membership
23 went down.

24 THE WITNESS: I'm not sure I'm
25 understanding -- just I think it would be

1 challenging. So you're asking for the variable
2 analysis or the fixed -- it's just -- so separating
3 out the costs of, you know, like I'll go back to the
4 claims processing unit or even like admin costs going
5 towards the online wellness tool that's managed by,
6 you know, those costs have to be spread across our
7 block of business.

8 BOARD MEMBER HOLMES: They don't have
9 to be spread evenly; right? They don't have to be
10 spread evenly. You could partition the Vermont
11 business and the New York business, attribute the
12 fixed costs in some way, and then adjust for the
13 membership changes. No?

14 THE WITNESS: I think -- most of the
15 fixed costs are shared both -- by both states. There
16 may be an item here or there. I'm not familiar off
17 the top of my head what exactly -- how that
18 allocation is split. But I think what you're getting
19 at would be like what is a Vermont-specific cost
20 versus a shared fixed cost; correct?

21 BOARD MEMBER HOLMES: Well I guess what
22 I would like to see is another methodology for
23 accounting for the fact that Vermont membership has
24 increased, and there should be some benefit in
25 administrative costs, you know, in the premium for

1 this year. So there must be a different way of
2 allocating fixed costs, attributing those fixed costs
3 in a way that accounts for that.

4 HEARING OFFICER HENKIN: You're asking
5 for those to be weighted?

6 BOARD MEMBER HOLMES: Yeah. I guess
7 so, to some degree weighted, yes. Thank you.

8 THE WITNESS: Okay.

9 BOARD MEMBER HOLMES: You can think
10 about it. If there is a follow up for that, that
11 would be great.

12 THE WITNESS: Okay. Thank you.

13 BOARD MEMBER USIFER: And I'll start
14 right where Jess's was ending there on administrative
15 costs and try to give you an example and use some
16 kind of round numbers.

17 So I think when we did the filing last
18 year the assumption was there was about 10,000 lives
19 that were going to be covered.

20 THE WITNESS: Yeah.

21 BOARD MEMBER USIFER: And roughly the
22 PMPM was \$40 per member. And we split that between a
23 fixed and -- a fixed and variable portion. And that
24 too was roughly 60/40. We can't say whether it was
25 50/50, but I think you guys had said before it was

1 about 60/40.

2 THE WITNESS: This -- it sounds right.

3 BOARD MEMBER USIFER: We actually had a
4 tremendous growth in Vermont, and we had 25,000
5 members come in under that plan. So if I did the
6 math, and these are kind of rough numbers, we would
7 have had about four and-a-half million dollars
8 generated by the PMPM for 10,000 members. And when
9 we -- if we then held the fixed and variable ratio
10 and just said that's what would have happened, we
11 would have then generated about 7.1 million dollars
12 from these plans.

13 However, since the number is fixed and
14 we used \$40, the plans last year actually generated
15 \$11.3 million versus the 7.1 million that would have
16 been done on a fixed variable ratio.

17 THE WITNESS: Okay.

18 BOARD MEMBER USIFER: To put that into
19 different terms, we had about \$40 of a PMPM, if I
20 held the fixed variable ratio and did that, it would
21 come down to \$26 per PMPM. And this is something we
22 had talked about last year about really getting the
23 synergies, there is only a certain amount of times
24 when you can get leverage from a growth in
25 membership. And now we head into the 2019, and on

1 the PMPM we are actually going up slightly. You
2 know, as a percent of premium it goes down because
3 premiums have gone up. But as a PMPM number, we are
4 continuing to see that go up.

5 And so a couple questions would be,
6 one, how -- what do you do with that excess that
7 occurred last year? Because I understand most
8 businesses aren't going to grow by 150 percent. So
9 going from 10,000 to 25,000 members, you know, we had
10 significant growth which generated over four million
11 dollars extra in the admin cost. You know, so how
12 are we get going to get this leverage? Because it
13 seems Vermont is not able to get that even in the
14 filing this year because you're talking about New
15 York losing members, and you know, and adjusting. So
16 kind of get your response and how do we deal with
17 this.

18 THE WITNESS: Yeah. I guess would be
19 to grow New York membership. It's the fact that most
20 of these fixed costs are shared by both states. If
21 the fixed costs were isolated to Vermont, then that
22 would be something that we would be able to pass on
23 to our Vermont premium rates. I know that going
24 forward it is always a goal of MVP's is to manage our
25 admin costs as low as possible because that's

1 something that helps us to promote a more affordable
2 premium rate.

3 Without being able to separate having a
4 claim operating system in Vermont for Vermont members
5 versus New York for New York members, most of those
6 -- those are some really big costs that we have, and
7 we can't really spread them to just Vermont or just
8 New York. It just wouldn't be sound in terms of
9 managing our admin costs. We would be short our
10 admin spend every year which would generate losses.
11 And it would hurt our solvency.

12 So it is our goal to manage costs down
13 as much as possible, but the only fixed costs that I
14 think we can really analyze in terms of Vermonters
15 will benefit from that growth, that 150 percent
16 growth that you referenced, is for the fixed costs
17 that are specific to Vermont which is not a
18 significant portion of our costs.

19 Most of our fixed costs are spread
20 across both states.

21 BOARD MEMBER USIFER: And I guess -- I
22 mean some disappointed that we are not seeing much of
23 a reduction, or we are not seeing a reduction at all
24 in the admin costs, and obviously that's going to be
25 something we will have to discuss as a board. Maybe

1 there is a way to get some of that back.

2 And when we look at CTR, you know, we
3 go the other way. So CTR you put in two percent
4 contribution to reserve against this business because
5 it's a growing business. And for your rest of New
6 York business it's 1.5. Yet what I'm showing for
7 this past year we put in four million dollars more in
8 -- somewhere into the world of MVP generating from
9 Vermont higher than maybe you should have gotten off
10 that business. So how do we think about that?
11 Because it kind of goes both ways; right? You're
12 generating a lot more people from Vermont which
13 generates a lot more fees.

14 Because what if Vermont had stayed at
15 10,000; right? And your business in New York had
16 gone down. You just would have ended up with less
17 money. We wouldn't have been covering that. Now you
18 got a bunch more from Vermont in total, and yet
19 you're bringing up your CTR as well.

20 THE WITNESS: I think if we were to
21 have lost members or stayed at 10,000 members in
22 Vermont, the admin would have been -- we would
23 propose the rates would actually had to have been
24 higher. So it's helping dampen the overall admin
25 increase that we are charging. I know it's not

1 something that you want to hear, but that is the
2 reality of it because of the fact that shared fixed
3 costs are shared amongst both states.

4 And I just want to clarify that only
5 our New York individual population would file a one
6 and-a-half percent CTR. We filed two percent for our
7 small group business. We recently filed the large
8 group rates which also reflects a two percent CTR.
9 That one and-a-half percent is only for individual
10 rates because we are expecting a decline in
11 membership as the individual mandate penalty is being
12 set to zero will impact us.

13 BOARD MEMBER USIFER: And is that
14 what's referred to in what New York had come up with
15 about saying that even though you requested two
16 percent, that it really -- when it says MVP Health
17 Plan assumed a profit of two percent based on the
18 information contained in the rate application, DFS
19 provides a profit ratio of 1.5 to be reasonable. Was
20 that across all markets or just across --

21 THE WITNESS: Just individual.

22 BOARD MEMBER USIFER: Just individual
23 market.

24 HEARING OFFICER HENKIN: What document
25 was that?

1 BOARD MEMBER USIFER: The last
2 document. C.

3 HEARING OFFICER HENKIN: They were not
4 admitted, I don't believe.

5 BOARD MEMBER USIFER: Okay. Just a
6 couple other questions. Do you know last year what
7 the impact of your filing from the hospital budgets
8 was?

9 THE WITNESS: Do you mean in terms of
10 what was our rate increase, or what was the trend
11 that we built into rates?

12 BOARD MEMBER USIFER: Well I guess the
13 thing is when you came here last year, when you're
14 talking about looking at the hospital budgets right
15 now as being known and potentially adding half a
16 percent increase, I think last year it was a
17 reduction. And the reason I say that is because when
18 you -- when we got your filing, right, we would have
19 said what was known was 6.1 percent. And we are
20 actually talking about somewhere around 3.8 percent
21 today for certain part of the market. And the
22 hospital budgets, yes, have been submitted. And if
23 we use that as known, it might generate an increase
24 in rates. But that's what they filed, and where we
25 actually end up will most likely be different from

1 that.

2 So, you know, just when we talk about
3 your recommendation on looking at the hospital
4 budgets.

5 THE WITNESS: Yeah. I think our
6 feeling is that if the hospital budgets are approved
7 as they were requested by the facilities, our rates
8 would need to be a half percent higher as a result.
9 To the extent that the rates -- the hospital budgets
10 are approved based on what was reflected in the
11 proposed rates, then it would be an actuarially sound
12 rate to not reflect that half percent.

13 BOARD MEMBER USIFER: Just a little
14 more on the individual mandate where you have two
15 percent in there. Do you know what plans those
16 people would have purchased? You know, we did have
17 yesterday in evidence from Blue Cross Blue Shield
18 that about 37 percent of the people that they expect
19 to drop were on bronze plans, and then, you know, 25
20 percent were on gold and platinum and the rest were
21 on silver.

22 Do you have any idea what plans those
23 people would be on?

24 THE WITNESS: We analyze member costs,
25 their annual allowed expenditures. And we didn't

1 necessarily bring in metal level to analyze level of
2 detail. Our general concept was if you're not
3 utilizing a lot of services, and you're paying
4 hundreds of dollars a month in premium, you're likely
5 to be someone that drops coverage regardless of
6 whether you're platinum, gold, silver or bronze.

7 This is purely an assumption on my
8 part. Healthier members tend to buy the bronze plan,
9 so I would assume a larger percentage would be bronze
10 than platinum, but that's just an assumption on my
11 part.

12 BOARD MEMBER USIFER: That's what we
13 are looking at, if the people are in the platinum and
14 gold plans are they really going to drop to nothing
15 if that's the plan that they had purchased?

16 THE WITNESS: Right.

17 BOARD MEMBER USIFER: And you also had
18 in your filing an additional cost for those plans
19 which was an increase in bad debt. And just
20 wondering why you did not assume that was in the two
21 percent that you had filed because you increased your
22 bad debt by .2 percent.

23 THE WITNESS: Yeah. Bad debt is used
24 to cover lack of premium payment. And with the
25 mandate penalty being set to zero, there is a grace

1 period. If you don't make the premium payment there
2 is a grace period where carriers still have to pay
3 for claims. Our assumption with the mandate penalty
4 being set to zero is that there is going to be an
5 increase in members at the end of the policy year to
6 drop coverage or to not pay premium.

7 So for example, you pay your first 10
8 or 11 months of premium, and then you're okay. Well
9 we are going to end up -- our benefits will reset on
10 January 1. So why bother paying the last one or two
11 months of coverage? We would still have to make
12 claim payments at that point, so to the extent that a
13 member like that had some sort of accident or
14 something tragic happen, MVP would still have to pay
15 for that claim even though there wasn't premium paid
16 for. And that's just what the increase reflects.

17 BOARD MEMBER USIFER: Just question
18 whether that's not included in the two percent
19 calculation in total when people -- when L&E and
20 other people were looking at it whether that would
21 have assumed those people that dropped from the
22 beginning and those people that may then kind of drop
23 during the course of the year.

24 THE WITNESS: Yeah. Our analysis at
25 2.2 percent figure did not assume that there was

1 going to be any kind of increase in the bad debt
2 allowance for truancy payment or lack of premium
3 payment. It's just an analysis of cost, claim cost
4 for lower members that are utilizing fewer services
5 than the average, that are paying more premium than
6 they are utilizing services.

7 BOARD MEMBER USIFER: And then lastly,
8 are you recouping the CSR cost for 2018 in your
9 rates?

10 THE WITNESS: No.

11 BOARD MEMBER USIFER: Okay. That's it.
12 Thanks.

13 HEARING OFFICER HENKIN: Robin.

14 BOARD MEMBER LUNGE: Hi, Mr. Lombardo.

15 THE WITNESS: Hello. How are you?

16 BOARD MEMBER LUNGE: I'm good. Thank
17 you. I was noticing in your CV that part of your job
18 responsibilities include assisting in developing
19 corporate strategic initiatives and managing
20 intelligence. Your CV is in tab 12 if one needs to
21 take a look at that.

22 I was wondering if you could talk a
23 little bit about what kind of market research you
24 might do.

25 THE WITNESS: The actuarial team we

1 analyze competitor rate filings to understand our
2 premium position. So for example, the Vermont Health
3 Connect filings are available on the rate review
4 website. So once those are posted, we analyze our
5 premium position based on where we are in 2018, when
6 we posted on May 11 or May 12, compared to where we
7 expect to be in 2019 on the proposed rates.

8 Once a final decision is made in a few
9 weeks, we will update that analysis to reflect our
10 final approved premium position. And then we
11 coordinate with our marketing communications team to
12 try to coordinate efforts towards where are we
13 concerning the members that we currently enrolled
14 that we may lose because our premiums are not as
15 competitive, or opportunities that exist because our
16 premium position has improved.

17 BOARD MEMBER LUNGE: And do you do any
18 or hire any consultants to do market research, or is
19 that an in-house activity?

20 THE WITNESS: From an actuarial -- from
21 a competitive premium position?

22 BOARD MEMBER LUNGE: Yes.

23 THE WITNESS: That's not something that
24 we outsource. Whether it's market intel on consumer
25 behaviors, that would be something that is not

1 handled by the actuarial department. I know that
2 there are studies done that are outsourced. I
3 understand utilization patterns, what are best
4 practices, how do we navigate care in a correct
5 manner. What do members want, what drives purchasing
6 decisions. Those are items that we do analyze that
7 helps inform our product designs.

8 BOARD MEMBER LUNGE: I see. Yeah.
9 Thank you. In response to Member Usifer's question
10 you indicated that in your individual mandate
11 analysis you didn't look to the level of the metal
12 level, is that right?.

13 THE WITNESS: Yes.

14 BOARD MEMBER LUNGE: And the individual
15 mandate adjustment, if you will, you do that prior to
16 other membership change adjustments, like for
17 example, cost sharing reduction.

18 THE WITNESS: We are not assuming any
19 membership -- we are only assuming membership shifts
20 in the calculation of the Cost Sharing Reduction.
21 Yes. So to your point, we are not reflecting who's
22 going to drop coverage, so we are not loading up the
23 CSR amount additionally for healthier members that
24 were enrolled in CSR dropping coverage.

25 BOARD MEMBER LUNGE: Okay. I believe

1 in your filing you indicated that you were expecting
2 for an individual with a subsidy that your bronze
3 plan would have a near zero premium.

4 THE WITNESS: Based on the proposed
5 rates, that's what we are assuming.

6 BOARD MEMBER LUNGE: Thank you. Also
7 related to the bad debt assumption, it's your
8 testimony that that's based on assuming that people
9 will stop paying towards the end of the year.

10 THE WITNESS: I said uh-huh. Yes.

11 BOARD MEMBER LUNGE: Yes or no. So it
12 was a clarification. Are you aware that currently
13 prior to the time the penalty was zeroed out that an
14 individual with up to three months of uncovered
15 wasn't charged a penalty?

16 THE WITNESS: I was aware that there
17 was a two to three-month grace period. Yes.

18 BOARD MEMBER LUNGE: Okay. Thank you.
19 Got to go back to my tabs. So bear with me. In your
20 filing, this is on page 35. I just want to clarify
21 what a particular term means.

22 In the summaries experience period
23 non-fee-for-service and capitation amount there is a
24 line that says chiropractic and acupuncture cap. Is
25 that the copayment limitation in Vermont law, or is

1 that something different?

2 THE WITNESS: Our chiropractic and
3 acupuncture services are provided from an outside
4 vendor, and it's a capitated arrangement, so we pay
5 them an amount per month up front regardless of how
6 many services are utilized.

7 BOARD MEMBER LUNGE: Got it. Thank
8 you. I just wanted to clarify what that actually
9 was. And then on page 80 you have a description of
10 some of the capitation and non-fee-for-service
11 medical costs, and those would include, I believe,
12 the Blueprint payments. Page 80. It's the third
13 paragraph.

14 THE WITNESS: Yes. That's correct.

15 BOARD MEMBER LUNGE: And it also
16 includes physician incentive payments. Could you
17 explain what those are, please?

18 THE WITNESS: There are times when we
19 have contracts in place that a physician meets
20 certain metrics in the contract, then there would be
21 a bonus payment provided to them. Maybe that's a
22 quality measure. Certain number of members having a
23 blood pressure screening or certain services such as
24 that.

25 Those figures come into -- our

1 financing handles those costs, and to the extent that
2 those costs are continuing in the future, then we
3 reflect that additional cost in our rates.

4 BOARD MEMBER LUNGE: Got it. To your
5 knowledge are those incentives primarily tied to
6 quality measures or are they tied to other types of
7 incentives?

8 THE WITNESS: I'm not overly familiar
9 with exactly what is tied -- how those incentive
10 payments are achieved.

11 BOARD MEMBER LUNGE: Okay.

12 THE WITNESS: My understanding has been
13 that it's a quality-based metric.

14 BOARD MEMBER LUNGE: If it's possible
15 to get more information on that, that would be
16 helpful. Would be helpful to see what kind of
17 quality metrics you're linking that to. Give me one
18 more minute. Checking. Some of my questions have
19 been asked, so I can go through the tabs.

20 In Exhibit 7 on page three these are
21 the responses from July 6. You have projected
22 members based on rate filing assumptions, and you
23 show individual agency only and individual 73 CSR in
24 terms of your projections around where they will
25 move. And you indicate non-silver APTC plans.

1 Do you have any sense of expectations
2 about whether people -- how many of these will be
3 buying up versus buying down? So buying up to gold,
4 for example, or down to bronze?

5 THE WITNESS: It's in our rate filing.
6 We are just -- so I guess we are not making specific
7 assumption about where they will go.

8 BOARD MEMBER LUNGE: Okay.

9 THE WITNESS: That's a subscriber-
10 dependent decision. And we think they will be based
11 on their health care utilization and what they
12 anticipate to actually spend on health care services
13 in the future. We are working with our marketing
14 communications team to direct the members that are in
15 the 73 and 77 percent plans or individual APTC that
16 are in silver plans towards a better benefit, whether
17 it's through a lower premium rate or a richer benefit
18 at a lower premium rate.

19 BOARD MEMBER LUNGE: And will you be
20 doing that through direct mailings, phone calls? Can
21 you talk a little bit more about the outreach efforts
22 if you know what the plan is?

23 THE WITNESS: At this point we are
24 still kind of --

25 BOARD MEMBER LUNGE: Developing.

1 THE WITNESS: Developing our strategy,
2 and how we are going to market and communicate that
3 it is definitely something that's very important to
4 us. We understand if we can -- I mean my general
5 feeling is if we weren't doing that, we would be
6 doing a disservice to our members. We should be
7 directing them into the right plan, and that's how
8 you build up trust and hopefully a good, long-term
9 experience for our members so --

10 BOARD MEMBER LUNGE: Thank you. You're
11 not intending -- it doesn't sound like -- to do
12 anything like auto enrollment or any sort of specific
13 mapping for members to plans in your outreach
14 efforts.

15 THE WITNESS: At this point, you know,
16 we are focused on the members that will benefit from
17 the APTC increase and trying to just guide them to
18 the right decision-making process. And you know, I
19 know that we are engaged in helping enroll members
20 through the individual mandate penalty being set to
21 zero. That's something we are hoping to retain as
22 many of those members as possible.

23 BOARD MEMBER LUNGE: Related to the
24 individual mandate what's your company's -- what was
25 your company's position, if you know, on the state

1 individual mandate?

2 THE WITNESS: I know Susan Gretkowski
3 participated in that. We supported it because we
4 think that members -- the community will be healthier
5 and members will be healthier if they are enrolled in
6 a health insurance plan. Peace of mind.

7 BOARD MEMBER LUNGE: Do you know
8 whether your company provided any information to the
9 legislators about the impact of the delayed date to
10 2020 on premiums?

11 THE WITNESS: I'm not familiar with
12 what kinds of information has been shared.

13 BOARD MEMBER LUNGE: If that's possible
14 to follow up on, that would be great. And then one
15 last area I wanted to talk about, which is you had
16 mentioned in response to Member Holmes' questions
17 around One Care Vermont and the APO program that some
18 of your -- that you are participating in value-based
19 payments in New York and Medicaid and in some
20 commercial plans. Do you know what programs you're
21 participating in in New York?

22 THE WITNESS: In New York there is
23 actually a road map for Medicaid.

24 BOARD MEMBER LUNGE: Yeah, I'm
25 familiar.

1 THE WITNESS: So we are working towards
2 achieving those targets. Effectively the -- there is
3 a penalty attached to not meeting those targets
4 through a reduction to Medicaid managed care premium
5 rates that are provided. So if you don't
6 participate, there is certain thresholds for each
7 year. So in 2019, if there is level one, two and
8 three arrangements. Level one is the carriers and
9 the care on the down side. Level two, there is a
10 shared risk arrangement between carriers and the
11 provider system. And level three is just a full
12 capitation almost like the old west coast Kaiser
13 model where you would pay the physician a set
14 capitation rate, and they manage the care and are at
15 risk for managing the costs down below that
16 capitation rate.

17 So we are on pace to meet those road
18 map targets for 2019 and 2018 at this point. And we
19 are engaged with providers to expand those efforts,
20 and I know we are also engaged with One Care to have
21 conversations about entering into that arrangement
22 with them. The structure and the terms of that
23 arrangement I'm not sure of what's been discussed,
24 but that is something I'm aware that there have been
25 conversations.

1 BOARD MEMBER LUNGE: And do you know
2 which level you are currently participating in in
3 2018? Level one, two or three as you described?

4 THE WITNESS: We have arrangements at
5 all three. Well we have arrangements at level one
6 and level two. And we are working towards a level
7 three arrangement, but it hasn't been finalized yet.

8 BOARD MEMBER LUNGE: Okay, great.
9 Thank you. I have nothing further.

10 HEARING OFFICER HENKIN: Member Pelham.

11 BOARD MEMBER PELHAM: Thank you. Thank
12 you. So I'm new here. I'm a relatively new member
13 of the board. And this is my first rate setting
14 process, and so I've kind of gone back to the basics
15 where my fellow board members are way ahead of me,
16 but just to kind of sort through how this process
17 relates to premiums that Vermonters actually face
18 after they go through the Vermont Health Connection
19 calculator.

20 THE WITNESS: Okay.

21 BOARD MEMBER PELHAM: So I took -- and
22 I think the Appendix form, attachment form, is the
23 one called Rate Increase Exhibits 2018, 2019, which I
24 think is this teeny print one that you were looking
25 at earlier. You don't have to look at it now, but

1 the print was pretty tiny. But I pulled out the
2 magnifying glass and just tried to get a feel for
3 what the premiums that we are talking about now, at
4 the end of this process, and before we go into the
5 Vermont Health Connect calculator process, how this
6 all flows.

7 And so if you take -- and I did this
8 for 2018 because the 2019 calculator isn't up and
9 running yet.

10 THE WITNESS: Yes.

11 BOARD MEMBER PELHAM: Just to get a
12 feel for it if you take your 2018 bronze standard
13 plan at \$850 a month for a couple, which is \$41,150,
14 250 percent of poverty, the resulting premium as a
15 percent of income is 24.8 percent. And for a family
16 plan again at 250 percent of poverty which is family
17 of four, 62,750, which is 22.8 percent of poverty.

18 A couple silver plans in the 250
19 percent of poverty, it's 21 percent for a couple.
20 It's 31 percent for a family of four. It's 28
21 percent. And then we kind of get off the subsidy
22 grid so those are kind of hard numbers, harder
23 numbers. At 400 percent of poverty the premium for a
24 standard silver plan is 19 percent, and for a family
25 of four it's 17.8 percent. So that's what we're

1 talking about here. And I'm just wondering whether
2 or not -- and to me it underscores how important the
3 subsidies are of this process. Do you think these
4 kinds of percent of incomes are affordable?

5 THE WITNESS: I would just like to
6 address the premium subsidy and how that's actually
7 calculated. So for a double contract which is like a
8 two spouses, if you're eligible for a subsidy I think
9 it's important to understand the premium rate for a
10 double contract is two times the single rate. So
11 it's a 100 percent increase. But if you're looking
12 at the federal poverty level, it's only, I think it
13 goes from about \$12,000 to like \$16,000. So 33
14 percent increase from one to two people. The premium
15 -- the way that the premium subsidy is computed is
16 based on a percentage -- a maximum percentage of out
17 of pocket of your income.

18 The fact that there is a disconnect in
19 the increase in the poverty level versus the premium
20 rate as you go from a single to a double or a family
21 contract, is an issue that is going to always make
22 those rates seem unaffordable for a double or a
23 family contract holder unless you exceed -- your
24 family contract holder and you exceed a certain
25 number of members of your household. That's actually

1 the only way to offset that impact.

2 So fundamentally because APTCs are
3 determined based on the Affordable Care Act language,
4 I believe you would actually have to have a change in
5 either the contract tier structure that you're
6 offering in Vermont, if you did that, and you were to
7 make it so it was aligned with from single to double
8 it was more well aligned, the challenge would be that
9 you would have to then add more to your single rates.
10 So your single rates would go up substantially, and
11 it would actually help mitigate that impact that
12 you're talking about right now.

13 BOARD MEMBER PELHAM: I do understand
14 that it gets very complicated, because as we moved to
15 the calculator and with the advanced premium tax
16 credit, it's actually a winner for some people to
17 allow them to maybe save money and go down to a
18 bronze plan or buy up to a higher plan. So --

19 THE WITNESS: Yeah.

20 BOARD MEMBER PELHAM: But I think my
21 question is more pointed in this ball park of, you
22 know, 21 to 28 percent just based on this process.
23 I'm not being critical here. I'm assuming maybe this
24 is a perfect calculation, a perfect world, it's just
25 the nature of the underlying cost of health care

1 including the cost shift. And that's something we
2 don't talk about.

3 But in these recommendations are
4 mitigating the cost shift from say Medicare,
5 Medicaid. Would you agree with that?

6 THE WITNESS: Yeah. I mean cost
7 shifting between from -- cost shifting of costs
8 between Medicare, Medicaid and commercial definitely
9 does have an adverse impact on commercial premium
10 rates.

11 BOARD MEMBER PELHAM: And in the
12 actuarial process we are not measuring that as a
13 discrete pressure, but it's definitely built into
14 utilization and trends and the pricing of health
15 care.

16 THE WITNESS: Yeah. It would be -- we
17 are reflecting our best estimates or our known and
18 assumed unit cost increases. And our utilization
19 trend in this filing for medical costs is actually
20 zero, as you know. So we are not assuming an
21 increase in the utilization in our rates. We are
22 just reflecting our best estimate of unit cost
23 increases.

24 We are doing our best to try to
25 negotiate costs down, but cost shifting when

1 providers and hospital are feeling pressure in a
2 reduction -- in form of a reduction and fee schedule
3 Medicare or Medicaid business, they are trying to
4 manage their admin costs, what we have discussed
5 earlier, and that it's sometimes creating pressure on
6 commercial rates.

7 To the extent that the Green Mountain
8 Care Board approved rate increases aren't reflecting
9 any kind of cost shifting, you know, for our Vermont
10 providers which is a large portion of our
11 utilization, then that's not reflected in rates.

12 BOARD MEMBER PELHAM: And then I took
13 some of your 2018 rates and then ran them through the
14 2018 calculator at Vermont Health Connect. And you
15 can see dramatic shift toward affordability that most
16 of the bronze plans according to say a standard, the
17 ACA standard are affordable. And then as you kind of
18 move up the middle ladder, they get less and less
19 affordable, but it makes a big effect.

20 So in this last legislative session
21 there were a couple of issues, there were three
22 issues that I've heard of that kind of affect the
23 situation. One was changes in cost sharing for
24 chiropractic services and for breast cancer screening
25 services. Did MVP participate in those deliberations

1 in the legislature? I understand you're an
2 actuarial, you may need to look over your shoulder
3 here, but do you know whether or not MVP participated
4 in those discussions with the legislature?

5 THE WITNESS: Yeah. I'm pretty
6 confident that Susan Gretkowski, our government
7 affairs employee for Vermont, she is involved in all
8 those kinds of conversations. I know that we did do
9 an analysis, and we are not adding to our costs for
10 these two changes. One reason is the chiropractic is
11 a capitated arrangement, so there shouldn't be an
12 impact as of right now on our costs. The breast
13 cancer mandate. We are hoping that that will help
14 manage costs overall. And we are not actually
15 building in any increase for that mandate.

16 BOARD MEMBER PELHAM: I'm not asking
17 you to either. But so in this same legislative
18 process there is an appropriations bill that was
19 approved in the special session. And there are the
20 appropriations for the state's share of the Vermont
21 premium-assisted program and the cost sharing
22 reductions that are funneled in the calculator and
23 help make your product more affordable to Vermonters.
24 And you know, these are entitlements, as I understand
25 it, but the legislature still has to appropriate

1 money for it.

2 And are you aware that the legislature
3 for 2019 appropriated a slightly lower amount than
4 they did for 2018 for these two subsidies?

5 THE WITNESS: Are you speaking to the
6 73 and 77 percent cost sharing subsidy?

7 BOARD MEMBER PELHAM: The Vermont
8 premium assistance which tracks the advanced premium
9 tax credit and the Cost Sharing Reduction.

10 THE WITNESS: I'm not aware of that.

11 BOARD MEMBER PELHAM: It's -- and I
12 think as Robin and I have discussed because it's an
13 entitlement, this state has to pay it anyhow. So the
14 actual amount can be fixed in the appropriations
15 bill. But it does seem to be a pattern of growth
16 every year. And then this year it went slightly in a
17 different direction.

18 But another major to me, as a former
19 state budget guy, area of opportunity maybe here, is
20 the Human Services case load reserve. Are you
21 familiar with the Human Services case load reserve?

22 THE WITNESS: No, I never heard that.

23 BOARD MEMBER PELHAM: Well it's -- I'm
24 trying to be fast here.

25 HEARING OFFICER HENKIN: Try to be

1 relevant too.

2 BOARD MEMBER PELHAM: This is quite
3 relevant too. So the Human Services case load
4 reserve was created back in the '90s to kind of set
5 aside money for recessions, when a recession occurs,
6 and it's under the Human Services programs. And
7 this last session there was some statutory changes to
8 that reserve language, and I would like to just read
9 you one of them.

10 THE WITNESS: Okay.

11 BOARD MEMBER PELHAM: Which is: Within
12 the reserve sub account for Medicaid-related
13 pressures relating to case load utilization changes,
14 changes in federal participation, could be the
15 individual mandate, in existing Human Service
16 programs and settlement costs associated with
17 managing the global commitment waiver.

18 So the funds set aside in this general
19 fund reserve are available, in part, to address these
20 types of issues which we are here to discuss today.
21 But the more important part is that the balance in
22 that reserve in 2018 was 22 million dollars. And the
23 balance in 2019 at the Joint Fiscal Office, and the
24 state budget people project is going to be a hundred
25 million dollars. And of that 14 million dollars is

1 designated toward this language.

2 So I'm just wondering that as others on
3 the board work to mitigate issues and complications
4 in this filing, like the individual mandate, would
5 you folks be amenable to kind of pursuing maybe an
6 incentive for -- to keep people insured through this
7 year of transition or other types of remediation
8 given the fact that the legislature doesn't have to
9 reconvene to spend this money. It can be
10 appropriated by the act of the emergency board which
11 is the Governor and the two House and Senate
12 legislators of the legislature.

13 THE WITNESS: Yeah. I'm not too
14 familiar with how those appropriations can be
15 utilized. Whatever is permissible within legal
16 grounds, I think, and will help maintain coverage for
17 Vermonters, MVP is definitely happy to try to
18 participate in any way that can retain members over
19 time. I don't know if we are permitted to supply any
20 type of incentive. That would be something I would
21 defer to our legal team for.

22 BOARD MEMBER PELHAM: Thank you.

23 HEARING OFFICER HENKIN: Are we done
24 with this witness?

25 MR. KARNEDY: I believe we are.

1 HEARING OFFICER HENKIN: Okay. Let's
2 take a short lunchtime, about 5 minutes until 1.
3 Everybody start. Five minute break.

4 (Laughter)

5 HEARING OFFICER HENKIN: Getting back
6 right before 1, and we will get done.

7 (Recess was taken.)

8 HEARING OFFICER HENKIN: Okay. I think
9 we are ready to go. We can go back on the record.
10 We can move ahead, and the Department of Financial
11 Regulation has testimony.

12 MR. LUSSIER: Good morning everyone.

13 HEARING OFFICER HENKIN: It's
14 afternoon.

15 MR. LUSSIER: Is it? Okay.
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1 JESSE LUSSIER

2 Having been duly sworn, testified
3 as follows:

4 THE WITNESS: Good afternoon. My name
5 is Jesse Lussier. I work for the Department of
6 Financial Regulation. I'm a Certified Public
7 Accountant. I have been with the department since
8 2011. I am involved in all aspects of financial
9 examination and analysis. Commissioner Piacek
10 yesterday kind of gave a high level summary of what
11 we do in terms of solvency. So if it's okay with
12 everyone, I would like to just skip that to save
13 time. Is that all right?

14 HEARING OFFICER HENKIN: You're self
15 driving, so go right ahead.

16 THE WITNESS: I would like to just give
17 a brief statement on insurance regulation in the U.S.
18 generally speaking. In the U.S. insurance is
19 regulated on a state-by-state basis. So that is
20 every state is responsible for their own insurance
21 companies that are domiciled within that state.

22 (Telephone interruption)

23 HEARING OFFICER HENKIN: I am assuming
24 that that is Kevin Ruggeberg from L&E who is one of
25 the actuaries, primary actuary on this, and he's

1 calling in on the line. And it is a public hearing
2 so --

3 MR. RUGGEBERG: That's correct.

4 THE WITNESS: Good afternoon. As I was
5 saying, every state is responsible for the insurance
6 companies that are domiciled within their state. And
7 as we have discussed before and as Matt alluded to,
8 New York is the primary regulator for MVP. New
9 York's examination and analysis procedures should be
10 substantially similar to that of Vermont and to all
11 other states in accordance with NAIC guidelines and
12 rules. And Vermont relies on New York to notify us
13 if there are any solvency concerns with any of the
14 companies in their state.

15 So now if I can just give a brief
16 overview of the solvency opinion. It looks very
17 similar to the previous opinion. The two main
18 factors are because MVP's a relatively small
19 footprint in Vermont, as Matt already discussed, and
20 New York has not expressed any solvency-related
21 concerns to us at this time, Matt read the summary
22 and the opinion, but just to reiterate, the
23 department believes that the rates as filed will
24 sustain MVP's solvency, and that adjustments should
25 not be made unless they are deemed to be actuarially

1 inadequate.

2 I'll also echo what Matt said that the
3 department believes that any block of business should
4 stand on its own. That means that premiums should be
5 for paper claims and related expenses. And that's
6 all I have to say. I'll open it up to questions.

7 MR. KARNEDY: Good afternoon, Jesse,
8 how are you?

9 THE WITNESS: Good afternoon. Good,
10 thank you.

11 CROSS EXAMINATION

12 BY MR. KARNEDY:

13 Q. So if you would, you were just representing --
14 turn to Exhibit 10. Do you have a binder in front of you?
15 It's a copy of your solvency letter.

16 A. Okay.

17 Q. And that's dated July the 10th; correct?

18 A. Correct.

19 Q. And I think you basically just said you've
20 adopted this as your testimony on behalf of DFR; correct?

21 A. Correct.

22 Q. On page one, the summary of the opinion, would
23 you read that sentence, please, under summary of opinion?

24 A. "MVPHP currently meets Vermont's financial
25 licensing requirements for a foreign insurance -- for a

1 foreign insurer, and DFR believes the proposed rate will
2 sustain MVPHP's solvency."

3 Q. And you stand by that; correct?

4 A. Correct.

5 Q. And would you please go to the next page, and
6 there is a heading that says: "MVPHP Solvency Opinion."
7 Let me know when you're there.

8 A. Okay.

9 Q. And would you read, please -- I don't -- I was
10 trying to save time. But I think it's important so the
11 board can understand my question.

12 Can you read the whole paragraph please?

13 A. "DFR is not MVPHP's the primary solvency
14 regulator, but it does require MVPHP to meet Vermont's
15 foreign insurer requirements. Currently MVPHP meets these
16 licensing requirements. Further, DFR has not learned of
17 any solvency concerns from the New York Department of
18 Financial Services, MVPHP's primary solvency regulator.
19 Finally, in 2017, all of MVP Holding Company's operations
20 in Vermont accounted for approximately 2.9 percent of its
21 total premiums written. Thus, DFR has determined that
22 MVPHP's Vermont operations pose little risk to its
23 solvency. Nonetheless, adequacy of rates and contribution
24 to surplus are necessary for all health insurers in order
25 to maintain strength of capital that keeps pace with

1 claims trends."

2 Q. Thank you. So what you're saying there is
3 that even though Vermont has a smaller percentage of MVP's
4 total premium, you still look at its Vermont premium in
5 this rate filing to determine adequacy; correct?

6 A. Correct.

7 Q. And when it comes to solvency, do you believe
8 it's a good idea to kick the can down the road to later
9 years and perhaps have a lower contribution to reserves in
10 one year of say one percent with the hope that you could
11 simply have a contribution of three percent the next year
12 to catch up if you're wrong?

13 A. No.

14 Q. Would you please read the paragraph under
15 "Impact of the Filing on Solvency," please.

16 A. "Based on the entity-wide assessment above and
17 contingent upon Green Mountain Care Board actuary's
18 finding that the proposed rate is not inadequate, DFR's
19 opinion is that the proposed rate will likely have the
20 impact of sustaining MVPHP's current level of solvency."

21 Q. I have to go back and ask you about my kick
22 the can question I just asked a moment ago. You said no.
23 Why?

24 A. Can you repeat the question?

25 Q. Sure. When it comes to solvency, do you

1 believe it's a good idea to kick the can down the road to
2 later years, perhaps have a lower contribution in one year
3 of say one percent with the hope that you can simply have
4 a contribution of three percent the next year to catch up?

5 A. No. As I stated before, the department
6 believes any block of business should be adequate, should
7 have actuarially sound rates.

8 Q. Okay. This letter of July 10th was based on
9 MVP's original filing in May; correct?

10 A. Correct.

11 Q. And MVP sought a two percent contribution to
12 reserves which DFR has found to be adequate; correct?

13 A. Correct.

14 Q. And you heard testimony here today from MVP?

15 A. Correct.

16 Q. And you heard Matt testify that based on L&E's
17 recommendations, MVP has reduced it's average rate
18 increase proposal from 6.4 to 4.6. Did you hear that
19 testimony?

20 A. Yes.

21 Q. And the explanations around that.

22 A. Yes.

23 Q. Do you have an opinion that a 4.6 rate
24 increase will likely have the impact of sustaining MVP's
25 current level of solvency?

1 A. Yes. Assuming that my understanding was
2 accurate in that the Care Board's L&E and MVP agreed on
3 certain changes to the rate; is that correct?

4 Q. Let me ask a more direct question because they
5 agreed on some things. They didn't agree on others. 4.6
6 percent, do you have an opinion at 4.6 percent rate
7 increase will likely have an impact of sustaining MVP's
8 current level of solvency?

9 A. Yes, assuming those rates are adequate.

10 MR. KARNEDY: Thank you very much.

11 MR. ANGOFF: No questions.

12 BOARD MEMBER USIFER: I have questions.

13 HEARING OFFICER HENKIN: Members of the
14 board? Let's start with you for today, this
15 afternoon.

16 BOARD MEMBER USIFER: I just had a
17 question on you talked about the book of business
18 would stand on its own. And talking obviously of the
19 CTR of two percent. You were here when I was talking
20 before about the administrative costs, and if we look
21 at just this book of business, not dealing with the
22 rest of their world, assuming for sake of argument
23 that claims were all covered under the claims area.
24 When we look at the admin expense, it should have
25 generated about four million dollars more than their

1 variable costs would have warranted if we did it
2 based on their math.

3 And so under this book of business that
4 four million would then drop to profits, per se. How
5 do you think about that as far as then relative in --
6 this business it's about 150 million dollars; right?
7 Of written policy. A little bit less. So a two
8 percent CTR is three million. They generated four
9 million extra on this business in '18.

10 Just looking at this, not worrying
11 about the fact that the rest of their business may
12 have had less membership.

13 THE WITNESS: I guess when you say
14 extra income, I'm not exactly sure what that means.
15 It's more of a complex question I think from a
16 solvency perspective, because I would want to see --
17 we are just taking this filing and talking about
18 income as it gets generated on this, I would want to
19 see also other factors such as if the number of
20 insureds increased and how that would affect surplus
21 supporting the underlying lives. So it depends.

22 BOARD MEMBER USIFER: Okay. Thanks.

23 CHAIRMAN MULLIN: So you talked about
24 reciprocity between states as far as regulation of
25 the adequacy of the reserves. Do you have any

1 concerns as a regulator about the way New York
2 calculates reserves?

3 THE WITNESS: No. I have no concerns.
4 They haven't expressed any concerns to us.

5 CHAIRMAN MULLIN: Thank you.

6 HEARING OFFICER HENKIN: Tom? Nothing
7 else. Congratulations. Very nice to see you and
8 hear from you. Thank you very much.

9 MR. BOYLES: Thank you.

10 HEARING OFFICER HENKIN: Next our staff
11 Attorney Sebastian Arduengo will be leading the
12 direct examination of actuary Jackie Lee. And
13 Jackie, you were here to get sworn in, I believe.

14 MS. LEE: Yes, I was sworn.
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1 JACKIE LEE

2 Having been duly sworn, testified
3 as follows:

4 DIRECT EXAMINATION

5 BY MR. ARDUENGO:

6 Q. Good afternoon, Jackie.

7 A. Good afternoon.

8 Q. We did a lot of this with Dave yesterday --

9 A. Yes.

10 Q. -- but so for that reason, we are going to go
11 through this first part pretty briskly.

12 Could you tell everyone who you are?

13 A. I'm Jackie Lee.

14 Q. And where are you employed?

15 A. I'm employed at Lewis & Ellis.

16 Q. And what is Lewis & Ellis?

17 A. Lewis & Ellis is a consulting firm based in
18 Allen, Texas.

19 Q. And what business is Lewis & Ellis primarily
20 engaged in?

21 A. Primarily engaged in actuarial consulting to
22 all types of insurance; health, life and property and
23 casualty. We do have some other smaller lines for
24 compliance.

25 Q. Okay. And what is your educational

1 background?

2 A. I graduated from Texas Lutheran University
3 with a bachelor's of science in mathematics. And I've
4 taken the exams as well from a professional standpoint, so
5 I'm also a fellow of the Society of Actuaries and a member
6 of the American Academy of Actuaries.

7 Q. How long have you been an actuary?

8 A. I have been an actuary for over 15 -- I have
9 been working in the actuarial field for over 15 years. I
10 have been a credentialed actuary for a little over 10.

11 Q. How long have you been retained by the board
12 to provide actuarial services to the State of Vermont?

13 A. Since 2014.

14 Q. And in that time how many Vermont health
15 insurance rate filings have you worked on?

16 A. I worked on every single one that has come
17 through the Green Mountain Care Board, and I think it was
18 a little over 60.

19 Q. And in what market segments have those rate
20 filings been?

21 A. They have been in the QHP segments as well as
22 small group and large group.

23 Q. So you would say that you're quite familiar
24 with the Vermont health insurance marketplace then?

25 A. Yes.

1 Q. Do you work on health insurance rate filings
2 in other states?

3 A. Yes.

4 Q. How many would you say?

5 A. Lewis & Ellis is currently contracted with
6 eight to review for the QHP filings effective 1/1/19.

7 Q. And in your work with other states do you do a
8 comparative look at the nationwide health insurance
9 market?

10 A. Yes. The states are varied throughout the
11 country, and so we get to see a wide range of the various
12 rates, the rate practices, and also just some of the
13 different -- how the different states handle their role as
14 far as an effective rate review.

15 Q. What do you do in your work to keep up with
16 changing health care reform issues?

17 A. Well we do a good job at Lewis & Ellis because
18 we work with so many states. I personally also volunteer
19 a lot with our society. I co-wrote an article for a
20 strategic initiative for the Health Section Council on the
21 individual mandate. I'm also currently the secretary and
22 treasurer for the council itself, so I'm on the leadership
23 team there and on the track to become the chair of the
24 health section for the entire actuarial community.

25 Q. You've kept up well with the changing

1 regulatory landscape and the health insurance market?

2 A. Yes. A lot of our continuing education also
3 promotes that. There are a lot of actuaries that put a
4 lot of time in that. So it's -- I'm part of that driving
5 force. But also we have got a community within our
6 actuarial world to help keep us up.

7 Q. So generally speaking how is the health
8 insurance rate filing reviewed?

9 A. Generally speaking, we have a lot of guidance
10 that we have to follow. We have got state regulations.
11 We will have guidance from the federal government as well
12 such as instructions. And our profession also has
13 guidance through actuarial standards of practice and
14 sometimes practice to help us formulate how we go about
15 reviewing and pricing health plans.

16 Q. And what's the process for reviewing a Vermont
17 rate filing in particular?

18 A. So we have three credentialed actuaries that
19 work on every filing. We keep them consistent from filing
20 to filing by carrier so that we can become familiar with
21 what's happening with the carrier.

22 So for this filing and all MVP filings we have
23 Kevin Rugeberg who is a society -- in the Society of
24 Actuaries. He is the primary reviewer so he gets on SERFF
25 and holds down the filing and has correspondence with the

1 carrier itself.

2 Q. Could you briefly explain what SERFF is?

3 A. Sure SERFF is the platform in which we
4 communicate through rate filings, and so a carrier can
5 file their rates that way and forms, and most states use
6 that as a platform to get their information.

7 Q. Do you do any peer review in your work at L&E?

8 A. Yes. I peer reviewed Kevin's work, and then
9 Dave who works on the Blue Cross filing as well also peer
10 reviews the work so that we are consistent across both --
11 we try to be as consistent as possible between both
12 carriers on their practices in Vermont.

13 Q. And when you review a filing are you
14 performing an independent analysis and calculation, or are
15 you just checking whatever calculation or assumption you
16 received from the companies?

17 A. That answer depends on the assumption we are
18 reviewing. If the assumption is large enough where the
19 great impact associated with that assumption is large
20 enough, then we will do an independent review on our own.
21 If the company has methodologies or process in place
22 either for smaller or even sometimes larger, we will in
23 addition review what they have performed to see if there
24 are any flaws in their methodology or the numbers that
25 they have used for those assumptions.

1 Q. And do you have a process for getting
2 additional information from the company if you need it?

3 A. Yes. We usually put together an inquiry
4 letter, and in SERFF, the system that I talked about,
5 making sure that the carrier's aware that there is a
6 letter. And we ask questions, and generally they respond
7 within a week or sometimes a tighter time frame depending
8 on where we are in the process.

9 Q. And did you do that with this filing?

10 A. Yes.

11 Q. And how long do you have to review a filing
12 from the time it's submitted to the board?

13 A. We have 60 days to provide a formal report to
14 the board.

15 Q. And is it your understanding that that's a
16 statutory deadline?

17 A. Yes. It is.

18 Q. Are you familiar with the filing that's under
19 review here today?

20 A. Yes.

21 Q. Did you write an actuarial report with respect
22 to that filing?

23 A. Yes. We did.

24 Q. I believe that report is Exhibit 11 of the
25 binder. Could you turn to that, please?

1 A. Yes.

2 Q. On page two of the report is a standard of
3 review. Is this your standard of review, or is it the
4 board's standard of review?

5 A. This is the board's standard of review for our
6 work.

7 Q. What is your standard of review?

8 A. Well we comply with what the board has
9 requested on us, plus we use our actuarial standards and
10 practice to supplement that. But our standard of review
11 is to determine if the rates are actuarially sound.

12 Q. Are there terms that are in the board's
13 standard of review that are defined in the actuarial
14 standards of practice?

15 A. Yes. There are.

16 Q. What are those terms?

17 A. Excessive, inadequate and unfairly
18 discriminatory.

19 Q. So we have heard some testimony today about
20 affordability. Is that the same thing as excessiveness?

21 A. No. We are -- we are opining on whether or
22 not the rate is excessive which means that the benefits
23 and admin in relation -- or the benefits in relation to
24 the premium and admin are not more than what they should
25 be.

1 Q. And what about adequate? What is the
2 definition of that according to the actuarial standard
3 practice?

4 A. We want to make sure that the rates are
5 sufficient, meaning that they -- the rates being charged
6 are able to handle the benefits and other costs that are
7 being administered by the carrier.

8 Q. And how is the term unfairly discriminatory
9 defined in the ASOP?

10 A. We have -- we want to make sure that the rates
11 are equitable for the same type of individuals that have
12 similar criteria, rating criteria, so that there is not a
13 -- people that same group that have a rate that differs
14 for reasons that are not appropriate.

15 Q. And when you say that given assumption in your
16 report is reasonable and appropriate, what does that mean?

17 A. It means if falls under the standards that we
18 just reviewed, those definitions, it meets those criteria.

19 Q. So did you make any recommendations to the
20 filing?

21 A. Yes.

22 Q. Can we turn to your recommendation regarding
23 the company's claims experience, in particular issue of
24 meet your enrollment?

25 A. Yes. We made a recommendation, which is on

1 page 11, that the carrier modify the mid-year enrollment
2 termination factor to adjust for only small group
3 policies, and that result was a decrease in rates of .3
4 percent.

5 Q. What did the carrier assume when it made its
6 with -- with it's filing?

7 A. So the carrier assumed that for this
8 particular factor, particularly they called it the average
9 duration factor, they assume that all policies would be in
10 force for a full 12 months. And that's what the
11 adjustment was to increase their claims in the base period
12 experience to account for the fact that not all policies
13 were in force for the full 12 months. You have
14 deductibles and such that lower it.

15 Q. And did you agree with that assumption?

16 A. We did not agree with that assumption.

17 Q. And why not?

18 A. We asked the carrier for their claims
19 experience -- or their -- we asked the carrier for the
20 number of policies that have 12 months of enrollment
21 versus all the rest, you know, versus the rest of the
22 duration time period. And in their response to us they
23 provided that it's I believe in Exhibit 3 page six, and
24 it's clear for 2016 and 2017 that there are enrollments
25 throughout the year, that not all policies have a full 12

1 months.

2 We did agree that open enrollment is different
3 for 2018 and '19. But that to assume all policies will be
4 in force for 12 full months is -- is not a logic -- or is
5 not a reasonable expectation.

6 Q. And you said this was based off of the
7 company's own data; is that correct?

8 A. Yes. This Exhibit 3 page six of their
9 response is based on MVP's data.

10 Q. And what reasons would people either enroll or
11 terminate their coverage mid year?

12 A. There are a lot of reasons. I would say a
13 good example, special enrollment periods. If you have a
14 change in your job, let's say you lost your job in the
15 middle of the year, then you lost your large group
16 coverage potentially, and then you could enroll as an
17 individual. Or let's say that you jumped on with a small
18 group, changed jobs, then you could jump on to the small
19 group.

20 Q. Do individuals voluntarily lapse coverage mid
21 year as well?

22 A. Yes, they do.

23 Q. So for those reasons, your opinion is that
24 MVP's assumption that all members will be enrolled for the
25 full 12 months is unreasonable?

1 A. Yes. We think that that is unreasonable.

2 Q. Okay. Let's move on to the next
3 recommendation which had to do with risk adjustment.
4 Could you briefly explain what makes the risk adjustment
5 calculation so complicated?

6 A. The risk adjustment is complicated mainly due
7 to the timing of data received as well as needing to know
8 information about other carriers in the market that is
9 proprietary or confidential. So it requires a carrier to
10 understand the health risk and the risk scores of those in
11 the entire market which means that, for instance, MVP
12 would have to understand Blue Cross's entire risk profile
13 in order to calculate this.

14 Additionally, used to be on June 30th but this
15 year it was roughly July 9th, CMS puts out their report of
16 the adjustment payments, and because of that falling in
17 the middle of our review period that, you know, puts the
18 carrier at a slight disadvantage because they don't have
19 that before the filing. So they have to make an educated
20 guess.

21 Q. So did you update the calculation with the
22 updated numbers from the federal government?

23 A. Yes. That was our recommendation was that
24 MVP use the report that came out on July 9 as -- and those
25 numbers as their starting point -- rather than the number

1 in which they used prior to having that knowledge.

2 Q. And is it your understanding that the company
3 agrees with that modification?

4 A. Yes.

5 Q. Move on to your final recommendation which
6 relates to unit cost trends and hospital budgets. Could
7 you explain your recommendation, please?

8 A. Yes. We recommend that most up-to-date
9 information regarding the hospital budgets and unit cost
10 trends be considered during these filings. Again, there
11 is a disconnect in the timing of this filing and the
12 hospital budgets, and that midway through our review
13 process draft budgets come out.

14 And in the past, we have incorporated changes
15 based on these -- this new information.

16 Q. Now these are draft -- these are budget
17 submissions. These aren't the final order; is that
18 correct?

19 A. That's correct. I believe the final order
20 happens sometime in August, September which is definitely
21 after the board makes its order. At least it has been in
22 the past.

23 Q. Have you had the opportunity to review these
24 submissions?

25 A. Yes, I have reviewed the draft submissions.

1 Q. And have you reviewed hospital budget
2 submissions and draft orders for past years?

3 A. Yes.

4 Q. For say the last three years what's been the
5 relation between the budget submissions and the final
6 budget order?

7 A. I don't have them all memorized. But roughly
8 for the last -- the last two years there's been a slight
9 decline in what was submitted versus what was approved.
10 Prior to that, they were roughly equal to one another. So
11 there's been a small averaging pattern, but definitely not
12 very conclusive.

13 Q. Okay. And have -- did the company make an
14 assumption regarding the hospital budget submissions?

15 A. Yes. In the original filing MVP set their
16 unit cost trends for 2019 equal to their 2018 unit cost
17 trends. Based on this updated information they have
18 updated the 2019 trends to reflect the new budget
19 submissions that we have been discussing. And they have
20 proposed that in the most recent objection and response.

21 Q. Do you have an opinion as to the company's
22 updated assumption?

23 A. We are still reviewing their assumption.
24 Right now they have put in the values that were in the
25 submission and that resulted in about a half a percent

1 increase in rates, but we have not presented a formal
2 opinion on that at this point because we were still
3 reviewing it.

4 Q. What is your initial assessment?

5 A. Our initial assessment is that it was -- we do
6 feel it's appropriate that updated budget information be
7 incorporated but that it's possible to consider the fact
8 that the last two years it's gone down slightly. So one
9 of the things we are going to look at is we are assessing
10 this facility by facility, if there are any patterns
11 between what was submitted versus approved specifically in
12 the last couple of years, but we have not formalized that
13 at this time.

14 Q. Okay. So with the recommendations that you've
15 made to the filing, what will be -- incorporating those
16 recommendations, what would the average overall annual
17 rate increase look like?

18 A. The average rate increase for the first two
19 bullet points that we have recommended, not including the
20 proposal of the updated trend at this point, that turns
21 the -- our recommendation would be an 8.5 percent rate
22 increase or what's felt by Vermonters of a 3.8 percent
23 increase.

24 Q. You said what's felt by Vermonters. Could you
25 explain that?

1 A. Yes. Because of the unfunding of the CSRs,
2 there have been the opportunity of the silver reflective
3 plans to be offered in Vermont. And because of that,
4 there were able to be some varying premiums such that
5 people who did not need the subsidies could move over to
6 these plans or not meet the cost sharing requirements.

7 And so therefore, the rates are lower in this
8 environment for Vermonters.

9 Q. The rates are lower because of the reflective
10 silver plans?

11 A. Yes.

12 Q. And is it your understanding that a
13 significant portion of the rate increase proposed by the
14 company will be borne by the federal government in the
15 form of premium subsidies?

16 A. Yes.

17 Q. Let's talk about some other aspects of the
18 filing that you didn't give recommendations on, but there
19 was some testimony today.

20 Did you review the company's medical trend?

21 A. Yes.

22 Q. The company chose a zero percent utilization
23 trend; is that correct?

24 A. That is correct.

25 Q. Did you find that assumption to be reasonable

1 and appropriate, and why?

2 A. When reviewing the utilization trend we took
3 into account -- we asked the carrier to provide us data on
4 utilization trend, and they did. It was -- there was no
5 clear pattern in their -- in this data that they provided
6 to us. We do know that there have been other carriers in
7 the state that have seen some utilization trends, but we
8 felt that MVP had enough information, and based on their
9 block of business that the zero percent trend was
10 reasonable and appropriate.

11 Q. And did you review the company's pharmacy
12 trend?

13 A. Yes.

14 Q. And did you find that reasonable and
15 appropriate, and why?

16 A. Yes. We did. We -- MVP as well as many other
17 carriers rely on their PBM to help predict the pharmacy
18 trends for the future year. It's a prospective look by
19 the PBM taking into account any changes in the drug mix,
20 between, you know, brands coming off patent and
21 utilization of that particular carrier that was used in
22 this. And so they relied on this data. We did ask for
23 the historical pharmacy data, and that indicated much
24 higher trends than what the PBM was projecting. And we
25 know it's not as -- not as good of an analysis because

1 it's retrospective versus prospective. So we agree with
2 the use of the PBM's trends.

3 Q. Okay. Now let's pivot a bit to another one,
4 one of the more significant changes in this filing over
5 last year which is the increase in premiums resulting from
6 the removal of the individual mandate penalty.

7 Did you review MVP's assumption as to that
8 change?

9 A. Yes.

10 Q. And did the company rely on its own assumption
11 or on the analysis that was commissioned by the board and
12 the Department of Financial Regulation?

13 A. Their memorandum states that they used the
14 report done by the board and the DFR.

15 Q. Do you recall when you prepared that report?

16 A. L&E, I believe, dated that report February,
17 2016 or 2018.

18 Q. Vermont passed a state-based individual
19 mandate. Was that passed before or after you submitted
20 your report analyzing the effect of the removal of the
21 individual mandate penalty on the market?

22 A. After.

23 Q. So you did not incorporate that into your
24 report?

25 A. We did not incorporate that into our report.

1 No.

2 Q. So let's just briefly turn to contribution to
3 reserves. In your analysis for your report do you review
4 for solvency and contribution to reserve?

5 A. Yes. DFR handles the vast majority of the
6 solvency over MVP, but as part of an effective rate
7 review, we do consider it and look at it as far as the
8 rate's development.

9 Q. And do you also look at confidential
10 information reviewing the company's solvency?

11 A. Yes.

12 Q. And did you find that the company's assumption
13 of a 2.0 percent contribution to reserve to be reasonable
14 and appropriate?

15 A. Yes.

16 Q. So with the recommendations that you outlined,
17 is this filing excessive?

18 A. No.

19 Q. Is it adequate?

20 A. Yes.

21 Q. Is it unfairly discriminatory?

22 A. No.

23 Q. All right. Thank you. I have nothing
24 further.

25 HEARING OFFICER HENKIN: Attorney

1 Karnedy?

2 MR. KARNEDY: Thank you.

3 CROSS EXAMINATION

4 BY MR. KARNEDY:

5 Q. Can I call you Jackie, Jackie?

6 A. Yes.

7 Q. You heard when I was talking to Matt, and you
8 just went over, if you look at Exhibit 11, please, in your
9 binder, your opinion. The three bullets. And you were a
10 moment ago testifying about the hospital budgets, so I
11 would like to talk to you a little bit about that.

12 Would you read -- well I guess we can cut to
13 the chase. You say in that bullet that L&E recommended
14 updated information about the hospital budgets should be
15 considered by the board; correct?

16 A. Yes.

17 Q. And it's your opinion that that information is
18 important and should be considered in the board's
19 consideration of our rate filing; correct?

20 A. Yes.

21 Q. Okay. Go to Exhibit 9, please. There is a
22 binder in front of you. And if I understand this is an
23 objection letter where MVP responded to a question that
24 was posed by L&E; correct?

25 A. Yes.

1 Q. Okay. And you pose that question because it
2 was an important question to L&E in doing your job on this
3 filing; correct?

4 A. Yes.

5 Q. And can you read the question, please, number
6 one?

7 A. "Please address whether the recent information
8 regarding the hospital unit cost increases for 2019 are
9 anticipated to have an impact on the proposed rates. If
10 so, provide updated trend build-up by facility and an
11 explanation of the sources of any updated assumptions."

12 Q. Okay. So as you sit here today, you would
13 again reiterate to the board that you're asking this
14 question because it's important information the board
15 should consider, right?

16 A. Yes.

17 Q. And you asked -- if you look at the letter you
18 received, the first paragraph, you received the request on
19 July 16th. Right? Do you see that in the very first
20 paragraph?

21 A. Yes.

22 Q. And then we responded on July the 17th, one
23 day later; correct?

24 A. Correct.

25 Q. Very prompt, right?

1 A. Yes.

2 Q. Okay. And that was all triggered by the
3 hospitals filing their budgets; correct? The proposed
4 budgets?

5 A. Yes.

6 Q. Do you know when that was roughly?

7 A. July 2? Don't quote me.

8 Q. Okay. So early July. Right?

9 A. Before July 16th.

10 Q. Okay. Excellent. Excellent. I asked for
11 that, didn't I? But it was after your July 10th opinion,
12 because you would have talked about it in the opinion if
13 you had known; correct?

14 A. I don't know that that's necessarily true.

15 Q. Okay. You're saying because who knows when
16 you have actually learned it, et cetera. Not that it's
17 not important, right?

18 A. Right. And we submit the report on the 10th
19 which I believe was a Monday. And so there were a couple
20 days the Green Mountain Care Board could have thrown that
21 up on the website, and even if it had been posted Friday,
22 we wouldn't have had enough time to digest it and
23 incorporate the report.

24 Q. Plus we have got the whole time difference
25 between Texas and Vermont. It's a whole hour.

1 A. In fairness I was in Europe at the time, so it
2 was much greater.

3 Q. Do you recall last year that this same issue
4 came up of whether the board should consider the hospital
5 budget proposals as opposed to the final decision?

6 A. Yes.

7 Q. And do you recall that the board determined
8 that they would consider that information even though they
9 weren't final hearings with the hospitals; correct?

10 A. Yes.

11 Q. Do you think that was appropriate?

12 A. I do.

13 Q. Do you think that's appropriate this year?

14 A. I do.

15 Q. If you go to Exhibit 9. You'll see a
16 paragraph -- I want you to read the first sentence. It's
17 1, 2, 3, 4 paragraphs down. Can you read that first
18 sentence, please?

19 A. Starting with "MVP analyzed?"

20 Q. Yes, please.

21 A. "MVP analyzed the effect of the proposed
22 trends on premium rates in the filing and found that they
23 would increase the originally proposed premium rates by
24 approximately 0.5 percent."

25 Q. Thank you. And if I understood your testimony

1 on direct examination, you don't necessarily disagree with
2 the .5 percent increase. You just haven't fully analyzed
3 it yet; correct?

4 A. I will say we have analyzed what MVP did, and
5 that yes, they incorporated those numbers properly. But I
6 have not determined if all -- if that's appropriate given
7 the submitted versus approved and taken that into account.

8 Q. You haven't fully yet come to a decision on
9 it?

10 A. Correct.

11 Q. That's not because MVP wasn't prompt. It's
12 sort of that calendar we were talking about, right?

13 A. Correct.

14 Q. Okay. And I think I heard you say you don't
15 recall exactly what happened last year in terms of you
16 think it might have ultimately been slightly less, the
17 amount that was approved, the hospitals versus what they
18 proposed, but you don't remember the exact numbers, right?

19 A. For 2018 it was on average .3 percent
20 according to the chart I looked at before I walked up
21 here.

22 Q. Well --

23 A. I didn't memorize all the years. That was
24 just '18. I think it went from 2.2 to 1.8 percent.

25 Q. So if -- let's just make this hypothetical

1 because you don't recall exactly. So if it were like 2.2
2 they knocked it down three points or something. Is that
3 what you're saying?

4 A. No. Point 3.

5 Q. But this chart you're talking about, do you
6 have that chart?

7 A. Back there I think.

8 Q. I want to move along, but it's fair to say
9 whatever it is, it is. Right?

10 A. Correct. Yes. whatever it is, it is.

11 Q. And --

12 A. It was slightly lower.

13 Q. And would you agree with me that MVP
14 requesting an increase based on this issue, you don't
15 disagree but you might disagree as to the amount, but
16 there should be some increase given what the hospitals
17 proposed; correct?

18 A. Yes.

19 Q. Okay. So that was bullet number three. The
20 hospitals. Now let's talk about the mid-year enrollment.
21 I think you and I had this discussion last year.

22 A. Yes.

23 Q. And you won. But I'm going to try again.
24 Actuarial, respectable approach, right?

25 A. Correct.

1 Q. Both approaches are reasonable, you think
2 yours is superior; correct?

3 A. I think mine is superior.

4 Q. Fair enough. Okay. Go to page three.

5 A. Of Exhibit 11?

6 Q. Yes, please. Okay. So you have your
7 paragraph numbered one. I'm just getting to this because
8 we are going to talk about it in case you wanted to
9 reference it. That is paragraph number one that goes page
10 three to four, right?

11 A. Correct.

12 Q. Your first full paragraph on four, third
13 sentence, I'm going to read it to you. "L&E agrees with
14 MVP's assessment that this adjustment is appropriate for
15 small group plans, which tend to be active for a full 12
16 months." Do you see that sentence?

17 A. Yes.

18 Q. So we have agreement on that; correct?

19 A. Yes.

20 Q. The area of disagreement is on MVP using the
21 12-month period on the individual; correct?

22 A. Correct.

23 Q. And L&E's estimating mid-term terminations and
24 enrollment, right?

25 A. Yes.

1 Q. That's based on some data you got from MVP?

2 A. Yes.

3 Q. So the dispute is, is there enough reliable
4 data there. Should we do it the way you've suggested or
5 do we take what we would call a more conservative approach
6 and just figure the whole year for everyone, right?

7 A. Correct.

8 Q. If Charlie is a mid-year enrollee, he will
9 presumably be less likely to achieve the deductible and/or
10 the out-of-pocket maximum than he would if he were in for
11 the whole year; right?

12 A. Yes.

13 Q. And he would also generate lower utilization
14 and claim costs in contrast to if he were in the plan for
15 the whole year; right?

16 A. Correct.

17 Q. None of us know actually exactly what's going
18 to happen in 2019. Correct?

19 A. Correct.

20 Q. And that relates to who is going to enroll,
21 who is going to terminate, when they were going to do it
22 during that year; right?

23 A. Right.

24 Q. We don't know whether Charlie is going to
25 terminate in July or October; do we?

1 A. No.

2 Q. Or at all?

3 A. Correct.

4 Q. We also don't know if it could be one person
5 or it could be thousands of people who terminate in July
6 for some reason; right?

7 A. That's right.

8 Q. And your job as an actuary is not guess?

9 A. That's correct.

10 Q. Make conservative estimates; right?
11 Assessments based on good data; right?

12 A. That's correct.

13 Q. And you would agree with me that having
14 adequate rates is important. Better to be safe than
15 sorry.

16 A. I would say adequate rates are important. I
17 wouldn't say that having adequate rates is necessarily
18 safe versus sorry. If they are adequate, they are
19 adequate.

20 Q. Fair enough. I was just -- not using actuary
21 language. I'm sorry.

22 If MVP's rates are inadequate though they may
23 need to charge more next year to make up for it;
24 correct --

25 A. Yes.

1 Q. -- if the board allowed them to do that;
2 right?

3 A. Yes.

4 Q. Your preference as an actuary though is to
5 have your 2019 rates line up with and be adequate to cover
6 the claims for 2019; right?

7 A. Yes.

8 Q. And you would agree with me that as it relates
9 to health insurance rates, actuaries don't like to gamble
10 on uncertainty. You want to pay for what you're going to
11 pay for in that year; right?

12 A. Yes.

13 Q. Get it right the first time; correct?

14 A. Yes.

15 Q. Okay. Let's go to the third paragraph on page
16 four of your report. It's the third full paragraph. It
17 starts "L&E recommends." Do you see that?

18 A. Yes.

19 Q. Okay. Can you read that sentence? It's a
20 couple sentences down which has the 91.6 in it. Could you
21 read that, please?

22 A. "Based on L&E's analysis of MVP's data, our
23 best estimate of the 2019 enrollment is that approximately
24 91.6 of members will enroll in January with .76 percent of
25 members enrolling in each of the other 11 calendar

1 months."

2 Q. And then read the next sentence, please.

3 A. "Additionally, we have assumed that
4 approximately 3.8 of all members lapse their coverage in
5 any given month."

6 Q. And the data you looked at didn't show that
7 things were spread out across the months evenly; did it?

8 A. I would have to go back and look. But I would
9 assume it was not uniform. No.

10 Q. Fair enough. This is your best estimate, but
11 it's not exactly what's going to happen next year;
12 correct?

13 A. No.

14 Q. And is it fair to say that the board should
15 take with a grain of salt attributing these particular
16 numbers to each month. They are going to be different,
17 aren't they, in actuality?

18 A. I think they should give a little more than a
19 grain of salt to it, because they are based on data. So I
20 just -- I agree with you that maybe it's higher in one
21 month than another, but across it should be averaged.

22 Q. Okay. Thank you. Next I want to talk about
23 contribution to reserves, if I could. Exhibit 11, page
24 nine, paragraph nine, please, to acclimate yourself. See
25 that numbered paragraph where you talk about contributions

1 to reserves?

2 A. Yes.

3 Q. Okay. So you found MVP's recommended
4 contribution two percent to be reasonable and appropriate;
5 correct?

6 A. Correct.

7 Q. You indicated while recommending that you
8 consider what DFR said on the issue?

9 A. Correct. Yes.

10 Q. And you heard Matt's testimony first adjusting
11 to the 6.1, then agreeing to the 2.9 percent for the risk,
12 and then adding .5 percent for the hospital budget
13 proposals. You heard all that testimony, right?

14 A. I think you mean 1.9 for risk adjustment, but
15 yes.

16 Q. I meant 1.9, yes.

17 A. Yes.

18 Q. Numbers matter.

19 A. Numbers do matter.

20 Q. So the amount, as you understand it, you've
21 heard that we are talking about today is a 4.6 percent
22 rate increase; correct? And L&E's recommending 3.8?

23 A. Yes.

24 Q. Okay. So whether MVP's final rate is 4.6 or
25 3.8 as you suggest, you still agree that the two percent

1 contribution to reserves is reasonable and appropriate?

2 A. Yes.

3 Q. Thank you very much.

4 HEARING OFFICER HENKIN: Attorney

5 Angoff.

6 CROSS EXAMINATION

7 BY MR. ANGOFF:

8 Q. Ms. Lee, you said that you assume that people
9 will drop policies during the year, right?

10 A. Yes.

11 Q. Okay. And did you say that MVP disagreed with
12 that?

13 A. Yes. For the individuals they assume that 100
14 percent of the policyholders will have 12 months covered,
15 so that means no one's coming off, and no one's coming on.

16 Q. That's what MVP told you?

17 A. That what their assumption was, yes.

18 Q. Could you turn to Exhibit 1 page 40. And look
19 at the second paragraph there. Headlined bad debt
20 expense.

21 A. Yes, I see it.

22 Q. Okay. Isn't MVP there itself saying that
23 people are going to drop out during the year?

24 A. Yes. That is what the bad debt expense
25 assumption is stating.

1 Q. That's right, and they are charging
2 policyholders for that; aren't they?

3 A. Yes.

4 Q. .6 percent?

5 A. Yes.

6 Q. When you found that a two percent contribution
7 to reserves was reasonable for Vermont, did you know that
8 MVP had filed for a 1.5 percent CTR in New York?

9 A. No.

10 Q. Knowing that now, would that change your
11 opinion as to whether or not a two percent CTR for Vermont
12 is reasonable?

13 A. I'm not sure that that would have impacted my
14 decision, because we don't review in New York, or I just
15 look to Vermont. And I think that with the uncertainty of
16 the risk adjustment payments, that's a risk to them as
17 well as other factors.

18 I still think two percent is appropriate, and
19 especially because they filed the same last year, and it
20 was approved. I felt like no change seemed reasonable.

21 Q. Did you know that MVP when you assumed -- when
22 you found that two percent CTR for Vermont for 2019 was
23 reasonable, did you also know that in the 2018 the New
24 York Department allowed MVP only a 1.5 percent CTR?

25 A. I did not know that.

1 Q. Okay. Knowing that now, would that change
2 your opinion as to whether a two percent CTR is reasonable
3 for Vermont for 2019?

4 A. Again, I don't really know what the -- what
5 was involved in the New York review. I don't know if they
6 proposed two percent, knocked it down to one and-a-half.
7 Or if they came in with one and-a-half. I think that
8 would be information I would like to understand before
9 making an opinion, changing my opinion to match New
10 York's.

11 Q. It might change your opinion, but you don't
12 know now?

13 A. I don't know.

14 MR. ANGOFF: I have no further
15 questions.

16 HEARING OFFICER HENKIN: Okay. Kevin,
17 you're already.

18 CHAIRMAN MULLIN: I just wanted to
19 follow up on that last line of questioning because I
20 was somewhat confused.

21 MVP has the healthier population when
22 it comes to QHP.

23 THE WITNESS: Yes.

24 CHAIRMAN MULLIN: So why would changes
25 in the risk adjustment be a risk to them?

1 THE WITNESS: Well just saying that it
2 could, you know, they -- on a PMPM basis the risk
3 adjustment payment or receivable, either one, is much
4 more impactful for them on a PMPM basis because while
5 their membership has been growing, it is small, a
6 smaller subset of the Vermont market. And so any
7 change in that has a direct impact. It may be more
8 favorable because they are healthy, but it can also
9 go the other way.

10 CHAIRMAN MULLIN: Okay. CTR, you said
11 eight states. I think David said nine. So one of
12 you is right. But however many states that you are
13 in, is it common to see different CTR levels among
14 different plans?

15 THE WITNESS: When you say plans, do
16 you mean carriers? Or do you mean like products
17 within the --

18 CHAIRMAN MULLIN: Products within an
19 individual company.

20 THE WITNESS: Sorry. Want to clarify
21 one more. Do you mean like gold, silver, bronze or
22 between large group, small group? Sorry.

23 CHAIRMAN MULLIN: Okay. So this
24 particular case Vermont has a merged market.

25 THE WITNESS: Yes.

1 CHAIRMAN MULLIN: Okay. I believe the
2 testimony we heard from Mr. Lombardo is that there is
3 a difference between 1.5 and two percent between the
4 small group and the individual in New York.

5 THE WITNESS: Okay.

6 CHAIRMAN MULLIN: And likewise, is it
7 common by companies in different states to have a
8 different level of a CTR in a rate filing based on
9 what that plan is?

10 THE WITNESS: Yes.

11 CHAIRMAN MULLIN: Okay. You have
12 testified that it was reasonable for a two percent in
13 this particular rate filing.

14 THE WITNESS: Yes.

15 CHAIRMAN MULLIN: Would it also be
16 reasonable for a 1.5 percent in this rate filing?

17 THE WITNESS: I think if they had filed
18 1.5, I don't think that would have changed my
19 response. I think that would have been okay.

20 CHAIRMAN MULLIN: Thank you.

21 HEARING OFFICER HENKIN: Ms. Holmes.

22 BOARD MEMBER HOLMES: If the hospital
23 budget submissions came in below the assumptions made
24 by the carriers in the filing, is it fair to say with
25 near certainty that the carriers' assumptions would

1 be wrong and should be adjusted downward? That is,
2 the board doesn't generally increase the commercial
3 rate above that which the hospitals have submitted.

4 THE WITNESS: Yes. That's what
5 happened last year.

6 BOARD MEMBER HOLMES: Right.

7 THE WITNESS: Right, yes.

8 BOARD MEMBER HOLMES: So it's fair to
9 say that the assumptions made by the carriers in the
10 situation last year were wrong because the hospital
11 submissions came in lower than their assumption?

12 THE WITNESS: Right. That is correct.

13 BOARD MEMBER HOLMES: Okay. If the
14 hospital budget submissions come in above with the
15 assumptions made by the carriers in the filing, is it
16 fair to say that the carriers' assumption may still
17 be right because there is some uncertainty about what
18 the board is going to do and by how much the board is
19 going to reduce potentially those commercial rate
20 asks?

21 THE WITNESS: Yes. And that's why we
22 wanted to take more time to review and have
23 discussions with the staff, and that's why I was
24 looking at how the past years have gone. A couple of
25 years ago most of the time submitted was approved.

1 However, the last two years, as I've testified
2 earlier, they have been on average .3 percent lower
3 than what was submitted.

4 So I recognize that there is a
5 difference, and that's why our report doesn't say go
6 with the hospital budget figures but with updated
7 information. And to me that would -- that is why we
8 want to take more time to assess, because broad scope
9 I could say it's a .3, but it does depend on the
10 facility. And I know the facility mix even just
11 between the two carriers are very different.

12 BOARD MEMBER HOLMES: So it would be
13 reasonable for there to potentially be some asymmetry
14 in how the board handles what's submitted and how we
15 then deal with the filing depending upon whether
16 what's submitted is above or below what the carriers
17 assumed?

18 THE WITNESS: I think that's possible.
19 I would like to advise the board to attempt to be
20 consistent where, you know, again, what my process
21 was going to attempt to do over the next couple of
22 days is to make sure that if I don't go all the way
23 to that number, that it's consistent with, if
24 possible, to find a pattern for let's say UVMC. If
25 they always -- it's always dropped a certain

1 percentage or amount to apply that and then consider
2 that.

3 Because it is fair to say that there is
4 a pattern there.

5 BOARD MEMBER HOLMES: Yeah. I would
6 just caution that is an entirely new board, so
7 whatever patterns are emerging are also board
8 dependent.

9 THE WITNESS: Yes.

10 BOARD MEMBER HOLMES: That's all my
11 questions.

12 BOARD MEMBER USIFER: I would just add
13 to that a little bit when we look at the hospital
14 budgets in total, in some of the guidance that we
15 gave, and it's very preliminary right now, but in
16 total the budgets came in under the overall guidance
17 that we gave. So we had given a 3.2 percent rate.
18 It came in at 2.9 percent.

19 So even with rates that may not get
20 approved, the commercial rate increases that are
21 higher, so you know, it tends to only go down rather
22 than go up from there. So how do other factors like
23 utilization, and things like that, there has to be
24 other factors that are driving that number down, if
25 in fact right now those submissions have a higher

1 rate.

2 So I guess when you're looking at that
3 kind of looking at the totality of understanding what
4 are some of the other assumptions that might be in
5 there.

6 THE WITNESS: Can you ask your question
7 differently? I'm not sure I'm following.

8 BOARD MEMBER USIFER: So if rates are
9 coming in at a certain percent, and that's driving up
10 the top line, but utilization is going down, for
11 instance, and utilization maybe was assumed to be
12 flat, you know, that's another factor potentially.
13 If we came in, and they said insurance -- the average
14 rate is X, I don't know what the blended average rate
15 is, three percent or something, two percent, but the
16 overall budget increase is even less than that, that
17 means other things are going on in that budget.

18 THE WITNESS: I'll have to take your
19 word for it. We only generally see the weighted
20 average at a very high level. We don't really dig
21 into all of those. I just know that we can't rely on
22 the weighted average number, whether up or down,
23 because even the distribution by facility, as I said,
24 between the two carriers can be very different.

25 But I will say I know that when these

1 budgets came out that there was one facility in
2 particular that was supposed to be flat, but then the
3 budget came in and it was much higher, and so we
4 would hope that the board is going to bring that
5 down, but that wasn't a red flag to us when we
6 originally saw it.

7 BOARD MEMBER USIFER: Just one other
8 question. When we are talking about a business
9 that's growing, and may continue to grow because the
10 premiums are different between MVP and Blue Cross, so
11 I know the assumptions are based on the number of
12 lives from last year at 25,000. And there may be
13 continued growth. And the discussion about admin
14 costs, and then how would we get the benefit from
15 that. And is there a way -- any factors that L&E
16 would ever put in to say if there were a growth in
17 membership what that would do to rates?

18 THE WITNESS: I think we generally rely
19 on the carrier to provide that kind of information to
20 us. Typically, if you see a growth in enrollment,
21 your point is we would like to see a benefit in the
22 admin costs going down, because you can spread it
23 across the entire, a larger portion of membership.

24 I think in MVP's case which they have
25 testified to is that they have a portion that's in

1 New York that's -- that they are having to bridge
2 this across, but that's not an uncommon practice to
3 have that happen across multiple lines of business,
4 even across states for larger plans.

5 I know you're comparing it to just Blue
6 Cross Blue Shield of Vermont, but they only do
7 business here in Vermont. So it's not that uncommon,
8 but like you -- I mean I think it's a little
9 disappointing that it didn't go down further.
10 Because I know that was something that the board
11 wanted, and I'm sure even too MVP wanted it because
12 it would have made their rates even lower which would
13 have drawn more members to them.

14 So I mean I think that based on what
15 I've seen, they are trying to be competitive, and
16 they want the market share, and it was something that
17 I wasn't even sure they could achieve, but they have.
18 And they really continue to have lower rates and to
19 kind of answer a question earlier, they do have the
20 lower rates across the board with the exception of
21 the catastrophic plan.

22 BOARD MEMBER USIFER: It still seems --
23 I mean Vermont's only 2.9 percent of their business.
24 And yet our business went up from 10,000 lives to
25 25,000 lives. So we went up 15,000 lives. The rest

1 of their business went down overall 10,000 lives. So
2 still the three percent of Vermont can't carry that
3 burden for the whole business. I mean even if you're
4 going to readjust, you have to align that across all
5 the lives, and there has to be about 8, 900,000 lives
6 there. So --

7 THE WITNESS: Good challenge for MVP to
8 consider for the future. But, you know, that's not
9 my business, so I don't know how they do it. And I
10 know that Matt did talk about it more extensively
11 than I can. But I do think that's a good challenge,
12 because I agree, that could benefit Vermonters
13 especially as that enrollment growth continues, which
14 it should, because rates are even lower relative to
15 Blue Cross's.

16 BOARD MEMBER USIFER: Okay, thanks.

17 BOARD MEMBER LUNGE: I just have one
18 question. Jackie, in your report on page seven you
19 have a description as to the individual mandate
20 analysis that L&E performed in February. And
21 yesterday your colleague, Dave, testified that the
22 report was based on financial impacts related to the
23 mandate. However, the report indicates financial and
24 non financial. Does that need to be corrected?

25 THE WITNESS: I believe that would need

1 to be corrected. I think that it was based on
2 financial only. Yes.

3 BOARD MEMBER LUNGE: Thank you.

4 THE WITNESS: Should we issue an
5 amendment for that?

6 HEARING OFFICER HENKIN: You can do
7 that on the record right now. I think that will be
8 accepted. I believe that you acknowledged there's an
9 error in the report and recorded here.

10 THE WITNESS: Okay. Thank you.

11 BOARD MEMBER LUNGE: Thank you.

12 BOARD MEMBER PELHAM: I have no
13 questions. I have no questions.

14 THE WITNESS: Thanks, Tom.

15 HEARING OFFICER HENKIN: Just looking
16 around to make sure that everyone is done. Thank you
17 very much, Jackie.

18 THE WITNESS: Thank you.

19 HEARING OFFICER HENKIN: I have public
20 comment here. Will you be offering anything else?

21 MR. ANGOFF: We have Mr. Fisher's
22 rebuttal testimony.

23 HEARING OFFICER HENKIN: I did offer
24 you that, but you did not make it clear if that was
25 going to happen.

1 MR. ANGOFF: Oh, yes. Absolutely.

2 HEARING OFFICER HENKIN: Okay. Mr.

3 Fisher, take the witness stand.

4 MR. FISHER: Good afternoon.

5 HEARING OFFICER HENKIN: Now you did
6 take the oath also this morning?

7 MR. FISHER: I did take the oath. And
8 I'll just -- it's good to be here. You guys throw a
9 great party.

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1 MICHAEL FISHER

2 Having been duly sworn, testified
3 as follows:

4 MR. FISHER: I will start with --

5 MR. KARNEDY: Object just as to form.

6 What's happening here?

7 HEARING OFFICER HENKIN: Well I said
8 that he could be a rebuttal witness. As to form, I
9 assumed there would be -- he would be lead in
10 questioning, but that does not appear to be
11 happening. I am not prohibiting his testimony unless
12 there is an objection to its contents as he's
13 presenting it right now.

14 MR. KARNEDY: So would you like me to
15 -- without knowing what he's going to say -- I'll
16 have to interrupt him at times.

17 HEARING OFFICER HENKIN: I do not know
18 what he's going to say either, but I would hope that
19 his attorney has prepared him to stick within the
20 bounds of rebuttal and not to venture into the
21 inadmissible materials we talked about today nor
22 outside of the record as presented.

23 MR. ANGOFF: That's correct.

24 MR. KARNEDY: I'll be polite, but I
25 have to speak up.

1 THE WITNESS: And I will do my best to
2 live in the bounds with whatever it is rebuttal
3 witness means. I'm sure I'll be corrected.

4 HEARING OFFICER HENKIN: I hope your
5 attorney explained that a little to you.

6 THE WITNESS: So I want to start by
7 just recognizing where it is I come from as the
8 health care advocate. And to just say out loud that
9 as I sit through a day-long proceeding like this, I
10 am receiving emails from people who -- for whom it's
11 not working so well. And I'm not going to tell you
12 -- I could give you an example, an email that came to
13 me during today. I'm not going to. But I just want
14 you to know that the passion that I come to this with
15 comes from the experience of listening to Vermonters
16 for whom this great, complex system of paying for
17 health care isn't working.

18 I have a few, I think, fairly high
19 level comments about what I've heard today. And so
20 first off, I heard a discussion about quality
21 improvements that MVP was making and their attempt to
22 direct people to primary care. And I appreciated
23 Member Holmes's focus on that. I do want to turn to
24 the page, it's tab five, page seven. It's a little
25 bit of irony for me to be focusing on this question

1 here. I don't bring it up and ask you to open it up
2 because I have anything in particular to say about
3 this filing today regarding these numbers, but I want
4 you to know that I found these numbers important.
5 And I plan to ask these questions every year. I
6 think that they provide a benchmark for us to measure
7 something that I think is important.

8 So the second issue is there's been a
9 great deal of focus on a report called -- report or a
10 study -- that was commissioned by the board and by
11 DFR with regard to individual mandate. I don't know
12 whether the board has seen that study or that report.
13 I don't know whether the carriers have seen a more
14 detailed analysis of that report than I've seen. But
15 I want to report to you that in the commissioning of
16 that study there was a discussion of not wanting to
17 spend too much money, a high level understanding of
18 the lay of the land. And I'm not an expert to tell
19 you whether it's efficient to direct the carrier to
20 increase the rates by two percent, but I will ask the
21 question -- I will ask the board to consider that
22 question as you're entertaining it.

23 I'm just aware that it was a high level
24 attempt to get a picture of the lay of the land, not
25 a detailed analysis. I've heard executive --

1 insurance executives say today and previous days,
2 that their companies are as lean as possible. And I
3 heard insurance executives say that there is a great
4 deal of the health care spending that's beyond their
5 control. There is not a lot they can do about it,
6 and it leaves me, as the Health Care Advocate, to
7 want to say that it can't be true. If that's true,
8 there is no role for us here to do anything about it.

9 I am as -- I will be as strong a
10 supporter. I would agree with much of the testimony
11 you've heard about the importance of solvency. I
12 agree an insurance company needs to be solvent. It
13 is a primary consumer protection. But I also would
14 assert with as much strength as I can, that
15 affordability is equally important.

16 I've heard many times in -- I don't
17 know, it doesn't matter whether the topic is how many
18 people are going to come on and off a plan during the
19 calendar year. And how many people are going to turn
20 65 on any other day than January 1, I'll put it that
21 way. How many people are going to -- is it
22 reasonable to put this amount in a reserve or that
23 amount into a reserve. I've heard again and again
24 this concept of it's better to say safe than sorry
25 from the insurer's perspective.

1 And I think the main point I want to
2 make is that there is a cost to being safe, being
3 more safe than sorry. That that decision to be -- to
4 err on the side of insurer solvency means people will
5 not be able to afford the care.

6 So I think I could have a couple of
7 very brief comments in response to some of the things
8 that have been raised, but I think I'll stop. Happy
9 to receive questions.

10 MR. KARNEDY: No questions.

11 HEARING OFFICER HENKIN: Does the board
12 have any questions?

13 (No response)

14 HEARING OFFICER HENKIN: Thank you, Mr.
15 Fisher. Did you want to say anything to close?

16 MR. KARNEDY: Well, being a lawyer, I
17 would say that I'm happy to waive closing if my
18 brother is as well. If not --

19 HEARING OFFICER HENKIN: I thought you
20 were going to say I feel compelled to say something.

21 MR. KARNEDY: But if he's going to
22 talk, I'm going to talk. Jay, if you are -- do you
23 want to do a closing? If you do, I want to do a
24 closing.

25 HEARING OFFICER HENKIN: You can say

1 anything brief, not at all.

2 MR. ANGOFF: I appreciate the offer,
3 and I hate to not accept it unconditionally. I would
4 just like to do a short closing. Two minutes tops.

5 MR. KARNEDY: Then I will be brief.

6 HEARING OFFICER HENKIN: Go right
7 ahead, Mr. Karnedy.

8 MR. KARNEDY: MVP requests a rate
9 increase of 4.6 percent as amended from our original
10 May 11 request of 6.4. Those numbers are the numbers
11 felt by Vermonters. This reduction recognizes a
12 decrease from an actuarial adjustment on silver
13 loading of some three percent, a risk adjustment
14 reduction of 1.9 percent, and an increase of .5
15 percent based on the hospital's proposed budgets.
16 MVP has met its burden. I'll leave you with a quote
17 from now retired Justice Dooley, one of his last
18 decisions was in our case in re: MVP Health
19 Insurance, where he questioned -- no, where we
20 questioned what to do about these non-actuarial
21 terms. And this is what he said. "That these terms
22 are general and open ended reflects the practical
23 difficulty of establishing quote, more detail, narrow
24 or explicit standards, end quote, in this field. A
25 difficulty due to the fluidity inherent in concepts

1 of quality care, access, and affordability given
2 advancements and setbacks in technology, medicine,
3 employment and economic well-being. Accordingly,
4 flexibility is required." It goes on from there.

5 So I read that because I dismissed the
6 notion that we have heard that we are sort of at sea
7 without an oar, or a life boat when we talk about
8 these concepts of affordability, quality of care, and
9 access. What Justice Dooley is saying that we don't
10 need to look to Webster's Dictionary to understand
11 what those words mean. What he's saying is whether
12 the rate is affordable or not, he's saying it's up to
13 the Green Mountain Care Board to determine that.
14 You're your own Webster's dictionary. You can decide
15 that.

16 And MVP has provided sufficient
17 evidence that will fall into the various buckets,
18 some not actuarial, some actuarial, but I think this
19 is not a problem. I think you have plenty of
20 evidence to find in MVP's favor and approve the rate
21 filing as amended. Thank you.

22 HEARING OFFICER HENKIN: Mr. Angoff.

23 MR. ANGOFF: Three points. First, this
24 business about MVP charging Vermonters more or
25 treating Vermonters less favorably than New York

1 residents I think is not only fundamentally unfair,
2 both having a higher CTR for Vermont residents and
3 not allocating the administrative expenses that
4 should be allocated to Vermont. Not only is that
5 fundamentally unfair, but it hurts Vermonters a lot
6 without benefiting New Yorkers much, because New York
7 is so much bigger. So it just doesn't make sense.
8 That's number one.

9 Number two, as far as the RBC issue is
10 concerned, you know what MVP's RBC ratio is. You
11 know you heard the Commissioner testify yesterday
12 that the no action level is 300. My only point is
13 that I think MVP's RBC ratio is fine. The board does
14 not need to be concerned about it, adding an
15 additional contribution to reserves. It's really
16 surplus. The board doesn't need to add a
17 contribution to raise RBC -- MVP's RBC ratio.

18 Third and final point, I essentially
19 agree with Mr. Karnedy that, yeah, the board has
20 tremendous discretion. This is a unique or near-to
21 -unique statute. That I'm told it's based on Rhode
22 Island's, but I don't think Rhode Island -- Rhode
23 Island has done too much with it. You're the only
24 regulatory board in the country that goes through
25 this process and has got to determine what those

1 words mean. And you do have discretion to do that.

2 And I think that there's the plain
3 meaning of those words and that the board -- the
4 board should take the unfair, excessive and
5 inadequate standards very seriously, but it should
6 take all the other standards equally seriously.

7 The board has a very difficult job in
8 balancing those standards. Thank you.

9 HEARING OFFICER HENKIN: A few matters
10 in closing. There were some questions that were
11 presented to MVP where we were going to get responses
12 from you, from the appropriate folks. I think we can
13 reduce that to a writing and get it off to you
14 hopefully by the end of tomorrow so you'll have those
15 questions available. There is no extension on times
16 for memo or anything else in this matter. We have, I
17 believe, other than these responses, all the
18 testimony. There's been no amendment. I believe we
19 will stay right on schedule with this which means
20 that memos will come in -- public comment closes
21 tomorrow -- tonight or tomorrow. Today's the --
22 tomorrow.

23 We have been receiving a lot of public
24 comment. We have a public comment period open
25 tonight. We will take some public comment. Today

1 there is a few people who signed up. And as I said,
2 we will send those questions out very promptly.

3 MR. KARNEDY: May I ask a question?

4 HEARING OFFICER HENKIN: Yes.

5 MR. KARNEDY: The questions -- we have
6 to prepare a brief. We will meet the deadline, but
7 when will the responses to the questions be due?
8 There were a number of fair and good questions.

9 HEARING OFFICER HENKIN: I think some
10 of them are very direct, and they shouldn't be, you
11 know, if you can quantify the traffic on your
12 website, for instance, on your consumer website.
13 These type of things, I think, should be pretty
14 direct.

15 I would like to have those questions
16 all back by no later than Monday. And --

17 MR. KARNEDY: I wonder if it's possible
18 given that the brief is due on Monday, could we get
19 the responses to the questions sometime later in the
20 week next week?

21 HEARING OFFICER HENKIN: Let's take a
22 look once I quantify these, and I'll take a look in
23 house. I have been very pleased with the fact that
24 Matt tends to do things before they are actually due.
25 If I can stress that that would happen again, I would

1 give you a few extra days.

2 BOARD MEMBER HOLMES: His mother is
3 very proud.

4 HEARING OFFICER HENKIN: I don't know
5 as that will happen. Please, I will try to work with
6 you on that. We want to get the answers as quickly
7 as possible, but we want them fully answered, so I
8 will consider that. But I'm not going to, as I said,
9 I do want to look at these closely and make sure we
10 can ask pretty pointed questions that will be
11 relatively -- I won't say easy -- but they will be
12 something you can answer and don't demand Matt to do
13 a huge essay which we are going to grade him on.

14 I think some of these he has to get the
15 information, or you have to get the information from
16 other persons at MVP.

17 MR. KARNEDY: It sounds like you'll
18 fairly work with us on that, which we appreciate.

19 HEARING OFFICER HENKIN: I will work
20 with you on that.

21 MR. KARNEDY: Thank you.

22 HEARING OFFICER HENKIN: Okay. We do
23 have a few people that signed up today to comment.
24 And again, there is a comment period this evening.
25 David Hills is the first person, if you could come up

1 and have a seat.

2 MR. HILLS: I'm going to withhold my
3 comments for now.

4 HEARING OFFICER HENKIN: Okay. Jill
5 Charbonneau.

6 CHAIRMAN MULLIN: You didn't bring
7 doughnuts.

8 MS. CHARBONNEAU: I didn't come to the
9 bakery this morning. I'll remember that.

10 My name is Jill Charbonneau. I'm
11 president of the Vermont State Labor Council,
12 AFL-CIO. Listening to some of the discussion here
13 today I'm not sure that my comments fit in, but
14 obviously stop me if you don't want to entertain what
15 I have to say.

16 I spend a lot of time in the
17 legislature, and I hear the term affordability a lot.
18 And also on the even years I spend a lot of time on
19 the doors, and I hear the term affordability a lot.
20 And one thing that I think Vermonters find is that
21 their health care is unaffordable. And I recognize
22 that medical insurance is not the same as health
23 care. But still, it is unaffordable to Vermonters.

24 I mean I hear stories of people working
25 less because they can't afford to work more and still

1 receive some of the benefits of health care through
2 the Affordable Care Act. I hear Vermonters going to
3 their doctors and getting prescriptions. One of the
4 solutions was, you know, we will give you a larger
5 dosage. It will be more affordable to you, but
6 you'll have to cut the pill in half. That's a great
7 solution when it works, but most of the time there
8 are many Vermonters where this doesn't work. So when
9 you examine what rate setting can do and whether an
10 insurance company needs two percent or 1.5 percent or
11 whatever it is that they may need, also reflect on
12 what it's going to cost Vermonters when they try to
13 receive medical care that they can't afford. Because
14 for many Vermonters health care is unaffordable. And
15 that's what I wanted to share.

16 HEARING OFFICER HENKIN: Thank you.

17 MS. CHARBONNEAU: Thank you.

18 HEARING OFFICER HENKIN: Jeff Hochberg.

19 Just because of apportioning this evenly with the
20 evening folks, I'm giving everyone three minutes.
21 I'm only kidding. Please.

22 MR. HOCHBERG: I'll be brief. My name
23 is Jeff Hochberg. I'm the president of the Vermont
24 Retail Druggists, also the director of the pharmacy
25 group. I wanted to bring attention to something that

1 may or may not be present in the binders, the
2 information you received from both Blue Cross and
3 MVP. It's certainly something that was discussed
4 about pharmacy trends and how cost of pharmaceuticals
5 are going up.

6 A lot of attention was directed at
7 specialty drugs. So I want to add some clarity for
8 the board on what a specialty drug is. It's a term
9 that's broadly applied to high-cost drugs. This term
10 does not have any federal, state or professional
11 regulatory rule definition. Loosely put, even
12 insulin can qualify for a specialty drug.

13 In 2018 MVP required all Vermont
14 beneficiaries on the exchange to utilize CVS Caremark
15 pharmacy solely for the distribution of specialty
16 products. This is a mail order pharmacy, not a
17 residential. And again, CVS Caremark had in its sole
18 discretion to define what drugs qualified under this
19 category of specialty drugs.

20 It may or may not be evident in the
21 binders that this is going to be -- this practice is
22 going to continue. I have been indicated by Brian
23 Murphy of Blue Cross Blue Shield that Blue Cross Blue
24 Shield of Vermont does intend to do the same thing
25 with its mail order pharmacy owned likewise by its

1 PBM, Accredo Pharmacy, owned by Express Scripts DSI.

2 So when I sit here and I listen to
3 comments about increasing access, and I appreciate
4 the efforts you're doing on the provider level, but
5 they are not -- frankly they are doing quite the
6 opposite on the prescription level. So at this point
7 if these plans were to exist, all the business
8 potentially could be forced to mail order. And
9 Vermonters would have very little access to
10 community pharmacies, to help drive costs down, to
11 help encourage lower cost substitutes, to help
12 coordinate benefits within the various providers.
13 This impacts both communities for retail pharmacies
14 and hospital outpatient pharmacies, particularly the
15 hospital pharmacies in relation to the 340b practices
16 which is a very significant portion of their budget
17 items.

18 And quite frankly, we take the position
19 that this is a violation of state statute. In the
20 2013-'14 session the statute under Title 8 Section
21 4089(j) section B reads: A health insurer and
22 pharmacy benefit manager doing business in Vermont
23 shall permit a retail pharmacist licensed under 26
24 V.S.A. Chapter 36 to fill prescriptions in the same
25 manner and at the same level of reimbursement as they

1 are filled by mail order pharmacies. With respect to
2 quantity of drugs, days supplies of drugs suspends
3 under each prescription. There is no financial
4 windfall for any consumer to receive the product via
5 mail versus a retail pharmacy as per the statute.

6 So I don't understand why it thinks
7 this. That was my comments. Thank you.

8 HEARING OFFICER HENKIN: Thank you.
9 Dale Hackett. Is there a Dale Hackett here?

10 MR. HACKETT: I have no idea who he is.
11 Okay. I wrote it as a consumer, is that okay?

12 CHAIRMAN MULLIN: That's fine.

13 HEARING OFFICER HENKIN: Have a seat.

14 MR. HACKETT: I'm a little concerned
15 like with all these do's, don'ts, and so forth.

16 CHAIRMAN MULLIN: We are in a public
17 comment period. You don't have to worry about it.
18 Those rules of evidence you don't have to worry
19 about.

20 MR. HACKETT: Oh shoot. That's not my
21 world. If I'm convinced of nothing else, it's that I
22 don't want to live in that world. And it's just a
23 tough world. That's all I'm saying. It's not my
24 world.

25 So my comments are simply from the

1 consumer perspective. What sounds good isn't what
2 looks good when you're the consumer doing the
3 purchasing. Actuarial can't tell you what you can
4 afford. They tell you what the company can afford.
5 There is very little in their discussion that is
6 what's in my head when I'm looking at what I have to
7 consider when I'm deciding what to buy for health
8 care.

9 Life is not data. It has emotions,
10 there is art, there is uncertainty, there is love,
11 there is aging, there is family, there is children,
12 school, housing, some of these things have expenses.
13 Food, education, day care. And you cannot escape the
14 consequences.

15 A consumer has to consider their
16 solvency when buying a health care plan that goes
17 well beyond the cost of the plan itself. It includes
18 the affordability of the utilization of the plan and
19 not just the premium cost. You have to consider how
20 often you use it, why are you going to use it, what's
21 the copays, far more than they ever discuss.

22 They do get at it. I'm just saying
23 it's more than they discuss. When we consider a cost
24 we think solvency and resiliency of our household
25 financial status as a consumer. What we think about

1 next is where we, as consumers, can disagree with any
2 insurance company and probably do as costs go up.
3 Where do we ever have the ability other than public
4 comment right now where we can actually listen to
5 this and come back and say, you know what, that's not
6 our world.

7 The services good health care requires
8 to be delivered is required of the plan, I have but
9 always not -- oh, of the plan I have, but not always
10 available. Do I need to repeat it or did that make
11 sense? Because I want to try to not take too long.
12 What a plan does not deliver does have a cost.
13 You've heard that before. We face that all the time
14 up here. It's not in the equation. Out there, it's
15 in the equation. These are what we call the
16 consequences.

17 What bothers me about the rate reviews
18 is the lack of focus on the affordability or just
19 what I have been talking about as we see it. For all
20 our regulations affordability of a social need by
21 society is not assured by an insurance company.
22 That's part of the problem. Their performance,
23 insurance companies, always fall short of needs by
24 society, they don't have to conserve. That, I think,
25 is a fact denied too often that we all if we just

1 stop and think about it realize that as soon as we
2 walk out that door, it is reality.

3 I'm done almost. Consumer solvency is
4 different in context than insurance companies
5 validate. I ask the board to validate consumer
6 solvency and health care expenses. At least consider
7 our point of view and what we live with. Most plans'
8 policies do not account for life experience, except
9 when they talk about risk adjustment. We need to
10 find respectful common ground. Sorry, long winded,
11 but at the same time, thank you for letting me say
12 that.

13 HEARING OFFICER HENKIN: Thank you,
14 Dale. With that, I will turn it back over to the
15 Chair to close the meeting.

16 CHAIRMAN MULLIN: Is there a motion to
17 close?

18 BOARD MEMBER LUNGE: I move to adjourn.

19 BOARD MEMBER PELHAM: Second.

20 CHAIRMAN MULLIN: All in favor.

21 BOARD MEMBERS: Aye.

22 CHAIRMAN MULLIN: Any opposed?

23 (No response.)

24 CHAIRMAN MULLIN: Thank you everyone.

25 I know it's been a long couple of days.

1 HEARING OFFICER HENKIN: And it's not
2 over.

3 CHAIRMAN MULLIN: 4:30 at Montpelier
4 City Hall.

5 HEARING OFFICER HENKIN: In the
6 Memorial Room.

7 (Whereupon, the proceeding was
8 adjourned at 2:34 p.m.)

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C E R T I F I C A T E

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3 I, Kim U. Sears, do hereby certify that I
4 recorded by stenographic means the hearing re: MVP Health
5 Care 2019 Vermont Health Connect Rate Filing at the
6 Vermont State House, Room 11, 115 State Street,
7 Montpelier, Vermont, on July 24, 2018, beginning at 9 a.m.

8 I further certify that the foregoing
9 testimony was taken by me stenographically and thereafter
10 reduced to typewriting and the foregoing 237 pages are a
11 transcript of the stenograph notes taken by me of the
12 evidence and the proceedings to the best of my ability.

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

16 Dated at Williston, Vermont, this 25th day
17 of July, 2018.