STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-007-17rr

IN RE: MVP Health Care 2018 Vermont Health Connect Rate Filing

July 19, 2017
9:00 a.m.
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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 19, 2017, beginning at 9:00 a.m.

P R E S E N T

BOARD MEMBERS: Noel Hudson, Hearing Officer
Kevin Mullin, Chair
Maureen Usifer
Jessica A. Holmes, Ph.D.
Con Hogan
Robin Lunge, JD, MHCDS
Judy Henkin, Esq.

CAPITOL COURT REPORTERS, INC.
P.O. BOX 329
BURLINGTON, VERMONT 05402-0329
(802)863-6067
E-mail: info@capitolcourtreporters.com

P R E S E N T

Kaili M. Kuiper, Esq., Office of the Health Care Advocate
Gary Karnedy, Esq., Primmer, Piper, Eggleston & Cramer, PC
Matt Lombardo, MVP
Jacqueline Lee, Lewis & Ellis
Jesse Lussier, Department of Financial Regulation
Scott Kline, Department of Financial Regulation

I N D E X

CHAIRMAN MULLIN: So good morning, everyone. Today's meeting is on the rate filing for MVP. Today's Hearing Officer will be Noel Hudson, and, at this point, I'll turn the meeting over to Noel.

MR. HUDSON: Good morning, everybody. Could I ask people to turn all cell phones off at this time so we can have a clear and distraction-free environment for the participants and for the court reporter? Also, the Sergeant-at-Arms has requested that I announce that there's a rule for the room that is water only, no coffee, and water needs to be in a covered container.

So my name is Noel Hudson. I am part of the Green Mountain Care Board staff, and today I'm sitting as the Chair's designated Hearing Officer. It is July 19, 2017. This is a hearing in the matter of MVP Health Care's Vermont Health Connect 2018 Rate Filing, Docket Number GMCB-007-17rr. The authority under which this hearing is conducted is 8 Vermont -- sorry -- Title 8 of the Vermont Statutes, Section 4062; Title 18 of the Vermont Statutes, Section 9375; and the Green Mountain Care Board's Administrative Rule 2.

The parties to the proceeding are MVP Health Care, Incorporated, represented by Attorney Gary Karnedy, and the Vermont Office of the Health Care Advocate, represented by Attorney Kaili Kuiper. We'll also be

hearing from the Vermont Department of Financial Regulation today. They are not a party, but they are serving as a witness as designated by statute. And we'll also be hearing public comments from any members of the public who are in attendance and wish to comment on the proceeding.

We have a court reporter with us today. This is Ms. Sunnie Donath. She's here to record the proceeding and produce a transcript. It will be available within a reasonable time. At this point, I'd like to ask Ms. Donath to swear in all the scheduled witness. They are Matt Lombardo, Jesse Lussier, and Jacqueline Lee.

(All witnesses sworn in by the court reporter.)

MR. HUDSON: So the first order of business is entering some stipulated exhibits into the record, and, since Attorney Karnedy and his staff kindly produced those exhibits, I'll give them the honors.

ATTORNEY KARNEDY: Thank you. I'll do that through the witness who's now been sworn in to that extent.

MR. HUDSON: That's fine.

DIRECT EXAMINATION BY ATTORNEY KARNEDY

Q. So, Mr. Lombardo, let's just start simply with where you work and identify yourself, and then we'll put the exhibits in and go over the proceedings.

A. Okay.

Q. So who are you, and where do you work?

A. Matthew Lombardo. I work for MVP Health Care.

Q. And you have a binder in front of you, correct?

A. That's correct.

Q. And those are stipulated exhibits, correct?

A. Correct.

Q. Would you turn to the first page, which is an exhibit list?

A. Okay.

Q. And I just want to identify these, and then we'll be talking later just to get them into evidence. Exhibits 1 through 7 are, Number 1 is MVP's rate filing, and 2 through 7 are a number of responses to questions posed in writing by L&E, correct?

A. Correct.

Q. And those have all been stipulated to, correct?

A. Correct.

Q. And you're familiar with those and you adopt those as part of your testimony here today, correct?

A. That's correct.

Q. And Exhibit 8 is a MVP Revised Rate Filing. Do you see that on the list?

A. Yes.

Q. And that's been stipulated to?

A. Correct.

Q. And that is similar to Exhibit 1, which was our original rate filing, with the exception of Page 116 and 126 which were switched out to show some changes in the filing, correct?

A. That's correct.

Q. And you adopt that as your testimony, right?

A. Yes.

Q. And Exhibit 9 is the Department of Financial Regulation July 11th Solvency Announcement Statement, correct?

A. Correct.

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

A. Yes.

Q. And Exhibit 10 is the L&E actuarial opinions dated July 11th 2017, correct?

A. Correct.

Q. And you reviewed those? You're familiar with those?

A. That's correct.

Q. And Exhibit 11 is your CV that you prepared, correct?

A. Correct.

Q. And all of these you're familiar with, correct?

A. Yes, that's correct.

ATTORNEY KARNEDY: So I would move for the admission of Exhibits 1 through 11.

MR. HUDSON: Are there any objections to the entry of Exhibits 1 through 11 into the record?

ATTORNEY KUIPER: No objections.

MR. HUDSON: Hearing no objections, let the record reflect that those exhibits are entered into the record. Would you like to offer an opening statement at this time, Attorney Karnedy?

ATTORNEY KARNEDY: I would. Thank you very much. Good morning. My name is Gary Karnedy. I'm from Primmer, Piper, Eggleston & Cramer, and I represent MVP in this 2018 rate filing. Since our hearings last summer, I know we've added several new board members, and I look forward to presenting evidence today to Chairman Mullin, Board Members Usifer and Lunge and along with Con Hogan and Board Member Holmes who've heard from us in prior hearings.

I'm here today. I think I have a familiar face. I'd like to introduce Susan Gretkowski, who is MVP's Senior Vermont Government Affairs Attorney. Susan is a former Deputy Commissioner of DFR. Back then it was called BISHCA, and I believe Susan won't be testifying but I wanted to acknowledge the fact that she personifies the long-term relationship that MVP has had

with the State of Vermont working to address the complex challenges of providing health insurance to Vermonters, and MVP intends to continue to be a part of the Green Mountain Care Board.

I've been representing MVP at these rate filings for many years now, and every year involves some complex actuarial evidence, and we attempt -- and I would underline "attempt" -- to explain those issues in simple terms so that even a layperson like myself can understand them. What I like about these rate filings in contrast to a jury trial that I might have down the street at the Superior Court is that the decision of the Board in contrast to a jury is grounded in methodical and sound actuarial advice.

In a jury trial the trial starts. The jury sees a barrage of evidence for the first time, and then they're asked at the end of the day to go shuffle into a room by themselves. The door closes. They're on their own. They review the evidence they just heard and, for the first time, all these exhibits are given to them and they have to decide while everyone's out in the courtroom with their feet tapping what is the exact dollar amount of some award. Although we call it jury deliberations, it doesn't often feel very thoughtful or deliberate.

In contrast, the evidence will show that this Green Mountain Care Board rate process started way back on May the 12th when MVP first submitted their rate filing. Mr. Lombardo passed MVP's baby to the hands of L&E. Since May 12th your actuary, L&E, has vigorously and rigorously pored over this rate filing. This year we had six rounds of detailed technical written question-and-answer, telephone calls, all to understand the basis of MVP's assumptions and methodologies. I counted 50 highly technical questions in writing alone. Over the past 60 days, L&E has analyzed, poked, and prodded.

The result is that L&E found several bases to reduce the amount of MVP's rate request that make prudent sense and have been adopted by MVP. Matt's baby had a battery of tests, a full physical, and all of its shots courtesy of L&E. L&E's professional skepticism has made this a better rate filing for Vermont insureds. Vigorous and rigorous, unlike a lay jury immediately after a trial, this experienced Board takes up this important, complex task of determining whether a rate increase is reasonable and meets the statutory criteria with the added benefit of your own expert's independent and thorough review over the last 60 days.

Most every year the actuaries of MVP and L&E have a dispute regarding many aspects of the rate filing. Reasonable actuaries can have a professional difference of opinion. L&E has never been afraid to challenge MVP's assumptions and methodologies. We've had some lively cross-examination over the years, but this year is different. The evidence will show that there's extraordinarily broad agreement between L&E and MVP. The evidence will show that MVP is reducing its rate hearing request from the original 6.7 percent down to 5.1 percent based on L&E's suggestions, which is almost a 25 percent haircut.

L&E would like MVP to drop another .3 percent to 4.8, so another .3 to 4.8, so there is, in fact, one issue of disagreement this year we'll need to address in this hearing. We believe the evidence will persuade you with the simple notion that a 25 percent haircut is sufficient and that, in light of the insurance options in the exchange this year, MVP's 5.1 percent increase is the most reasonable increase available to Vermonters. Thank you very much.

MR. HUDSON: Thank you, Attorney Karnedy. Attorney Kuiper, do you want to offer an opening statement at this time?

ATTORNEY KUIPER: Yes, I would. Thank you.

Hello. My name is Kaili Kuiper, and I'm a staff attorney with the Office of the Health Care Advocate. We are a project of Vermont Legal Aid, and we offer help for Vermonters who have issues related to access to health care including health insurance. We also represent Vermonters in health insurance rate setting cases before the Green Mountain Care Board like this one today.

Today you'll hear from Lewis & Ellis, the Board's actuaries, who recommend a reduction in MVP's overall rate increase from 6.7 percent to 4.8 percent based on four rate modifications. You will also hear from the Department of Financial Regulation. You will hear that MVP is a strong company and that its Vermont business makes up only a small portion of its overall business. The federal government -- or sorry. Each one of these witnesses will address the issue of affordability.

The federal government requires all Americans to purchase health insurance, and the State of Vermont has chosen to require all individuals and small businesses to purchase health insurance on the Vermont Health Insurance Exchange. This is good public policy because it stabilizes the health insurance market, but the fact that Vermont, Vermont requires individuals and small businesses to purchase insurance on the Exchange

obligates the Board to ensure that rights are affordable and justified.

MVP's proposed cost increase looks good in comparison to its competitor, but that is not a valid benchmark for affordability. Everyone see this chart? So from 2014, the time the Vermont Health Insurance Exchange started, in the past three years, MVP's rates have increased 17.8 percent. If MVP's total proposed rate increase from this filing was implemented, it would get us up to a 25 percent increase over four years. If L&E's modified rate increase is implemented, it would still get us to a 23.5 percent increase over four years.

If we compare that to wage growth over the same period, the latest data goes through 2016 and is a 4.8 percent rate increase. The gap between these numbers show how Vermonters are struggling to afford health insurance while putting a roof over their head and food on the table. It also negatively impacts the bottom line for small businesses and, as a result, affects solvency for small business and also wage growth in Vermont.

We know that the Board takes seriously its responsibilities, its regulatory responsibilities to Vermonters. We ask the Board to set health insurance

rates at a level to help Vermont's small businesses and families thrive. Thank you.

MR. HUDSON: Okay. So, at this point, we're going to proceed to the examination of witnesses.

ATTORNEY KARNEDY: Just one preliminary matter. That graph isn't in evidence yet. So we'd stipulated to exhibits in advance. So I'd ask that it just be set down until we get to that point.

MR. HUDSON: Okay. Before proceeding to the examination of witnesses, I would just note that the Board's rate review rule allows any Board member to question any witness at any time, but I would ask the Board to, during the examination and cross-examination of witnesses, limit questioning to any immediate clarification needed and keep substantive questions for later. So, Attorney Karnedy?

ATTORNEY KARNEDY: Thank you very much.

DIRECT EXAMINATION BY ATTORNEY KARNEDY

Q. So, Matt, we're kind of sitting next to each other here, so I want you to focus your attention to the Board and not to me, okay?

A. Okay.

Q. So who's your employer, Matt?

A. MVP Health Care.

Q. And what is your position at MVP Health Care,

please?

A. Director of Actuarial Services.

Q. And what do you, or how long have you worked at MVP, generally?

A. I've worked at MVP for about ten years, and I've worked in the health care industry for about twelve at this point.

Q. And have you moved up in the ranks at MVP over time --

A. Yes, that's correct.

Q. -- to your current position?

A. Yes.

Q. And do you have any professional memberships?

A. I'm a fellow of the Society of Actuaries. I'm a member of the American Academy of Actuaries.

Q. Thank you. And what are your job duties, please?

A. There's various responsibilities, one of which is managing our commercial rate filings for both New York and Vermont, overseeing provider risk share arrangements, internal financial reporting, as well as competitive analysis on our premium position as well as setting IBNR and reserves.

Q. So is part of your job to review the cost drivers?

A. Yes, that's correct.

Q. Matt, if you would just turn to the binder for a

second, all this is in evidence now, but I wanted to point out, in the bottom right-hand corner of the various exhibits, there's red-numbered pages. Do you see those?

A. Yes.

Q. And so what I'd like you to do so the Board can follow us as we go through the documents is refer to those page numbers, okay?

A. Okay.

Q. And I'll do the same. What does MVP offer in terms of products in Vermont?

A. In Vermont we offer fully insured commercial products, which would range from individuals through large groups as well as self-insured ASO business, so larger employers, and we have a small Medicare presence, about 1,500 members, as well.

Q. And could you tell the Board about MVP's market share and how that may have changed over time?

A. Yes. So in 2016 MVP had approximately 10 percent of the Vermont Exchange market. In 2017 we were able to offer a more competitive premium rate, and, as a result, we've grown our membership as a percentage of the total. So now, as of today, we've grown, we've grown by about 50 percent, maybe even a little more, from June of '16 to June of '17, and we hold about 15

percent of the market.
Q. So it used to be 10, and now it's 15 this year?
A. Correct.
Q. And how do you account for that, generally, for that increase in market share? How did it happen?
A. Well, we've been trying as hard as possible to manage down costs, and we recognize that costs are increasing, but we are trying to manage our costs down to offer the most affordable premium rate to Vermonters, and in 2017 our premium rate was more competitive than it has been in the past relative to Blue Cross Blue Shield.
Q. And we'll get into more detail in a moment, but MVP's, what was the amount of MVP's original filing, the rate increase?
A. 6.7 percent.
Q. Okay. With modifications that you'll be testifying, what is the rate that we're seeking the Board to consider today?
A. 5.1 percent.
Q. So, based on the rates as filed and modified, do you have an opinion regarding market share for MVP for 2018?
A. Yeah. So we analyzed our premium position on the proposed premium rates relative to Blue Cross Blue

Shield, and we already had a competitive premium rate in 2017. Our proposed rate increase is more favorable than Blue Cross Blue Shield's. So, if the rates are proposed -- if the proposed rates are approved in a similar fashion, we do expect to continue to grow market share in 2018.
Q. Matt, if you would, go please to Exhibit 8.
A. Okay.
Q. And, again, if you could identify for the Board what Exhibit 8 is in the binder?
A. Exhibit 8 is MVP's Amended Rate Filing that was submitted per L&E's request on July 7th 2017.
Q. So we'll be referring to this when we walk through and talk to the Board about your rate filing, correct?
A. That's correct.
Q. Could you go to Exhibit 10, please, and identify it?
A. Exhibit 10 is L&E's Actuarial Opinion of MVP's rate filing.
Q. Would you go to Page 10 of Exhibit 10?
A. I'm there.
Q. I want to wait until the Board's there.
A. Okay. That makes sense.
Q. Great. You see there's four bullets under "Recommendations"? Do you see that?

A. Yes.
Q. And this is going to be a frame of reference as we go through your testimony today, okay? So, if you go to the very last sentence below those bullets, what does it say?
A. "After the modifications the anticipated overall rate increase will reduce from 6.7 percent to approximately 4.8 percent."
Q. So that would be about, if you took that reduction, about 1.9 percent if my math is right?
A. That's correct.
Q. And that would be about a 30 percent reduction?
A. Yes.
Q. And the differences that they make reference to -- you've read this and are familiar with their opinions -- does it relate to, in some way, to the four bullets above?
A. Yes.
Q. So let's look at that second bullet.
A. Okay.
Q. And we'll talk in more detail on all of these, but just generally at a high level, that second bullet makes reference to a decrease of what?
A. .5 percent.
Q. So, as the second bullet, do we have agreement

between MVP and the Green Mountain Care Board's actuary?
A. Yes.
Q. We agree to that reduction, correct?
A. Yes.
Q. And the fourth bullet, risk adjustment, do you see that?
A. Yes.
Q. And do we have agreement on that reduction?
A. Yes, we do.
Q. And then the very first bullet there's a decrease of .3. Do you see that?
A. Yes.
Q. And that's something we don't have agreement on; is that right?
A. Yes. We have a professional disagreement on it.
Q. And then, as to the third bullet, tell me. Is there a particular decrease in rate percentage in that third bullet?
A. No, there's no specific amount quantified in that bullet.
Q. Okay. But you'll be testifying a little bit about that bullet in the issues, correct?
A. Correct.
Q. Great. So we're at what number?

A. 5.1 percent.
Q. And L&E is at what number?
A. 4.8 percent.
Q. Okay. So I want to start by just generally understanding the rate filing and walk through it. So, if you go back to Exhibit 8, please, and, Matt, you see the numbered pages, right, on the bottom right-hand corner?
A. Yes.
Q. So Page Number 1, when, when was the original rate filing filed?
A. The original filing was submitted on May 12th 2017.
Q. Okay. And there's some summary tables up front in the filing that I'm going to ask you about. Go to Page 3, please.
A. Okay.
Q. Would you please explain some of the numbers on this page, please?
A. Sure. So the 6.74 percent, that represents the overall average rate increase. That was a figure that you had referenced earlier, Gary. That 6.74 percent increase, based on our February 2017 enrollment, results in an increase of premiums of $3.7 million.
Q. And that's the next column over?

A. Next column over.
Q. Yeah.
A. Moving to the right one more column, the 4,889 policyholders are impacted by this rate filing. So just to define policyholder, the Exchange in Vermont is a merged market, so it's small employers, up to a hundred employees, plus individuals. So, if the policyholder is the person that's paying the premium, for a small group that would be the employer group, for an individual that's going to be the subscriber, and our current premium that we're --
Q. That's the next column?
A. Yeah. Go to the next column?
Q. Yeah.
A. We are projecting to collect $55 million approximately in 2017, and there has been a couple of modifications to benefits that we're offering. So we're not offering a flat 6.74 percent rate increase to every policyholder. They're going to vary between 2.28 percent at the bottom and up to 10.55 at the top.
Q. So those last two columns show the range; is that correct?
A. That's correct, using the 6.74 as an average.
Q. And then, because of the concessions we've made because of L&E's good work, some of these numbers are

going to change a bit, right?
A. Yes.
Q. Okay, thank you. Would you go to Page 8, please, of the rate filing?
A. Okay.
Q. So there's a number of columns. Again, at a high level, could you explain what a nonstandard plan is versus a standard plan and talk a bit about the metal levels?
A. Okay. Part of the Affordable Care Act when it was rolled out, it was understood that health care is very complex and, to try to simplify a consumer's understanding of what they're buying, what they're actually purchasing for their premium dollar, the federal government came up with two different concepts.
One of them is having standard benefit design offerings. So what that means is that the competitors in a given state -- so in Vermont it would be MVP and Blue Cross Blue Shield -- are going to be offering the exact same benefits for the standard plans that are offered. That means that a consumer can then go on the Vermont Exchange and compare premium rates directly and know that it's an apples-to-apples comparison.
Nonstandard plans are also in place which give the carriers a little bit of flexibility to come up with,

you know, some different cost-sharing elements like copays for visiting your doctor, pharmacy copays, but we do have to comply with the metal levels which are Platinum, Gold, Silver, and Bronze.
So what those correspond to is the actuarial value of the benefits being offered. So an actuarial value would say, if it's a Platinum plan, it's approximately 90 percent. So 90 percent actuarial value means that, for a given service, it would be anticipated that a member would pay $10 if it was a $100 service and MVP would pay $90 down to Bronze where it's 60 versus 40.
Q. Thank you. On the table there's a couple of words that I'd like you just to, at a high level again, explain. See in under "Nonstandard Plans" there's the letters CSR and non-CSR; do you see that?
A. Yes.
Q. What's CSR, please?
A. So. CSR is another element of the Affordable Care Act. It stands for cost share reduction, and that was a program that was put in place, and it's available to individuals purchasing Silver plans where members that are lower on the, have a lower income are actually subsidized by the federal government to help them with their cost sharing. So an example would be, if a standard, if the non-CSR Silver plan had a $30 copay,

the CSR plan may only have a $10 copay, and then that $20 difference is funded by the federal government to MVP.
Q. Thank you. And, over at the far right, do you see the reference to "Catastrophic", the last column --
A. Yes.
Q. -- in Table 4? What's catastrophic, please?
A. So that's one of the other elements that the federal government introduced in the Affordable Care Act. So one of the concepts of the Affordable Care Act is for everybody in the country to have insurance or have health care coverage, and a way to entice younger individuals that may not utilize a lot of services, a catastrophic plan was introduced. So the catastrophic plan is available for members under age 30 or members facing financial hardship, and what that plan provides is just, you know, similar to a Bronze benefit, but we're able to adjust the premium rate for that plan design for the population that's going to purchase it.
Q. Last question on this table, please. Do you see down three, down three it says "2018 Proposed Rate Increases" on the far left. Do you see that, "2018 Proposed Rate Increases"?
A. Yes.
Q. Just generally, these numbers that go across from

there and then they end with a 6.7 total revenue change, do you see that?
A. Yes.
Q. So what are these? At a high level, what do these numbers across the table reflect?
A. Those figures represent the rate increase that MVP is proposing by plan for the plans that are currently in place as of 2017. Going down, it, you'll see that they're consistent within each column. So, if you're looking at the far left column, each one of those numbers is 10.5 percent, and that's because we're projecting the same rate increase for single policyholders or family policyholders regardless of what contracts that they purchase.
Q. So it just shows the range of increases across the different products; is that right?
A. That's correct.
Q. If you go to Page 10 please, Page 10, again, this is, Matt, to get a general understanding of the filing. The second paragraph makes a reference you'll see in the middle of it to essential health benefits. Do you see that, "Essential Health Benefits"?
A. Yes.
Q. What are the essential health benefits? What does that mean? It says they are covered. What does that

mean?
A. So, under the Affordable Care Act, every plan that's offered has to meet an essential health benefit requirement, and what that's ensuring is that the plan that's being provided to a member provides comprehensive medical and pharmacy coverage and they meet a certain list of criteria that each state determines. So Vermont has determined a set of benefits to benchmark against that we have to provide coverage for, and MVP's filing includes, ensures that we're covering all of those benefits.
Q. The third paragraph if you count down --
A. Okay.
Q. -- it makes reference to a wellness benefit. Do you see that?
A. Yes.
Q. Can you explain that, please?
A. For MVP's nonstandard plans, we're also, we're offering a benefit that's in excess of the essential health benefits, and that's a reimbursement for a gym membership to help members, you know, maintain or start a healthy lifestyle if they want to start exercising.
Q. Which you do every day, correct?
A. That's incorrect.
Q. Let's go to Paragraph 5, please. That starts with

the book of business. Let me know when you're there.
A. Okay.
Q. And would you just walk through those numbers? I think you already pretty much explained this but, specifically with the numbers in the rate filing issue, what those different classes are.
A. Yes. So starting with the 4,889 policyholders, again, in a small policy that's the employer group. It's the person that's actually paying the premium or who's receiving the premium bill in the mail. In an individual policy, that's a subscriber. So, if you move over to the right one more to subscribers, you'll see that we have 6,847 subscribers. For individuals that equals policyholders, but for small groups that would equal employees. And then, moving over to the last number, 10,305, members would include subscribers plus any of their dependents, so spouses or children.
Q. Thank you. And, in the last paragraph on this page, there's a discussion around data in past years. Do you see that, the last paragraph?
A. Yes.
Q. So can you explain how this year is in some ways different than prior years in terms of past experience that you have to come up with a fair rate?
A. Yes. So in past years when the Affordable Care

Act was rolled out in 2014, there wasn't much of an individual market, or we didn't have data on the individual market for the State of Vermont, so we had to make a number of assumptions about what the individual market would look like, how those members would utilize services differently or similarly to small group policyholders where we had credible experience.

So that was in 2014. So, as individual members have enrolled, we've gotten a little better feel for how their experience compares to small groups, but then there was another wrench thrown into the Affordable Care Act data, and, actually, wrench is probably a mischaracterization, but there was a change to the definition of who is a small group in 2016. So, rather than it being 2 to 50 employees as a small group employer, it's now 2 to 100 employees.

So in prior rate filings we had to make assumptions about who was actually going to be transitioning into the Exchange, versus today we are basing our rate filing only on Exchange enrollment because all of that turmoil has kind of gone away.

Q. Thank you. If you go to Page 11, please --

A. Okay.

Q. -- count down one, two, three, four paragraphs,

the second-to-last paragraph, let me know when you're there.

A. I'm there.

Q. There's a reference to IBNR. Do you see that?

A. Yes.

Q. What is IBNR, and how does that relate to this rate filing?

A. IBNR is an acronym commonly used amongst actuaries. It stands for incurred but not reported claims, and what that is generally trying to do is quantify. It's a, it's an estimate of claims that haven't yet been paid although they've been incurred. So suppose I go to the doctor on December 30th for a visit. That claim may not be paid until months down the road, but we don't know about it until the claim is actually paid, so we have to add in --

Q. We meaning the actuaries?

A. Yes, the actuaries have to add in our best estimate of what that incurred but not reported claim amount is into our rates. If we failed to do so, our rates would be deficient, and they would not be sustainable.

Q. So MVP did that as part of this rate filing, correct?

A. Correct.

Q. And did, was MVP's IBNR-related work reviewed by any outside entities?

A. Yes. So each year MVP's financial statements are audited by a third-party auditor, and they also hire actuaries who review all our reserves to make sure that our financial statements are sufficient and adequate, and they reviewed our financial statements and our reserves and had no issues with them.

Q. The last paragraph on that page, see, it makes a reference to RX rebates. Do you see that?

A. Yes.

Q. What is that, please?

A. Pharmacy rebates are a function of brand and specialty pharmacy claims. So, if a pharmacy claim costs $300, the pharmaceutical manufacturer will actually reimburse the carrier a portion of those dollars back. So, when we set our premium rates, we look at what those RX rebates are, and we speak with our pharmacy team to try to get our best estimate of what pharmacy rebates will cost in the future, and we reduce our claim projections by that amount.

Q. So does MVP make efforts to maximize those rebates?

A. Yes. It's a rigorous job every year of our pharmacy team, and, yeah, they work hand in hand with

our Pharmacy Benefit Manager to try to reduce those, reduce costs as much as possible.

Q. And is that considered in this rate filing?

A. Yes.

Q. And is that passed on in the rates?

A. Yes, it is.

Q. Page 12, please. The very first paragraph there references, "To account for volatility in high-cost claims", do you see that?

A. Yes.

Q. Can you explain again at a high level how high-cost claims are considered in this rate filing?

A. Sure. So high-cost claims, MVP's defining them as claims in excess of $100,000. So each year there's a lot of volatility within that tail of those high-cost claims. So one year you may see a 10 percent average cost of those high-cost claims, and next year may be 20 percent. So, because there's so much volatility in those claims, the best approach isn't necessarily to take that amount in a given year at face value. So, rather than just take the average cost of high-cost claims in 2016, MVP looks back three years and then takes an average of the high-cost claim ratio to try get a better feel for a more average high-cost claim rate.

Q. Thank you. Would you go to Page 13, please?
A. Okay.
Q. There's a reference to medical trend factors. Do you see at the very top?
A. Yes.
Q. What is a medical trend factor, again, at a high level?
A. Sure. So medical trend is, in some, in a short summary, is just the change in expected medical costs from one year to the next. So, if a claim costs $100 in one year, provider reimbursements are changing or utilization patterns may be changing, and that claim may end up costing $105 in the following year.
Q. And in the second paragraph, the last sentence in the second paragraph, you reference some buckets, which I like that term, "buckets".
A. Um-hum.
Q. Can you explain that, please, and how it relates to the medical trend?
A. Okay. So, when we look at our medical claims, we break them into three buckets, as Gary was saying, inpatient, outpatient, and physician claims, and that's because our contracts are changing differently for inpatient, outpatient, and physician claims every year and we see different utilization patterns within those

three buckets.
So inpatient claims would be any claim where you're admitted to a hospital and you spend the night. An outpatient claim would be you go into a hospital or a free-standing am-surg center and you leave the same day, and then a physician claim would be just your standard office visit to a PCP or a specialist, or it could be a component of the inpatient or outpatient bill that we're seeing.
Q. The next paragraph, the last two words in that paragraph are frightening to me as a nonactuary. It's "regression analysis". Do you see that?
A. Yes.
Q. So what is regression analysis at a high level, please, and was it used in this rate filing?
A. Regression analysis was used in this rate filing to estimate our utilization trend. It's a statistical measure where we look at historical data, and then we, what we're trying to assess is how well our historical data fits to a given graph and if there's a trend that we can see in the graph. If there's a high correlation or R-squared value, then that means that there's some statistical significance to that trend, and, when we analyzed our data, we did see statistical significance in our regression analysis, and we're applying that

through utilization trends.
Q. If you go to the next page, please, see the heading at the top "RX Trend Factors"?
A. Yes.
Q. Is that the same notion as you described for medical trend factors?
A. In, in concept, yes.
Q. As it relates to the pharmacy, correct?
A. Correct.
Q. Okay. And in that paragraph there's a reference to -- in the second sentence it says, "Forecast provided by MVP's PBM". Do you see that?
A. Yes.
Q. What's MVP's PBM, please?
A. PBM is an acronym that stands for Pharmacy Benefit Manager. So, rather than MVP contracting with stand-alone drug stores on a one-to-one, on a store-by-store basis, we contract with the PBM, or Pharmacy Benefit Manager, to just get a reduction to the rates that we're charging. So, rather than paying $100 for a given prescription, MVP's pharmacy team negotiates discounts off of that $100, and then that's what we're actually seeing in our experience peer data and we're reflecting in our claims.
Q. So what's the benefit of having, farming that out,

in a sense, to a PBM?
A. One is efficiency so we can reduce administrative costs, so rather than having our pharmacy team going to every pharmacy and negotiating discounts, so there's some efficiency there. Another part is that the PBM has a lot of negotiating power with the pharmaceutical companies, so we can improve pharmacy rebates, so that helps bring down costs.
And then the other aspect of it is just that they are also just, they live and breathe that data every day, so they can provide us with a technical analysis. They have their finger on the pulse of the market, so which drugs are going to be hitting the pipeline, which drugs are coming off of patent, and that helps inform our trends that we're expecting in pharmacy.
Q. Okay. Matt, we're almost done with this section. If you go to page, all the way in the back to Page 157, please, and from Page 157 to 159 there's a table there. Do you see that?
A. Yes.
Q. We hear most years about the URRT, if I'm saying that right. What is the URRT, and what is this table?
A. The Unified Rate Review Template is a template that's mandated to be filled out for small group and individual ACA-compliant rate filings by the federal

government. While the data is consistent in terms of allowed dollars that we're representing, this isn't the methodology that we use, so premium rates, but it's just a mandate that we have to fill out this template for the federal government.
Q. Thank you very much. Now, Matt, if you would, please, let's go to those four issues that we talked about. If you go to Exhibit 10, please, Page 10 of Exhibit 10.
A. Okay.
Q. The first bullet, Matt, relates to mid-year enrollment. Do you see that?
A. Yes.
Q. Would you please explain this issue to the Board?
A. Yes. So policies offered on the Vermont Exchange are calendar year benefits. So that means that the policy year begins on January 1st and it resets on December 31st, on January 1st of the following year. So in 2016 and in 2017, there was an open enrollment period of November 1st through January 31st. So what that means is that members could enroll for coverage without penalty during that time period, that 90-day time period.
For 2018 the federal government is scaling that back 45 days from November 1st to December 15th.

Q. So the window is smaller now?
A. The window is smaller.
Q. What are those dates again, the window? I'm sorry.
A. Yeah. For 2018 it will be November 1st through December 15th.
Q. Okay. So how is that change in window reflected in the rate filing? What are MVP's views on that, please?
A. So, during 2016 and 2017 or in the past when members could enroll through the end of January, if you enrolled during the month of January, your coverage didn't begin on January 1st. It actually began on February 1st or on March 1st instead. So, rather than having a 12-month policy, you had an 11-month policy or a 10-month policy. Because there are a lot of deductibles present in these policies, what that means is that, members that were enrolled for 10 months, it's less likely that their claims are going to exceed the deductible that is in the policy that they are being offered, and that means that it's reducing MVP's claim expense by that amount.
So, going forward with the reduction in the enrollment period, we're anticipating that members are going to be enrolled by January 1st. Because, if you

sign up by December 15th, that's when you'll be effectuated is January 1st, which means that our historical data in 2016 isn't necessarily representative of how we expect members to meet deductibles in 2018.
Q. So this new enrollment period is narrower, correct?
A. That's correct.
Q. And it's completed by December 15th, correct?
A. Correct.
Q. And, your analysis, you aren't making any exact assumptions on what people will do in terms of mid-year enrollments next year, correct?
A. Correct. That's very challenging to estimate.
Q. Okay. So that's how MVP views it. How does L&E view it?
A. L&E generally agrees with that the shortened enrollment period will lead to more members being enrolled by January 1st. So MVP had proposed that this adjustment was worth .7 percent, and L&E feels that the correct number is closer to .4 percent, which is where that .3 percent gap is coming from. L&E's rationale is that, you know, members will still be enrolling mid-year, so not every member is going to be enrolled for a full twelve months on their policy.

Q. And what is your respectful concern about their approach and how that would play out next year and in the years to come?
A. So we don't have any data to support what is actually going to happen in 2018 at this time, whether everybody is going to enroll on 1/1 or whether it's going to be a mixed bag. So, if our assumption is correct and L&E's position is approved, then what's going to happen is we're going to have to increase our rates further in the following year. So what we plan to do is analyze the 2018 enrollment in January, February, March, for setting our 2019 premium rates and see how much enrollment is actually coming in the door in February and March.
If it's more in line with our estimates of everybody enrolling on January 1st, then we're going to feel more comfortable with the .7 percent we've proposed and we're going to have to pass that on if L&E's proposal is adopted.
Q. So, if you went with L&E's approach and it turns out that they were incorrect, what would the result of that be for the future rate filings?
A. I would estimate that we would have to increase our rates by approximately .3 percent.
Q. You'd have to make up the shortfall?

A. Correct.
Q. And so MVP's approach is to try to line up the premium with the claims making the assumption that everyone can be a full year, right?
A. That's correct.
Q. Then there's no shortfall, correct?
A. Correct.
MR. HOGAN: Clarifying question. That .3 percent translates to what kind of dollars?
MR. LOMBARDO: So I can estimate this. I can't provide that.
MR. HOGAN: No, that's fine.
MR. LOMBARDO: So, if we have -- I'm just going to use 2017 premium as an estimate. We had about $55 million of premium that we're estimating for 2017. So 1 percent is about $550,000. So .3 percent is 30 percent of that $550,000. So we would say that it's 150 to $200,000.
BY ATTORNEY KARNEDY:
Q. Thank you. If it's okay, I'll move on to the next bullet. So that next bullet, can you just briefly explain what that was about and MVP's position on that?
A. Yes. So MVP receives contract trend information from another internal department in the company, and, when we received that information, there was a

disconnect on one of the hospital's rate increases between what was approved by the Green Mountain Care Board for 2017, and we agree that that was, that was an oversight on our part, and, when we made the adjustment to reflect the Green Mountain Care Board's approved hospital rate change, it will decrease our payment rates by .5 percent.
Q. Okay. The third bullet, can you -- this appears to relate to hospital budgets, 2018 budgets. Would you please explain that issue as you understand it?
A. Yes. So, when we set our premium rates for 2018, at the time, it was -- our premium rates were submitted on May 12th of 2017. At that time, there was preliminary discussions about what 2018 hospital budgets would look like, but our understanding is that they won't be finalized until mid-August after this rate filing is closed. So, in our opinion, we would just, we would just be concerned about making any changes to this rate filing until decisions are finally made.
Q. Okay. And, again, this third bullet, is L&E actually recommending a particular percentage increase of any kind?
A. No, they're not.
Q. Okay. And then the fourth bullet, this relates to

risk adjustment, correct?
A. Correct.
Q. And we have agreement on the decrease, correct?
A. That's correct.
Q. So, very briefly, what is risk adjustment, please?
A. Risk adjustment is another mechanism of the Affordable Care Act. There are a lot of changes that we had to account for when the Affordable Care Act rolled out. Risk adjustment is, the concept that I've heard used is level the playing field amongst providers. So suppose that average -- suppose that two carriers have the exact same discounts at a given hospital but Carrier A has all the sick members and Carrier B has all the healthy members. Carrier A's claim costs are much higher. Risk adjustment is trying to normalize for that and bring back the average to represent what an average person's health risk looks like.
Q. Matt, one issue that came up in the back-and-forth between L&E and MVP this year was related to CSR defunding, correct?
A. Correct. There was a discussion about CSR defunding.
Q. So what is, what is the issue, please?
A. CSR, again, it's a mechanism, cost share reduction

of the Affordable Care Act, and there have been conversations at the federal level about that subsidy that I described earlier being removed so the federal government would not pay carriers that amount but we would still have to offer members that benefit.
Q. And what is MVP's view on what, how this could be addressed if there was defunding?
A. So, if this, if the CSR is defunded, then our premium rates will not be adequate because it's a significant portion of our premium. It's approximately 3.1 percent right now. That's what it will be worth. MVP's approach is that, as long as a change is made uniformly to both carriers in the market -- meaning you can either adjust all premium rates at all metal levels or just Silver premium rates because CSR is only available to Silver members -- as long as it's consistently done between MVP and Blue Cross Blue Shield, we are okay with that. Failing to do so would hurt the competitive integrity of the marketplace because one carrier would have overpriced Platinum, Gold, and Bronze plans, and the other carrier would have overpriced Silver plans if they're done separately.
Q. On this issue, would you please go to Exhibit 10?
A. Yes.

Q. Page, it's Page 9, actually, 9 to 10.
A. Yeah.
Q. And you do you see that heading -- again, this is L&E's report -- "Cost Sharing Reduction, CSR"? It's down towards the bottom. Do you see that?
A. Yes.
Q. And do you see the discussion runs into Page 10?
A. Yes.
Q. And would you please read the fourth paragraph that starts, "MVP has provided"?
A. "MVP has provided their analysis of the impact of both methods. Under the first method, MVP's Silver premiums would increase by 8.7 percent. Under the second method, all of MVP's rates would increase by 3.1 percent. L&E believes both of these figures appear to be reasonable."
Q. Okay. So, when you described a moment ago how this might work whether you spread it out across all plans or focus it on the Silver plan, was L&E generally in agreement on that approach just to be consistent?
A. Yes.
Q. Okay. I want to ask you now some questions, just general background on MVP. What was MVP's total revenue in 2016?
A. In the State of Vermont or across all of our

product lines?
Q. For the State of Vermont.
A. Approximately $90 million.
Q. Okay. And let's hear the number across.
A. Approximately $3 billion.
Q. All right. So, focusing on the State of Vermont, what are the percentages in terms of cost pass-throughs versus overhead and reserves?
A. So approximately 90 percent of the premium dollar that's being charged is directly related to claim expense, so that's passed through directly to paid claims.
Q. And what's the 10 percent?
A. The 10 percent would fund overhead such, and contribution to reserves. So overhead would just be basically running our operations systems, being able to process claims, paying for rent of buildings, and such as that.
Q. How does MVP allocate administrative costs between your New York and Vermont business lines?
A. Our finance team every about six months or so has a pretty rigorous process where they meet with department heads and they basically interview them to understand what the cost drivers are of their expenses. So each department has a budget, and then our finance

team works with them to understand how should these costs be allocated amongst product lines and amongst states.
Q. And are there some particular costs in Vermont that are allocated? Does Susan have a desk, for example?
A. Yes, Susan does have a desk. So Susan's desk would go towards Vermont, but my desk, because I sit in New York, would go towards our New York expenses.
Q. Would you explain how the process of -- well, let's use the hospitals as an example. The Green Mountain Care Board approves utilization of budget increase, and then how does MVP then try to follow up?
A. So MVP's contract, MVP has a contracting team that works in Vermont, and what we do is the contracting team -- I should give them credit for it -- they go to those hospitals and those providers, those doctors, and try to negotiate a further decrease to that rate.
Q. And how did we fare in that regard?
A. It varies. It depends on how basically the, the hospitals or the physicians are managing budgets similar to any kind of organization, and, if they're concerned that they can't meet their budget based on any kind of approved budgets from the Board, it's, they're probably not going to be as willing to

negotiate a further decrease.
Q. Would the increased market share give MVP a better position in terms of negotiating, do you think?
A. Yes, definitely. It will bring more volume to them so they will be more likely to have a further conversation with us.
Q. You talked about the administrative load, the 10 percent or thereabouts. Can you explain to the Board how -- let's say you reduce that by 10 percent. How would that impact the rate filing?
A. So, just to keep it on a high level, if, if we reduce 10 percent of our claims costs by 10 percent, then the premium rate will go down by approximately 1 percent. So --
Q. I think you said claims costs. My question related to administrative costs.
A. I apologize. Yes, I was speaking to administrative costs.
Q. Okay. So let's do it again so just so our record's clear. If, 10 percent of the overall rate filing is these administrative costs and surplus, right?
A. That's correct.
Q. So, if you were able to reduce administrative costs at MVP for Vermont business by 10 percent, what

impact would that have on the overall rate filing?
A. 1 percent, approximately.
Q. And, if -- you don't need to do the math, but, if you were able to reduce on the cost side, it would have a larger impact, obviously, right?
A. Yes.
MS. USIFER: Can I ask a clarifying question on your administrative costs? How much are fixed versus variable when you look at that 10 percent?
MR. LOMBARDO: It's constantly being analyzed, but it's somewhere around two-thirds fixed, one-third variable.
MS. USIFER: So, as you grow 50 percent, it seems like you should get quite a benefit from that fixed load, but I'll ask those questions later.
MR. LOMBARDO: Yeah. We've managed down our costs as much as possible, but, as we continue to grow, we will continue to monitor it, and, if we do feel that we can reduce costs further, we're more than willing to do so because that means that we'll be able to offer a more affordable, a more competitive premium rate.
BY ATTORNEY KARNEDY:
Q. Can I continue? Does MVP track the lines of business in Vermont separately from New York?
A. Yes, MVP tracks our businesses, our lines of

business in a much more, in a detailed manner by state and market and product type. Failing to do so would, it's not an actuarially sound approach. We could really expose ourselves to risk. If we were trying to roll in all of our commercial product lines together and we were to grow disproportionately in one market versus another market and the other market was implicitly subsidizing the total market, our premium rates would be short, and we would be at risk of going insolvent or reducing our contributions, our reserves.
Q. So, as an actuary, should the New York lines be subsidizing Vermont?
A. No, and neither should Vermont be subsidizing New York.
Q. Should reserves be rated in the Vermont lines to cover New York business?
A. In my, from an actuarial perspective, no. That's a poor approach to take.
Q. So, MVP, you said about $3 billion in business; is that right?
A. Yes, that's correct.
Q. So what percentage of that is Vermont then?
A. So approximately 3 percent, somewhere in that range.
Q. Great, okay. I want to ask you about customer

service and how MVP is serving its customers in Vermont as it goes into these rate filings. So give me some examples of how MVP is servicing Vermont insureds.
A. So MVP has a comprehensive case management and medical management team where, as members of chronic conditions enter into the health system, we have nurses provide outreach to the members to help them navigate through the health care system. It's really complex, and it's overwhelming, especially if you have some sort of chronic condition.
Q. When you say "outreach", what do you mean?
A. It's contact a member through email, phone call, a letter in the mail, items like that.
Q. Is there a phone line available?
A. Yes, there is a 24/7 phone line available. Additionally, MVP offers, provides a tool to help understand how a cost would differ, the same, the same service would differ in cost by two different providers. So Physician A may charge a different amount for the same service than Physician B, so we have an online cost calculator that would help a member understand where they could go to basically have the lowest out-of-pocket cost, especially if a deductible is present.
We're also offering a telemedicine benefit which

provides members with 24/7 access for routine kinds of questions about their physical if they're sick or something like that, and they can get a prescription by using basically their iPad. It's pretty neat.
Q. Does MVP help the insureds find doctors?
A. Yes. So, in addition to those services, we also have, we also have an online search tool. So members in Vermont can go to MVP's website, and you can kind of type in your zip code and then understand here's where all the providers are in the area that will provide that coverage or provide that service, and then you can kind of leverage that with the cost calculator to understand what's your best course of action in terms of a financial implication.
Q. And does MVP have any networking opportunities for insureds outside of Vermont if I'm on vacation and get hurt?
A. Yes. So MVP offers, in addition to just having a comprehensive network in New York and contracting with Dartmouth-Hitchcock in New Hampshire, MVP also contracts with Cigna who provides access to about 500,000 physicians and 5,000 hospitals throughout the country. So, whether you're in Vermont or in Florida or Maine or California, you should be able to have access to a provider, an in-network provider, and just

be subject to your cost sharing and have your service covered.
Q. Corporate organization, explain the corporate structure at a high level, Matt, of MVP, please, and how it works in Vermont.
A. Yeah. So MVP Health Care is a not-for-profit. This filing is submitted under MVP Health Plan, Inc. That's one of the legal entities that roll up to MVP Health Care. It's also a not-for-profit legal entity where we offer our HMO business, our Medicare business, and our Medicaid business in New York.
Q. Are you licensed to do business in Vermont?
A. Yes.
Q. Let me ask you about competition. Why is competition good for Vermont insureds as it relates to insurance companies providing health insurance in Vermont?
A. Competition is, it keeps carriers kind of competitive with one another. So you're always kind of benchmarking yourself against somebody, and you're always trying to squeeze that last few cents out of the premium dollar, and MVP recognizes that health care is such a high portion of someone's income, and that's our single biggest focus is, How do we address this exploding health care costs in the country? It's

challenging to do so.
I don't have a good answer for how we actually address that, but without competition one carrier would be able to dominate negotiations with a provider, and you may see premium costs increase. So it's in the best interests of the consumers to have a nice competitive market.
Q. And with this rate filing do you believe MVP will be more competitive in the marketplace?
A. Based on the proposed rates that we've seen from MVP and Blue Cross Blue Shield, yes.
Q. And would you tell the Board a little bit about the fact that we border New York and sort of the New York and Vermont populations and treatment?
A. So yeah. It's, throughout, MVP has a comprehensive network of facilities and physicians in New York and in Vermont, but our Vermont members that live in Bennington, they may have easier access to a hospital such as Albany Medical Center which is only probably about 40 minutes away from them rather than going to a different hospital in the State of Vermont. So the fact that our borders line up with one another, it does provide ease of access for the members. So they can either go to a New York hospital, or members in Rutland may want to go to Dartmouth-Hitchcock, and

then for our New York members they can also cross over the border and go to UVMC or Rutland Regional or any of the hospitals that are in Vermont as well.
Q. Next is contribution to surplus. What is MVP proposing this year?
A. 2 percent of premium.
Q. And what did we propose last year?
A. 1 percent of premium.
Q. So why the difference?
A. So, to maintain solvency, insurers are, MVP is domiciled in New York, so New York's Department of Financial Services monitors MVP's solvency requirements. Solvency requirement in New York State is approximately 12-and-a-half percent of premium. So, as you grow premium, you need to increase your reserve level, or else you're going to fall below that 12-and-a-half percent threshold. So premiums are outpacing the way, the amount of the reserves that we have, so we need to charge a 2 percent premium just to basically meet the 12-and-a-half percent threshold that New York State deems as a minimum. To get to our target amount, we would have to actually charge closer to 4.8 percent.
Q. So, you know, we're sitting in Vermont and you've got a Green Mountain Care Board and you've got Vermont

regulators. Why, why do we care about New York and what they think, this 12-and-a-half percent?
A. So, again, it's because the New York regulators are governing our solvency to maintain, to make sure that markets are efficient, and they review all of MVP Health Plan or all of the MVP Health Care, for that matter, because all of our companies are domiciled in New York. And DFR does opine on MVP's proposed solvency or proposed contribution to reserves, but they do rely heavily on New York regulator opinion.
Q. Would you go to Exhibit 10, please, Page 8? And this is, this is L&E's report, correct?
A. Correct.
Q. And, if you go to Paragraph Number 9, and please read the last two sentences in that paragraph.
A. "The proposed 2 percent contribution to reserves, while higher than approved last year, is consistent with the assumptions found in MVP's other recent filings. The contribution to reserves assumption appears to be reasonable and appropriate."
Q. So L&E, but they generally agree with a 2 percent surplus, correct?
A. That's correct.
Q. Would you go to Exhibit 9, please? This is the DFR Solvency Letter, correct?

A. Correct.
Q. And would you please go to the first page, and you see in the middle it says "Summary of Opinion"?
A. Yes.
Q. Would you read that sentence under "Summary of Opinion", please?
A. "DFR is of the opinion that the rate as proposed will have the impact of sustaining the current level of solvency of the MVP Health Plan."
Q. So the 2 percent was proposed to DFR, correct?
A. That's correct.
Q. And then, if you go to the second page, please --
A. Okay.
Q. -- the very last paragraph, would you please read under "Impact of the filings on solvency"?
A. "Based on the entitywide assessment above and contingent upon the Green Mountain Care Board actuary's finding that the proposed rate is not inadequate, DFR's opinion is that the proposed rate will likely have the impact of sustaining MVP Health Plan's current level of solvency."
Q. Thank you. If you go back to the first page, what's the date of this letter?
A. July 11th 2017.
Q. And when did we file the amended rates?

A. July 7th.
Q. So this letter was after we had gone from 6.7 to -- well, let me strike that.
I'm going to ask you, At this point in time, we hadn't done the full reduction, correct?
A. That's correct.
Q. But we'd done part of the reduction, right?
A. Yes, we were -- yes, there was one change made, and that was through the risk adjustment.
Q. So we had reduced by 1.1 percent?
A. That's correct.
Q. Which gets you to 5.6?
A. 6 percent.
Q. Fair enough. So DFR provided a solvency opinion on that lower amount, but we haven't asked them about the .3 that we're talking about here today, right?
A. Correct.
Q. In your opinion, will reduction from the original 6.7 down to 5.1, the effects you testified to today, that modified rate increase, will that adversely impact the solvency of MVP?
A. No, it won't, because the changes that we're proposing we think are more appropriate in line our future claims costs with the premium that we'll collect. So the changes that we've made, we think, are

appropriate and adequately will represent a 2 percent contribution to reserves.
Q. Now, administrative costs, generally, what does MVP do to keep down administrative costs?
A. Well, MVP is -- there was actually MVP's single goal a few years ago was to just reduce administrative costs and be as efficient as possible. So some of the items that we've done are that we analyzed ways that we can get more efficient by automating processes. We've consolidated our departments to try to basically merge services so there is not any overlap or redundancies.
We've also, any time we have a contract, for example, with a PBM that we were discussing earlier, we take them out to bid every year or two and try to basically compare them against other PBM's to try to get their contract reduction to as low as possible to try to keep rates down.
Q. Fairly, though, you've testified about an increase in market share?
A. Correct.
Q. So have you taken that into consideration, and, overall, how does that impact your estimate of administrative costs for the 2018 filings?
A. MVP, again, what we try to analyze is how our administrative costs today in 2016 with our current

market share in 2017 would stack up on a per member per month basis, and that's what we're actually charging. Because, when we set our premium rates, we didn't know what Blue Cross Blue Shield's proposed rates would actually be, so we don't have a good benchmark at the time we set our premium rates on how competitive we're going to be in 2018. We just know what we're doing today.
Q. So, in short, are administrative costs going up next year? They staying the same? What?
A. They're going up slightly.
Q. Okay. Now, I want to run through -- we do this every year run -- through the statutory criteria, all right? Do the MVP rates meet the standard of affordability?
A. Yes.
Q. Why?
A. Because the premium rates that we're offering, although, again, we recognize that they may be unaffordable for a number of Vermonters and somebody like myself or could be very unaffordable or challenging to meet, but we are doing everything we can to meet our contribution to reserves. If we failed to meet our surplus requirement, the market would become unstable. So we are offering the most affordable

premium rate possible.
Q. And you testified earlier about working with the providers on the cost side, correct?
A. That's correct.
Q. Is that with an eye towards affordability?
A. That's correct. And, also on administrative expenses, we are constantly analyzing, trying to reduce costs as much as possible or keep costs down.
Q. So do the products and services covered fairly equate to the premium that's being charged?
A. Yes.
Q. Do the rates promote quality of care and access to health care?
A. Yes. As we had discussed, MVP has a comprehensive network throughout the country, so and we also provide tools to help members navigate through the health care system as well as possible.
Q. And you testified about that already, but just to follow up, what about on credentialing or case management or medical management?
A. Yes. So, to be part of MVP's network, physicians and hospitals have to go through a credentialing process to ensure they meet quality standards. So every provider that you're seeking has met a national standard of what is considered a quality provider. And

we also offer, again, case management or care management for members with complex cases and complex conditions to help them manage their way through the health care system.
Q. So that touches both on promoting quality and access, correct?
A. That's correct.
Q. And the out-of-network benefit that you testified, does that promote access?
A. Yes, but I wouldn't characterize that as out-of-network. That's a national network.
Q. Sorry. How about the great Health Care Advocate; what does MVP do as it relates to them, and how does that relate to this criteria of quality of care and access to care?
A. MVP helps fund the Health Care Advocate, and which they offer a 1-800, 24/7, 1-800 line for members to ask questions, and we help fund that.
Q. Are the rates unjust, unfair, inequitable, misleading, or contrary to Vermont law?
A. No.
Q. Are the rates reasonable based on the data that you've reviewed?
A. Yes.
Q. Are they actuarially sound and fairly charged

premium for the services covered?
A. Yes.
Q. Are the rates excessive or unfairly discriminatory?
A. No.
Q. Why not?
A. Again, going back to the affordability, MVP is doing everything possible to keep the premium rates down. That's through both contracting efforts or just keeping claim costs down as well as our administrative costs.
Q. And all of that is actuarially sound in your view, correct?
A. That's correct.
Q. Are the rates inadequate?
A. No.
Q. And why not?
A. Because both MVP and L&E, MVP did their due diligence of reviewing our rates and making all of our calculations to project what premium we need to collect to maintain our solvency, minimum solvency requirement in 2018, and L&E has done a rigorous and vigorous process, as Gary had said, to review the rate filing, and they've agreed that our rates are not inadequate and within our program.

Q. And what about DFR?
A. DFR agreed that the proposed 2 percent contribution to reserves would maintain MVP's current level of solvency.
ATTORNEY KARNEDY: Thank you very much, Matt. That's all the questions I have of this witness at this time.
MR. HUDSON: Thank you, Attorney Karnedy. Attorney Kuiper, do have questions for this witness?
ATTORNEY KUIPER: I have a couple.
CROSS-EXAMINATION BY ATTORNEY KUIPER
Q. Good morning.
A. Good morning.
Q. First, I would like to direct you to your, you recall, your consumer disclosure about proposed health insurance rate increases which is in your filing on Page 155.
MR. HUDSON: Attorney Kuiper, which exhibit are you referring to?
BY ATTORNEY KUIPER:
Q. It's a part of the SERFF filing. I'm sorry. Exhibit 8. So almost at the bottom of the disclosure is a list of bullet points, and one of the things that this says is, "Increases in premium rates are driven by many factors including exit of healthy individuals from

the insurance market plans as the cost of insurance increases"; is that correct?
A. That's correct.
Q. So increases in premiums cause healthier people to drop insurance causing additional increases in premiums, correct?
A. That's correct.
Q. And this is called an adverse selection spiral; is that correct? Is that a common term for the --
A. I would, I suppose I would call it more of just an affordability.
Q. Okay. Could you explain how you, whether you considered this or how you considered this when you developed your rates?
A. Yeah. So what this is really getting at is just that, over time as insurance premiums increase, there is a penalty that's attached to the Affordable Care Act if you don't have coverage. So healthier members are probably are, were, are making an economic decision on, Should I pay the penalty, or should I pay the premium? And, as premium rates continue to increase, it's more and more likely that healthier individuals who aren't going to be seeking services are going to drop coverage.
So we did not make an explicit adjustment in our

rates to actually increase for a morbidity increase to members that we're expecting to purchase coverage. It's just a general statement that, from 2015 to 2016 as health care costs have gone up, it's likely that members that are healthier have dropped coverage which means that our 2016 data was a little bit more adverse than our 2015 data.
Q. Okay, thank you. So I'd just like to direct you to this chart again. It shows MVP's increases over the past three years. Does this look correct to you that it's increased about 17.8 percent cumulatively over the past three years from 2014?
ATTORNEY KARNEDY: I just want to object to the extent that we had a prehearing where we submitted all exhibits. The Witness hasn't seen this. It wasn't stipulated to. So I'm fine with the questioning, but perhaps, if he could go over and look at it for the first time --
MR. HUDSON: Yeah, I agree. If you want to take a closer look at that, Mr. Lombardo, go ahead.
MR. LOMBARDO: And, yeah, I will take a look at it.
MR. HUDSON: Attorney Kuiper, do you have paper copies for the Board? It's hard to see for that.
ATTORNEY KUIPER: Yes.

ATTORNEY KARNEDY: And this is not in evidence, correct?
MR. HUDSON: Unless you want to move to put it in evidence, and I'll hear objections as appropriate.
ATTORNEY KUIPER: I wasn't planning to introduce it into evidence. I was just going to use it as a visual for questions. Would you still like paper copies? Would that be --
MR. HUDSON: Yes.
ATTORNEY KUIPER: I could move this forward into the room too. We weren't sure where the best place was for everybody.
MR. HUDSON: With the paper assistance, I think we've got it.
BY ATTORNEY KUIPER:
Q. All right. So can you confirm that this is the increase that MVP has had over the past three years, are you aware?
A. I don't have the exact rate increases in front of me, but these look approximately correct, and so I can say that that's approximately correct. I don't know the exact number to the decimal place if that's right.
Q. That's fair enough. Thank you. And this graph also shows wage growth in Vermont through 2015 which

was the most recent time that we could find Vermont statistics. Is that something that you look at when you're developing your rates?
ATTORNEY KARNEDY: I'm going to object to this, lack of foundation.
MR. HUDSON: I have to sustain that. Attorney Kuiper, this chart was not presented at the prehearing conference, and, to the extent that it's being offered on a surprise basis --
ATTORNEY KUIPER: Let me just be clear. I'm simply asking if he looks at that. I'm not asking him to confirm that it's correct.
MR. HUDSON: If you're not asking for his opinion on its accuracy, what is the direction on the questioning in line?
ATTORNEY KUIPER: So we plan to provide citations to these statistics in our post-hearing memo. At this point, I was just -- if Mr. Lombardo says this is not something that he's familiar with, I was simply going to ask him to take it then as a hypothetical. If, hypothetically, these numbers are true --
ATTORNEY KARNEDY: So I'm going to object. That calls for speculation.
MR. HUDSON: And the Board's attorney, Attorney Henkin, do you have a position on this?

MS. HENKIN: We have as of a record what each year's increase has been. I don't know what you've laid for a foundation for this, but it doesn't seem like that's occurred yet. So I think that Mr. Lombardo could testify to, he could be asked questions regarding that basis for this, but I don't, I don't know if he can calculate this on the spot here.

MR. HOGAN: You know, I don't know why we're arguing about this. This is a very simple little graph that tells a story whether you like it or not. I don't know what the problem is here.

MS. HENKIN: Member Hogan, that's fine, but I think that, because this is an administrative hearing done under the rules, that we did have a conference on this as to agree to what would be admitted or not, and, if there's not a proper foundation for this, I don't -- I think that it's an issue. So I, as you know, we have done these hearings, and we have the record of what the increases are, and, if this is a compilation of that, that's not very clear.

MR. HOGAN: And what are the issues? You said there would be some issues. What are those issues?

MR. HUDSON: The issue is the propriety of entering evidence into the record that hasn't had

adequate --

MS. HENKIN: These have not been stipulated to, but, as we know, there can be notice of what the past increases are, and there may be a basis for this.

ATTORNEY KUIPER: Let me be clear. Again, I'm not asking this to be admitted into the record. I'm simply using it as an illustrative example for questioning the Witness.

MR. HUDSON: That's a semantic distinction that, I think, elevates form over substance here given that we've got a chart and numbers in front of it and questions are being posed to a witness. That said --

MS. HENKIN: If there's no agreement as to what that cumulative total is, I would not be using this as a supposition that there's an agreement to that, and I don't, I don't know because I haven't added up to see what those numbers are and how that was, how you ended up with that, but that, it's, it hasn't been stipulated to. I know -- if you're not adding for, asking for its admission, I still question what the value of saying, Suppose this was the increase, without the basis for actually showing what the increases were.

ATTORNEY KUIPER: All right. I can turn this around if that's the, that's the decision.

MR. HUDSON: Well, my concern at this point

is that the cat's somewhat out of the bag here. Attorney Karnedy, would you be amenable to taking some sort of or even assenting to this being entered into the evidence with the, you know, with the stipulation that you would be permitted ample opportunity in a post-hearing memo to contest its validity or its accuracy?

ATTORNEY KARNEDY: No. Respectfully, no. I'm fine with you asking the Witness questions, and if he knows what the Vermont wage growth was for the last couple of years, you can ask him that, but there's no foundation for particular questions about this document. She can ask questions, but to put this in front of him, I have no idea where this came from. There's no witness to authenticate the numbers. She can certainly ask him general questions. I have no objection. But the exhibit I have an objection to.

MR. HUDSON: I have to agree that that's a reasonable position on this, and I'm going to sustain it.

BY ATTORNEY KUIPER:

Q. So, for the record, do you look at wage growth when you assess where you're going to set your rate increases?

A. That is part of -- that is not part of an

actuarial analysis to understand what produces a reasonable premium rate. What we are analyzing is how claims costs are projected to change, how the market is expected to change year over year, and how, and how any administrative or nonclaim expenses are going to change year over year.

Q. Okay, thank you. Hypothetically, if you were in a market where health insurance rates increased at a much faster pace than wage, would you agree with me that, on an ongoing basis, that would be unsustainable as far as affordability goes?

A. Yes.

Q. Thank you. The average, so you spoke a little bit about actuarial value in your testimony. The average actuarial value for Exchange plans in 2018 actually decreased slightly from the year before; is that correct?

A. I would have to go through the exhibits. I don't have that in front of me. Can you point to a specific exhibit?

Q. I'm, I don't believe I have that. So I believe there is one, but I'm not getting my hands on it right now. If, if that was true, that would mean that members are paying more cost sharing in proportion to what MVP is paying; is that correct?

A. Assuming that statement is true that actuarial value is going down, then, yes, that's correct.
Q. Thank you. And so I'd like to then go on to the topic of the enrollment. So that on L&E's recommendation, Page 10, you had talked a little bit about their .3 percent reduction for mid-year enrollment?
A. Yes.
Q. Are you familiar with the term "special enrollment periods"?
A. Yes.
Q. And could you, could you explain what those are?
A. Yes. So a good example would be, if you enrolled in a policy during the open enrollment period which was November 1st through January 31st in 2017 and you were a single subscriber, suppose that you got married on June 15th. You could add your spouse to your policy if they didn't have, you know, if they didn't have coverage or they wanted to come on board with your coverage through a special enrollment period.
Q. And there's several categories for special enrollment?
A. Yeah.
Q. And are deductibles prorated when someone comes on with the special enrollment period so that those people

have a smaller deductible depending on when they start mid-year?
A. They're calendar year benefits, so deductibles reset on January 1st calendar year.
Q. So there wouldn't be a prorated deductible for that portion of the year?
A. No, there would not.
Q. So you stated that, if you are correct about the mid-year enrollment projections and L&E is wrong, then, then MVP won't get enough money for, on the basis of this, this issue; is that correct?
A. Correct.
Q. I'm sorry.
A. We feel we would not meet our target contribution to reserves by .3 percent.
Q. Okay. And would you agree with me that the reverse is also true that, if L&E is correct and you are wrong and your request is implemented by the Board, then consumers will be overcharged on that basis?
A. I would agree with that.
ATTORNEY KUIPER: Thank you. I have no further questions.
MR. HUDSON: Thank you, Attorney Kuiper. At this point, I'd like to open it up to questions from the Board.

MR. HOGAN: Yeah, I do. You are in a growth mode. 50 percent increase is a big deal, and by your own testimony you feel like you're going to grow more in '18. The solvency letter that Attorney --
ATTORNEY KARNEDY: Karnedy.
MR. HOGAN: Say it again.
ATTORNEY KARNEDY: Karnedy.
MR. HOGAN: -- Karnedy mentioned was stronger than you reflected at a little piece that you took out. It was, I thought it was the strongest solvency letter I've seen on the Board, so just a matter of clarity. What is the percentage -- and I haven't calculated it -- of the 150, the 175, the $200,000 regarding the .3? What is that percentage of the $90 million revenue that you have now? Could you calculate that?
MR. LOMBARDO: I'd say the $175,000, that's related to the .3 percent, correct?
MR. HOGAN: That's right.
MR. LOMBARDO: So we are budgeted for $90 million of revenue in Vermont. I'm going to estimate that, I mean --
MR. HOGAN: That's fine.
MR. LOMBARDO: -- to be somewhere around 2 percent. I'm sorry. .2 percent.
MR. HOGAN: .2?

MR. LOMBARDO: Yes.
MR. HOGAN: Would you consider that kind of a number in the framework of noise? Is this a significant number?
MR. LOMBARDO: It would not -- I would say that we make a number of assumptions in our filing, and we may miss an assumption by a tenth of a percent or two in either direction.
MR. HOGAN: It's noise.
MR. LOMBARDO: Right.
MR. HOGAN: I would also -- and, Noel, you'll have to correct me if I shouldn't be asking this question, okay? What is the rate increase in New York?
MR. LOMBARDO: I guess I'll wait for Noel's opinion.
MR. HUDSON: Well, I'm not sure where this is going exactly, but --
MS. HENKIN: I would have asked that question myself, so --
MR. HOGAN: You would?
MS. HENKIN: I would like to know what the rate increase is in New York.
MR. HOGAN: Okay, thank you.
MR. LOMBARDO: So New York is a little different than Vermont. We have, where Vermont is a

merged small group and individual market, New York has a separate small group market and a separate individual market. So our rate increases are different between small group and individual markets in New York. These aren't exact numbers, but our small group rates in New York are going up approximately 11-and-a-half to 12 percent. That's what we're proposing. And the individual rates are going up a little higher, closer to 13-and-a-half percent, approximately.

MR. HOGAN: And the difference between that and what's happening here is what?

MR. LOMBARDO: There's a number of different items that have to go into it. It's basically --

MR. HOGAN: I'd like you to, I'd like you to go into that.

MR. LOMBARDO: Okay, yeah. So the biggest issue is that you have to make a correction for prior year rates, or you have to adjust for how much your rates were different than expected or your claims were different than what was expected when you set your premium rates. So in Vermont I believe L&E quantified the correction to our rates from last year to be about .3 percent, 0.3, whereas in New York we had a much larger correction that we needed to make. Claims have been increasing at a higher rate than we anticipated.

Also, our risk adjustment payment, as we, you know, kind of touch on the risk adjustment concept, when you build your premium rates, you have to estimate a risk adjustment payment or receipt into your rates. What we had estimated in our New York rates was deficient. So we have a higher trend of claims is one thing. Second is that we have to correct for just a correction to last year's rates and a correction for our risk adjustment assumption that was in our New York rates.

MR. HOGAN: Thank you. I also want to offer a compliment. The quality of the information you've been providing has definitely been on an upswing. That's greatly appreciated.

MR. LOMBARDO: Thank you.

MR. HOGAN: And the clarity of your testimony was absolutely excellent. So thank you for that.

MR. LOMBARDO: Thank you very much. I appreciate that.

MR. HUDSON: I believe Member Holmes was, wanted to ask a few questions.

MS. HOLMES: I do. Thank you so much. So my first question, in your testimony and also in your filing, you talk about how you treated the hospital rate budget submissions and how that impacted your unit

cost calculations, and, if I understand correctly, you were basing your unit cost trend and calculations on last year's 2017 budgets --

MR. LOMBARDO: Correct.

MS. HOLMES: -- so and adjusting slightly upward for a couple of hospitals that had rate decreases last year assuming that there would not be rate decreases again this year, so sort of returning those hospitals to trend?

MR. LOMBARDO: Yes, yeah.

MS. HOLMES: Have you done any calculations that would actually quantify what the impact on the unit cost would be if you used, not only the hospital budget submissions for 2018, but also the letters and the guidance that we've submitted or we've sent to the hospitals, particularly those hospitals that had budgets that, or actuals that exceeded their budgets last year?

MR. LOMBARDO: So we have not performed that calculation. If it's something that you want, you would like and it would help inform your decision --

MS. HOLMES: It would.

MR. LOMBARDO: -- we can go back and -- okay, we'll take a note of providing that.

MS. HOLMES: Yeah, that would be fantastic.

MS. HENKIN: Could you tell me how fast that could be done and when you could provide that?

MR. LOMBARDO: I think we could provide that in relatively short order.

MS. HENKIN: By Friday?

MR. LOMBARDO: I would think Friday is reasonable.

ATTORNEY KARNEDY: So did you want it as part of our brief next week? It sounds like you want it earlier.

MS. HENKIN: As soon as it's done, we'd like to look at it. So it does not have to be part of your memo.

MR. LOMBARDO: Can I ask who you'd like us to send that to?

ATTORNEY KARNEDY: Send it to me first.

MS. HENKIN: And you'll know who to send it to.

ATTORNEY KARNEDY: We can follow up on that.

MS. HOLMES: And I guess I'd like you to use, not only the 2018 budget submissions, but also look at the letters that were sent to the hospitals in, I believe it would be, April with budget guidance, March, April with our budget guidance.

MR. LOMBARDO: So let me just clarify so I

know I'm giving you the right information. One would be there was a recent proposal that hospitals sent to the Board, correct? So that would be scenario one is hospitals to the Board, and then the second scenario is what you had sent to the hospitals, and keep those separate and distinct? So you kind of are looking for two rate increases or two rate impacts? One would be --

MS. HOLMES: Look at the rate decreases as best we can clarify.

MR. LOMBARDO: Yeah, sorry about that. Okay. That's, we will provide that.

MS. HOLMES: Thank you. Most appreciated.

ATTORNEY KARNEDY: Along with the calculation, would you like some opining on what the numbers mean from MVP's perspective? I think I'd like to be able to do that in the letter as well, so the record's clear.

MS. HOLMES: As a state, we're making every effort we can to bend the cost curve, right, and trying to reach the population health goals that we've laid out in this agreement with the federal government in the all-payer model, and we're very much aware of inefficiencies in the system, you know, in terms of under-utilization of really helpful, effective

preventive care and perhaps over-utilization in some areas in services that may not be deemed cost effective.

So I'm wondering if you can share with me what initiatives MVP has taken last year and then what you're expecting to take this year to direct resources in ways that basically reduce bad utilization and increase good utilization to help us reach those population health goals and financial targets?

MR. LOMBARDO: So, yes, our right now what we're trying to do is just, through medical management, we try to manage those high-cost cases and try to have the customer outreach try to direct care to members so they can know where they can access and provide that online cost tool so they can understand, Where is a lower cost provider for the same service?

You know, we are still exploring participating in risk arrangements in Vermont with providers which we're hoping that, if we can start, as we can grow, we're constantly assessing whether or not it makes sense for us to participate in a risk arrangement with a provider group. We are participating in those risk arrangements in New York, but we have more critical mass in New York.

So, as we're growing in Vermont, we're constantly

evaluating that, and that, we think, is another way that we can try to basically have providers watch their, watch their claims a little bit more carefully and make sure that their prescribing patterns, their referral patterns are as efficient as possible.

MS. HOLMES: Okay. I think some of my other colleagues will probably have questions about the ACO, so I'll let them do that, but let me ask you about one of the things you mentioned was the price transparency website and directing consumers to it. What has been your usage on that website, and how are you trying to increase traffic to that website so that people can make more cost-effective choices?

MR. LOMBARDO: I don't have the exact usage number offhand. I could work with someone if it's needed to understand that, but, generally speaking, we've been evaluating our website in a lot of scrutiny recently, and we've made a lot of changes to it to try to make it more consumer friendly so that items such as the online cost tool are more apparent to a customer. It wasn't as obvious in the former versions of the website. So I don't think there is any direct outreach that I'm aware of, but I, I shouldn't say that. So --

MS. HOLMES: Any more information you can provide on how you're trying to make more consumers

aware of that website and the actual usage of it I think would be really helpful.

MR. LOMBARDO: Okay.

MS. HOLMES: Just one other question along these lines. With respect to directing, helping to incentivize the most cost-effective services and products, you're projecting in here about a .3 percent increase, I think, if I got this right, in utilization for brand name drugs as part of your pharmacy trend analysis and a 13.8 percent increase in unit cost for the brand name drugs, and what I'm wondering is, What incentives are you deploying to try to encourage more people to switch from brand names to generic drugs when we're seeing a decrease in expected prices for generics? How are you switching people from brand names to generics in your --

MR. LOMBARDO: So our current generic dispensing rate, that's basically the percentage total scripts that are generic fill, are somewhere around 90 percent. So our goal would be to try to move that even further along. But I think another way to look at this would be to say, Okay, well, how much are, how is generic drug costs changing hand in hand with the brand drug costs?

So what we've seen in recent times is that the

pharmaceutical manufacturers, as their drugs are coming off of patent and they're going generic, they're losing revenue for those brand of drugs. So, when they have new drugs in the pipeline, those generally are higher cost. So, you know, it's our job to try to manage costs and maintain a formulary where, if you have some sort of illness, that we have a prescription on our formulary to cover your, to cover the drug that, that would help treat your disease state.

So, through contract negotiations with our Pharmacy Benefit Manager, through rebate negotiations, so those trend numbers that you had quoted, those don't reflect any rebate increases. So we calculate, we trend our claims, and then we make an adjustment for any kind of changes to our rebate costs. So that's kind of, those are two separate numbers, so the actual trend on brand may be a little bit -- it's less than what we're actually seeing in that filing number. So that, those are kind of the different routes that we're trying to take to help.

MS. HOLMES: My final question actually has to do with CTR, and you mentioned in your testimony and I did read it in the filing information about this New York State regulation that requires this minimum of 12.5 percent of premium to be allocated to reserves.

Is it my understanding that that applies to the whole MVP book of business and not to individual plans but that they look at MVP in its entirety to look at what the percentage of premium that goes into reserves?

MR. LOMBARDO: They evaluate our, every legal entity separately. So, within MVP Health Plan, which is where this filing is submitted, there are Medicare policies, Medicaid policies in New York, as well as other fully insured HMO products both in New York and Vermont. So they are looking at that from the top, a global view, but our job as actuaries is to come up with a sustainable rate for the block of business that we're analyzing.

So what we do is we only focus on the Vermont Exchange data because we want to be sure that we're insulated from any kind of shifts in membership to or from the Vermont Exchange block. Because, if we fail to kind of look at it in that regard, we could be exposed to financial harm.

MS. HOLMES: Okay. But from a regulatory perspective, would a reduction in CTR on this filing have a material impact on your ability to comply with the New York State regulations?

MR. LOMBARDO: I wouldn't -- I would have to work with New York State Department of Financial

Services on that. It would be, it would be hard for me to opine on that right now. I don't feel comfortable answering that without more data.

MS. HOLMES: Maybe you can get back to us on that too. My laundry list is long. Thank you.

MR. HUDSON: Member Lunge, would you like to ask some questions?

MS. LUNGE: Always. Thank you for joining us, and thank you for your testimony. So I wanted to ask you. I'm going to follow up on Board Member Holmes's questions around risk arrangements with providers. So, when you were talking about that, were you thinking, are you thinking about specific risk arrangements with hospitals or with Accountable Care Organizations or both? Or maybe you're not there yet.

MR. LOMBARDO: Yeah, I'm kind of touching -- I, I'm involved very heavily in our New York provider risk arrangements, but because we don't have them in Vermont, our contracting team is who's managing that right now.

MS. LUNGE: I see.

MR. LOMBARDO: In New York -- I can use New York as a baseline.

MS. LUNGE: Yeah.

MR. LOMBARDO: We are, we are contracting

with provider groups, and some of those provider groups are employed by hospitals. So, I guess, directly it's physicians, but indirectly it would also tend to be through a facility.

MS. LUNGE: And do you have any Accountable Care Organization arrangements in New York?

MR. LOMBARDO: I guess, so --

MS. LUNGE: And, if you don't know, that's fine.

MR. LOMBARDO: Well, Accountable Care Organization, I'm not that familiar with that term. When I hear Accountable Care Organization, I think about upside, downside risk arrangements with providers, but there may be a, there may be some definition differences. We are in upside and downside risk arrangements with providers in New York, though.

MS. LUNGE: Okay. Thank you.

MR. LOMBARDO: Yeah.

MS. LUNGE: Related to the cost sharing reductions, I had a couple of questions around your estimates. So are you familiar with Vermont's state cost sharing reduction program?

MR. LOMBARDO: Correct, yes. The additional layer for members between 250 percent, 300 percent of the federal poverty limit?

MS. LUNGE: Yes. And, when you did your estimates of impacts of the cost sharing reduction elimination at the federal level, do those include the elimination of the Vermont CSR as well or --

MR. LOMBARDO: It would assume that all CSR was defunded.

MS. LUNGE: Okay. So would it be possible for us to understand the impact if the Vermont CSR was not modified in any way, since that would require a statutory change?

MR. LOMBARDO: Yes. We can -- again, I don't have that at my fingertips, but we'll take that back.

MS. LUNGE: And that's okay. Also, are you aware of your company doing any legal analysis on whether the current state of the Vermont cost sharing reduction would actually absorb any reduction in the cost sharing reduction at the federal level? So, if the federal -- sorry. Let me restate that, because that was a confusing way to ask that question.

If the federal CSR goes away, has your company done any legal analysis that you're aware of that, about whether or not the Vermont program would essentially absorb that loss as opposed to the company or the consumer?

MR. LOMBARDO: I'm not aware of any kind of

legal analysis that's been performed.

MS. LUNGE: Okay, thank you. And then you also calculated two different methodologies, one where the percentage would be spread across all plans and the other where it was targeted to Silver. Does your company have a preference for one methodology or the other, and what do you see are the pros and cons?

MR. LOMBARDO: In all honesty, we are indifferent to which approach is taken as long as it's uniformly applied to both MVP and Blue Cross. So I guess there is no pro or con, in my opinion, of which one -- well, so I'll put it in terms of premium tax credits, I guess.

So, if you were to pass on the full rate increase to the Silver plans, then premiums on the Silver level would be higher. Premium subsidies, advance premium tax credits, are developed based upon the second lowest cost Silver plan in the marketplace. So what that would basically mean is that members that are below 400 percent of the federal poverty limit would benefit from that, from applying the increase only to Silver plans, but members above 400 percent of federal poverty limit would actually be hurt by that at the Silver level.

MS. LUNGE: And, because Vermont has a merged market, small businesses would be in a similarly

situated situation to individuals above 400 percent in the example you just gave?

MR. LOMBARDO: Yes, that's correct.

MS. LUNGE: Okay. And then, obviously, there's some unknowns at the federal level related to the cost sharing reduction which may or may not be resolved prior to the open enrollment period. I know you reserve the right to come back to us should something happen at the federal level. What are the timing issues or considerations related to this in your opinion? At what point is it too late?

MR. LOMBARDO: So I, I don't have an exact date. It's, I think most of the work would have to go to DVHA, correct?

MS. LUNGE: DVHA, yeah.

MR. LOMBARDO: Yeah, they're the ones who are managing the Exchange, Vermont Health Connect.

MS. LUNGE: Yeah.

MR. LOMBARDO: So I think it would be more a conversation with DVHA to understand their timing, because, for MVP, you know, once the open enrollment period starts, obviously, it will hard because members would enroll and then pay "X", and then, if the real rate should be "X" plus 3 percent or something like that.

MS. LUNGE: Right.

MR. LOMBARDO: But, as long as it's implemented according to DVHA's timeline, MVP should be able to meet those timelines.

MS. LUNGE: Okay, thank you. Well, hopefully, you know, given the recent federal events, we won't have to come back to this issue at all. I also had just a technical question about the New York State HCRA surcharge of .25 percent. Could you tell me what that is?

MR. LOMBARDO: Yes. So New York, so in Vermont there is a paid claim surcharge assessed, a claim cost. The HCRA in New York is somewhat similar to the Vermont paid claim surcharge, but it's only for inpatient and outpatient hospital claims. So there's a percentage of claims that MVP is assessed for services that are accessed in New York which we then have to pass on to develop an adequate rate.

So in New York we review members that are accessing Vermont hospitals. So we have to build on that .99 percent. In Vermont it goes the other way. So Vermonters who are accessing New York hospitals, there is this additional cost that MVP incurs through this tax.

MS. LUNGE: Okay, thank you. So earlier in

your testimony you mentioned that there are some additional benefits that you take into consideration and that's why there's a range in terms of the way the premium rate impact is applied. Were those the wellness benefits you were referring to, or are there additional benefits?

MR. LOMBARDO: So there's additional benefits, because every year the federal government -- not every year, but, actually, since 2014 almost every year, maybe every year, there's been a change to the federal AVC calculator which is how we define if a plan meets the metal level requirements. So there were changes made to the federal AVC for 2018, and when we put our benefits through that federal AVC, some of the plans fell out of the metal levels. So, when the plans fell out of the metal levels, we had to make an adjustment, and that adjustment is reflected in the premium rates that we're charging.

MS. LUNGE: Okay, thank you. That was helpful. And then, lastly, on your Pharmacy Benefit Manager, you mentioned that you put that out to bid every couple of years. What kind of transparency or other contractual provisions do you include in your PBM contract to ensure that you are truly seeing the rebates that are due to the company and to your

subscribers?

MR. LOMBARDO: So, in terms of rebates, when we contract with our, with the PBM, we set -- there's a guaranteed amount, and then there's a shared amount above that guaranteed amount. So the guaranteed amount basically says that, for every brand or specialty script that comes in the door, you're guaranteed to receive this amount.

Now, what the PBM actually receives from a pharmaceutical manufacturer may be something different than that based on the mix of the drugs that we're experiencing. So, if that amount is different, if it's higher, then MVP basically shares the amounts above the guarantee. If actual rebates come in below the guarantee, we're actually still getting the guarantee. So our pharmacy team tries to raise that guarantee every year. That's our goal. We're not building in, though. What we're building in is our best estimate, which is something above the guarantee, to our rates.

MS. LUNGE: Okay, thank you. I'm good.

MR. HUDSON: Yeah, I saw you, Con, but I want to give Member Usifer a chance.

MR. HOGAN: Oh, I'm sorry.

MS. USIFER: You referred a few times to the reduction, 25 percent reduction from the rate that was

submitted versus what you've dealt with, and I think, you know, I really appreciate the collaboration that you have with L&E. I just, when I look at those adjustments, they seem like they're more corrections or they were errors that were in there. So I, you know, I just don't like the -- that doesn't sound like we, you know, adjusted by 25 percent when I think you guys aligned that may be the risk part of it was in error and part of it was a risk number that came down. Could you --

MR. LOMBARDO: So I would say the half percent for the hospital rate increase, that was a correction, but the risk adjustment change, that's a really challenging number to quantify, and we don't receive our actual risk adjustment results for the 2016 plan year until June 30th. So we submitted our rates on May 12th. So we have to basically make our best estimate of risk adjustment before we have actual data.

So, in my opinion, I think that's more of -- I guess it's a matter of how you define adjustment versus correction, but throughout any carrier, small group or individual rate filings, you're probably going to see a change made for risk adjustment. It's really challenging to hit that nail on the head.

MS. USIFER: Yeah, I do appreciate the

collaboration that you've had. I think, you know, we talk about administrative expenses. We're kind of in a unique position, or you guys are because you've seen, like, 50 percent growth, and then you expect another big growth this year.

MR. LOMBARDO: Yes.

MS. USIFER: So I was surprised that the administrative adjustment was only .2 percent of your total rate, and I did some calculations based on what you said was a, possibly a two-third fixed, one-third variable, and if we had increased year over year, if we started out at a 10 percent base and you increased, you know, just kept the fixed fixed and increased the variable, the one-third variable by 50 percent, that would bring the rate down to 7.8 percent, and if we carried that forward again for another year saying, We're going to have a big increase, and let's say it was 50 percent again, that would bring it down to 6.3 percent, and I'm happy to share that math with you.

And, you know, I agree that we shouldn't be subsidized off of New York, and you don't get this opportunity that much when you get, you know, 50 percent increases, and, if you have a large part of your administrative fee that's fixed, then that stays fixed and your variable, you know, and I agree, when

you have a 50 percent rate, maybe some of your fixed you need to add some more heads and do certain things, but, you know, this is our one opportunity to really gain leverage on administrative expense, and a .2 reduction just doesn't seem to work in the math.

MR. LOMBARDO: Yeah. I just want to throw, kind of explain a little more fact of what's going on in the Vermont market. We're growing very well in the Exchange market, but we are shrinking in the larger market. So the fixed costs that we have in Vermont -- I don't have the exact membership numbers -- but we have seen a significant reduction in our large group block over recent years.

So we do have to try to manage the entire. All of our Vermont fixed expenses we kind of look at globally, whereas our variable expenses we look more on a member basis. So we should actually look at them hand in hand. So without knowing exactly how much our total market has changed, you know, I do agree with you that, as you grow, you're spreading out fixed costs over more members so you should see a decrease, but I think we should try to look at the Vermont market as a whole, and, you know, it is based on our best estimate of how 2018 will, what 2018 will cost at the time our rates are set, which is based on our 2017 market share.

MS. USIFER: So I don't know if you can provide any more detail maybe on the history of kind of the administrative costs, fixed versus variable, for '16, '17 and maybe what you're projecting for '18?

MR. LOMBARDO: For MVP as a total or for Vermont?

MS. USIFER: You came up with an allocation process for Vermont.

MR. LOMBARDO: So you're looking for Vermont?

MS. USIFER: Yeah, I'm looking for Vermont. I understand from an allocation sometimes you don't revisit, in my past history, you don't always revisit allocations during the course of the year, and, if your growth is coming in a lot higher than what you might have expected, maybe that allocation needed to shift. I just think this is the opportunity when we have such a high increase that we should be leveraging the administrative fees.

ATTORNEY KARNEDY: Can I just ask a procedural question then? It sounded like the hospital issue, you want that right away. These other issues, could we have a little more time over the next week, other issues that the Board asks?

MS. HENKIN: If it can come in in your memo, at least, but as soon as it can be ready, because it

all has to be reviewed, so and I have been keeping track of these somewhat. So, hopefully, we'll be able to clarify at the end exactly what you're going to be sending in.

ATTORNEY KARNEDY: Thank you, thank you.

MR. LOMBARDO: Can I just clarify? So you're looking for a Vermont administrative expense, I think you said, over the past couple of years, correct? So are you looking for, like, '16 through budget for '18 our best estimate of '18 or --

MS. USIFER: Yeah, that would be good, and, if it's two-thirds fixed, a third variable, kind of seeing -- you know, we should be seeing a fixed base staying fixed and the variable rate increasing, and, if we're increasing our membership by 50 percent, that's a good time to get your, gain quite a bit of leverage, like 2 percent, you know, my math, but that's based on the two-third, one-third fixed fee.

MR. LOMBARDO: Okay.

MS. USIFER: I just wanted to understand a little bit on -- you know, deductibles are going up quite a bit, particularly for the Silver plan. So we're going to $2,150 this year to $2,600 next year, and how, what percentage rate reduction, you know, from the premium would that, would that relate to? Because,

obviously, if people have to pay more on their deductible, you guys aren't coming in until later, and do you know what percent that would be?

MR. LOMBARDO: So I think we were asked before basically an apples-to-apples, if it was a $2,150 premium or deductible that we were proposing for '18, that rate increase would have been something a little bit higher, correct? So what's that gap, is that what you're asking?

MS. USIFER: Well, the consumer now has to pay a higher deductible, going from $2,150 to $2,600. So I think, on an insurance rate, you don't kick in until after the $2,600.

MR. LOMBARDO: Yes.

MS. USIFER: So that should be represented in a reduction of rate.

MR. LOMBARDO: Yes.

MS. USIFER: And it's probably -- I'm sure it's baked in there somewhere --

MR. LOMBARDO: Yes.

MS. USIFER: -- but do you know what that is?

MR. LOMBARDO: That's an easy number to provide, but I would have to have my computer with me to give that to you. So we can provide that along with -- are you looking for just that Silver plan?

MS. USIFER: Well, Silver is where the -- I mean, I was using that as an example because Silver is the highest plan, but really overall and where that was in your rate filings as a change.

MR. LOMBARDO: I believe L&E may have included that in their opinion, but I could be mistaken. Let me just -- so maybe I was mistaken. It may not be in here. Oh, no. Changes in actuarial value. So, if you go to Exhibit 10, Page 3, the number, Bullet Number 12 is .6 percent.

ATTORNEY KARNEDY: You're on the table?

MR. LOMBARDO: Yes. And then, if you go to Page 9, there's more of an explanation of that analysis.

ATTORNEY KARNEDY: Where on Page 9?

MR. LOMBARDO: Page 9, you'll see that there's a Number 12. It says "Changes in actuarial value". So L&E computed that to be worth .6 percent of the increase, so --

MS. USIFER: But, when you guys were building your rates, you must have included that in your analysis, right? I mean, it must be in that.

MR. LOMBARDO: Well, what we look at is we take our claims from 2016 and whatever deductible is present. So let's say the deductible that was present

was $2,000. There's some inherent claim costs that's associated with that plan. And I'll just -- I'm going to kind of use a hypothetical. So suppose that's a 70 percent actuarial value.

If the deductible goes up to $2,600, that 70 percent actuarial value will flow through. The change from 70 percent may go down to, like, 65 percent. So that number will flow through into the premium rate that we're proposing, and it's reflected in the rate increases that we're showing. Off the top of my head, I can't provide you with a number, but that's something that gets baked into the rate increases that we have, but, globally, L&E is quantifying that to be .6 percent.

MS. USIFER: And just a question on your IBNR. You talked about that, so, obviously, there's a pretty large accrual or estimate for what's going to come in for that.

MR. LOMBARDO: Yeah, yes.

MS. USIFER: And how does that get reconciled? And, if it comes in favorably, you know, does that just end up going to increase reserve? And, if it comes in unfavorably, is it just a reserve adjustment? You know, how does that end up getting reflected back into premiums if, in fact, there is an

adjustment? You know, because it's pretty large.

MR. LOMBARDO: Yeah. So we did, we did review our IBNR, our incurred estimate that we built into our rates versus when we had additional claim run-out, so through May. We compared those two numbers, and it was less than a tenth of a percent different. So we're, you know, we don't think there's any real material rate impact associated with the IBNR changes from the time we set our premium rates to the time through May of 2017. So, if that was a question that we were asked by the regulators, we could quantify that, and that could be reflected in the future.

MS. USIFER: Okay, thanks. And I'd also like to compliment you on your materials. This is my first time through.

MR. LOMBARDO: Thank you. I really appreciate that. Thank you very much.

MS. USIFER: Thanks.

MR. HOGAN: Just an asterisk. I finally calculated that $90 million into the $150,000. It's .0018. So it's not even noise. It's a speck of dust.

MR. LOMBARDO: Yes. So it's -- yes, I agree. So it's about two-tenths of a percent, correct?

MR. HOGAN: I have, I have .002 if you want to do it that way.

MS. HENKIN: We could probably get that clarified if we know what those numbers are and come out with that.

MR. HOGAN: Thank you very much. I'm not good at it.

MR. HUDSON: This format is not good at providing numbers at that level of specificity, so --

ATTORNEY KARNEDY: I didn't know this would be a math test.

MR. HUDSON: All right. Hearing no --

MS. HENKIN: Does the Chair want to?

MR. HUDSON: Yeah, that's what I was getting at. Just making sure. Chairman Mullin?

CHAIRMAN MULLIN: Thank you. Following up on an earlier question that talked about taking a look at what the filings were for the hospitals, can you tell me if MVP's customer base inside the QHP filing mirrors the percentages of monitors in the exchange relating to those hospital service areas, or do you have higher concentrations of business in specific areas?

MR. LOMBARDO: I don't, off the top of my head, I do not know what the whole state distribution of services look like. Generally speaking, a lot of our services are concentrated in Burlington at UVMC. I don't have the exact number off the, to compare it to

the state, but that's something that -- is the state information publicly available? Because, if it is, we could definitely put a comparison together and show that information. When we -- I'm sorry. But let me just expand a little bit.

When we set our rates, the way that we come up with our aggregate trend number is that we used the distribution of MVP's claim costs by facility. So it's specific to MVP. So, if the state was 50 percent in Burlington and 50 percent rest of the state but MVP is 40 percent Burlington, 60 percent rest of the state, we're reflecting that 40/60 blend, whereas the hospital budget may reflect the 50/50 blend.

CHAIRMAN MULLIN: Okay, that's helpful. Several times you talked about managing down costs, and as a follow-up to Member Holmes's question, you talked about one specific strategy. I was wondering if you could tell us, you know, what other strategies you're using to manage down costs, what have been successful and what have failed?

MR. LOMBARDO: Yes. So I would like to just highlight. From 2012 through 2016, we've done a pretty -- I think, we've done a good job as an organization to manage down costs because our administration budget across all of our legal entities has stayed flat over

that time period while we've actually grown membership. So we're pretty proud of that, but there's been a lot of different mechanisms that we've had to pull. Some of them are easier, and some of them are harder. We did go through a series of significant layoffs a few years back where reducing, you know, eliminating redundancies maybe or inefficiencies resulting in employees losing jobs, so --

CHAIRMAN MULLIN: How many years ago was that?

MR. LOMBARDO: I want to say that was around 2014, somewhere in that timeframe, 2013 to 2014 timeframe. It was over a couple-of-year time period. So that actually brought, did bring down costs significantly. Otherwise, just trying to create -- we've, you have to spend some money in technology up front to have some long-term efficiencies. So we've invested in technology that helps us receive claim data more efficiently and analyze our data in a more efficient manner. So we think -- I would say that those two items, other than just also contracting with providers and contracting with our PBM and trying to get reimbursements as low as possible, have been our most effective.

CHAIRMAN MULLIN: So in your testimony you

talked about the fact that administrative costs were going to increase next year, and you further spoke about how you believe that competition is very helpful in the marketplace to make sure that people are trying to get as many efficiencies as possible, and, given that emphasis on competition that you were stressing, you seemed to take some pride in what your percentage of overall bulk administration costs were, but you're still a point or two higher than your competitor here in Vermont on the Exchange filings. So I'm curious, you know, what further efforts might be undertook to try to reduce those even further given that you're higher than your competitor?

MR. LOMBARDO: Yes. So I think that's a very good question. Board Member Usifer's comment, as we grow, we should be able to reduce costs. So I think that's our competitor's number one advantage over us is they can spread their fixed costs over a larger membership base. So, if we can grow our business, we should be able to bring down our costs. So that is something that we are definitely trying to monitor. Otherwise, we're just constantly trying to -- our goal is to offer the most competitive premium rate, and we are fully cognizant of how expensive health care is, and we're trying to manage down those costs as much as

possible.

So, specific levers to pull, again, I think we have to try to stick with, Where can we improve our technology to make processes more efficient, evaluating our organizational structure to ensure that there aren't redundancies, and items such as that, working on our provider risk arrangements. If we can, the more that we can put providers at risk, then hopefully we can actually start bending the cost curve a little more favorably.

CHAIRMAN MULLIN: So, on that same theme of competition, when you did your filing, you weren't privy to what your main competition in Vermont's filing would look like. Given the fact that you now have seen accounts, although through the media, I would say, of what those are, have you internally done calculations? Because you referred to increasing the books of business in the past. Have you done internal calculations of what you think your increase in your book of business would be if there was an approval anywhere close to what the filings have asked for?

MR. LOMBARDO: So we did build into one of our responses, which was through risk adjustment to L&E, an assumed increase in membership. We assumed that we would increase by the same amount in terms of

gross members. So, if we increase by -- I'm going to, I may be off by a couple hundred members -- 3,500 members from 2016 to 2017, we think we'll continue to grow in a similar fashion, somewhere around the same amount, 3,500 members in 2018 based on the proposed rates.

The reality of it is, you know, we are, we are aware that Blue Cross Blue Shield of Vermont has a very strong brand presence in Vermont, and MVP is trying to increase our marketing presence and to improve that brand strength, and, hopefully, if we can improve our presence, we can actually surpass that number, but, for the time being, that's our biggest barrier. Because the dollars coming out of a small employer's pocket or an individual's pocket is much more favorable if you choose MVP, but it's that change in mindset coming off of Blue Cross Blue Shield and going to MVP that we face as a headwind.

CHAIRMAN MULLIN: What number do you believe is the number that would entice a consumer to change the product? What does the difference have to be?

MR. LOMBARDO: So we've done -- there has been -- we have conducted analytics and also hired consultants to review these kinds of, quantify these kind of metrics, because the Blue brand is very strong

whether you're in Vermont or western New York or throughout.

ATTORNEY KARNEDY: To the extent something's proprietary or confidential, I just would be careful about that, Matt, in your response, and we can always, if we need to, answer the question, but go ahead.

MR. LOMBARDO: Okay.

ATTORNEY KARNEDY: Based on that, try to answer the question.

MR. LOMBARDO: So what, the way I was going to answer it is that the figures that we've been provided, they're more generalized. They're not specific to a given market. And what we've seen is that the numbers that we've been provided with, which are arranged in between the mid to high single digits, is how I put it, it's not necessarily what we've actually experienced because that's kind of a generalized statement, and with these breakouts such as Blue Cross plan brands has a different spread than what our span is. We think it's a little bit higher.

CHAIRMAN MULLIN: Now, on the price transparency website that you discussed in, in answering the previous question, what type of access does someone as a consumer have prior to becoming a member of MVP? Do they have full access so they could

see specifically how their particular drugs that they're taking or whatever their particular illness is, how that would be treated on your website, or do they have to have a member access to, to get to that?

MR. LOMBARDO: I don't have that answer at my fingertips, but we can include that in Board Member Holmes's requests. We can incorporate that in.

CHAIRMAN MULLIN: Great, super. Okay. On the PBM question, what type of -- you know, you talked repeatedly about how you had strategies in place to try to manage down the costs. What type of counter-detailing efforts do you, does MVP use with providers so that they really know when they are prescribing, that they're not -- when I talk to doctors, what they tell me is they don't know the costs of the different alternatives that are in front of them oftentimes, and so I'm curious. What type of counter detailing efforts you, as an organization, use with members of your network to try to help them have the tools so that they can try to use cost-effective medications?

MR. LOMBARDO: This is a little bit outside of my comfort zone, but and I can speak in general terms to it. We have a quality department, and what they do is they review physician referral and

prescribing patterns, and they provide outreach to both the inefficient and the efficient providers to inform them and say, you know, Inefficient provider, respectfully, we see that your costs are a little bit higher relative with the same quality metrics compared to an efficient provider. So here are some steps that you can take to try to bring down that cost and become deemed as a more efficient provider.

And we provide similar information to the efficient providers to help them understand that there is, they've been, we're happy with the job that they've been doing, and, currently, we are contracting with an IT vendor that will help evaluate provider efficiencies so we can understand even more detail regarding where these efficiencies exist and where the inefficiencies exist. So it's something that we are, we're trying to move forward with it, but that's about the extent of my knowledge of those programs at this time.

CHAIRMAN MULLIN: Okay. And, again, on that managing down the costs theme, you've talked about the providing gym memberships, and I'm curious. Have you done any type of internal analysis on what you think your rate of return for offering those are?

MR. LOMBARDO: It's really challenging to isolate how, how providing a gym membership is going to

impact someone, because you have to have their prior history to understand their prior gym or exercise utilization to try to quantify those numbers. So we don't have the calculation to provide. There are external studies that have been performed. That's managed by a different part of the company, so I can't really provide a good answer to that. Our thought is just generally that, if you're exercising, you're probably going to have a healthier mindset and may eat healthier. You're going to think more about the decisions that you're making, and that will hopefully influence and bend the cost curve.

CHAIRMAN MULLIN: But you don't have any internal data to show a rate of return on that type of investment, on a prevention or wellness investment?

MR. LOMBARDO: We don't have, we don't have that information, no.

CHAIRMAN MULLIN: So we know that one of the larger cost drivers of health is tobacco use. What do you use there to try to encourage your members to not be smoking?

MR. LOMBARDO: I can research that. I know we do have tobacco cessation programs in place. So those are -- we do have programs in place to help reduce nicotine usage.

CHAIRMAN MULLIN: Okay. Going back to the PBM's, I think everybody saw the press a few years back about how the PBM's may have been profiting on the savings that they were getting through the rebates that weren't actually getting to the companies. I think you talked about that in your answer, but you also talked about there were two really different -- when you contract with the PBM, some of them you're getting the full share, and some of it's a shared. I'm curious. What's the percentage share between you and the PBM on that?

MR. LOMBARDO: My understanding is -- actually, I think this is a proprietary number, so I don't know if that's --

ATTORNEY KARNEDY: So we're happy, if you want to clear the room, to answer it now, or we can answer it in the confidential filing after.

MR. HUDSON: Yeah, that seems more efficient than clearing the room, yes.

CHAIRMAN MULLIN: Sometimes I have to think before I ask these questions. I guess that's it for me for now.

MS. HENKIN: I just have a quick question or two. Member Hogan asked you about your New York State filing. Do you know what your contribution to surplus

is in that filing?

MR. LOMBARDO: 2 percent.

MS. HENKIN: It's also 2 percent? And I just want to clarify. You have in your -- I think it's Exhibit 4. You discuss, you answer some questions about whether the 2 percent versus 1 percent would change your New York State, your requirement to meet the 12.5 percent premium, and I just want to clarify that you're looking at the, just this book of business not making the 12.5, or are you looking at your whole MVP book?

MR. LOMBARDO: It's specific to the Vermont Exchange population. Because, again, we try to -- our goal is to produce an actuarially sound rate for each block of business that we're setting premiums for.

MS. HENKIN: Okay. And this is 2.2 to 3 percent of the entire book?

MR. LOMBARDO: Correct.

MS. HENKIN: So a change from 2 to 1 would not likely put you out of compliance with New York State, can I assume that?

MR. LOMBARDO: Again, yeah, and I'm not fully privy to those calculations, but, when you just generally think about it, I think that's fair.

MS. HENKIN: Okay. And one other thing,

there's one thing at issue here which is that .3 percent which has to do with the difference between the 7 and 4 on the population all coming in in January, correct?

MR. LOMBARDO: Correct.

MS. HENKIN: And you're saying, if they come, no one new will be added?

MR. LOMBARDO: Correct.

MS. HENKIN: What about people leaving that will go to Medicare or Medicaid; have you considered any impact on that by people actually coming off of the, their membership, their 12-month?

MR. LOMBARDO: So a rate filing is generally assuming that the population that we have insured in '16 is going to be the population that's going to be insured in '18. So, obviously, members will age out into Medicare, but we'll also have the rest of our block is aging up a little bit. There's going to be newborn babies that are going to replace current newborn babies.

So we aren't making any explicit adjustment for age. What we're trying to really isolate here is just the change in the special enrollment period or the change in the open enrollment period. So I think those are separate factors. We're not considering any kind

of population move shifts from commercial to Medicare or Medicaid in our rate filing.

MS. HENKIN: Okay, that's it. Thank you.

MR. HOGAN: Again, one more asterisk. It was either three or four years ago that you announced here that you were going to reduce your administrative costs and it was going to be difficult. I recall that testimony directly. In your memo to Jessica back, you might want to put a little more detail about how that transpired. Thank you.

MR. LOMBARDO: Thank you for the recommendation.

MR. HUDSON: So --

ATTORNEY KARNEDY: A couple of redirects if I could?

MR. HUDSON: Proceed.

REDIRECT EXAMINATION BY ATTORNEY KARNEDY

Q. Matt, you were asked by the Health Care Advocate Counsel about affordability and generally. Specifically with the statute, your testimony on direct related affordability to the cost of the products and premium and whether they lined up or not; am I correct in that?

A. That's correct.

Q. She asked you a broader question, a more

philosophical question about, if people's wages are going up, you know, in a small amount and the health increases more than that, whether that's affordable for people. Can you opine on that as an actuary?

A. That, an actuary's job is not necessarily to try to solve this disconnect between basically wage increases and health care cost increases. Our job is to try to produce a sustainable rate that will meet our reserve requirements and maintain market stability.

Q. In the rate filing that's filed that's considered each year, the criteria that's set forth in statute, wage growth isn't a factor in that; am I correct?

A. I haven't seen the statute, but I would assume that's correct.

Q. We talked about -- probably shouldn't ask this. We talked about noise, and then we talked about a speck of dust.

MR. HOGAN: Exactly.

BY ATTORNEY KARNEDY:

Q. As an actuary, though, it is your job in doing a rate filing to drill down to every dollar and every nickel you can, good or bad, to figure out what's an appropriate rate filing that would meet the statutory criteria, correct?

A. That's correct.

Q. So, good or bad, if it's $100,000 or $200,000 or $5, that should be part of your rate filing, shouldn't it?

A. Yeah, our best estimate of rates should be reflected in the premium we're charging.

Q. And then you were asked --

MR. HOGAN: Would you agree that that's our job too?

ATTORNEY KARNEDY: Absolutely.

MR. HOGAN: All right. Thank you.

ATTORNEY KARNEDY: I'll agree with anything you say, Mr. Hogan.

BY ATTORNEY KARNEDY:

Q. Finally, you were asked by General Counsel about the 2 percent versus the 1 percent, and you went from 2 to 1 if you look at the overall block of the New York business. Do you recall that question?

A. Yes.

Q. As an actuary, do you look at the four corners of this particular line in determining surplus, or do you consider being able to tap into the New York reserves?

A. We've set our premium rates for this block of business to maintain our solvency independently for this block of business.

Q. And so this year is 2 percent, right?

A. That's correct.

Q. And L&E generally agreed with that, correct?

A. That's correct.

Q. And DFR, subject to checking on the last bit of reduction, agrees with that as well, correct?

A. That's correct.

MR. HUDSON: All right. Thank you. Well, I have a request in up here at the table for a very brief five-minute recess, and after that we'll be hearing from DFR.

(A recess was taken from 11:27 a.m. to 11:34 a.m.)

MR. HUDSON: Okay, everybody, we're out of recess, and we've got our next witness in line which is the Vermont Department of Financial Regulation, the Commissioner or his designee. So, sir, if you would identify, yourself for the record.

MR. LUSSIER: Good morning, everyone. My name is Jesse Lussier. My title is Administrative Insurance Examiner at the Department.

MR. HUDSON: And could you give a brief description of the nature of your job?

MR. LUSSIER: I am involved in all aspects of company licensing and analysis.

MR. HUDSON: And just a note for the record that the gentleman sitting right next to you today is

Scott Kline, correct?
ATTORNEY KLINE: Yes.
MR. HUDSON: And then the General Counsel for the DFR.
MR. LUSSIER: Just some more background, I've been at the Department for a little over six years now. I am a certified public accountant. I'd like to briefly discuss DFR's role in solvency and regulation generally and then as it applies to out-of-state companies and then briefly discuss our opinion.
Solvency regulation consists of monitoring financial health of insurance companies that write business in Vermont. It's a complex, dynamic, and prospective analysis, and it takes the form of two primary functions, that of financial analysis and examination. Analysis, in a nutshell, consists of gathering, reviewing, and monitoring information on a quarterly basis.
We receive information from several sources including company-submitted financial statements, the National Association of Insurance Commissioners which houses a database for all insurance companies, rating agencies like A.M. Best, company auditors, company actuaries, other regulators.
An examination is more robust in nature, and it

takes place every three to five years or earlier if necessary. It consists of identifying prospective risks the company faces, gathering and understanding of the company's internal controls and policies, their risk mitigation strategies, and also gaining an understanding of and assessing the company's corporate governance.
Additionally, DFR has access to an entity's books and records at all times. We also monitor the company's RBC level. RBC, which is risk-based capital, is a tool that helps us monitor the adequacy of a company's surplus. Overall, it's a large amount of data that is available to us. A lot of it is confidential, proprietary. During the course of analysis, data examination, our role is to kind of take this data, distill it into various reports and summaries and then assess it on both a qualitative and quantitative basis.
Now, to kind of give a brief background of the US regulatory environment, US, in the US, insurance regulation is state based so that, wherever a company is domiciled, that state is their primary regulator. This is necessary just because of the volume of companies. It would be extremely difficult for any one state to regulate every single company in the US. And

so, in the case of MVP, New York is their primary regulator, and all states rely on one another for this solvency regulation of insurance companies within their state, and, as such, Vermont relies on New York. New York has available to it, you know, all the procedures and tools and utilizes those the same as Vermont would for our domestic companies.
And now, if I could just briefly discuss the filing, like I said before, MVP's primary regulator is New York. With respect to this filing, our opinion is that the filing's effect on MVP's solvency, as long as the actuaries find the rates to be adequate and not excessive, will have the effect of maintaining MVP's current level of solvency. This conclusion has remained relatively consistent over the years in large part due to the size of MVP's footprint in Vermont. It's a relatively small component of their business, and that does affect our solvency analysis.
And, again, just as a final note, our conclusions are contingent based upon the actuaries determining that the rates are adequate and not excessive.
MR. HUDSON: Are you prepared to take questions from the Board?
MR. LUSSIER: Yes.
MR. HUDSON: Does MVP have any questions for

this witness?
ATTORNEY KARNEDY: Can I sit over there?
MR. HUDSON: Sure.
CROSS-EXAMINATION BY ATTORNEY KARNEDY
Q. Can I call you Jesse?
A. Absolutely.
Q. Jesse, so, if you would, there's a binder in front of you. You may just have a copy. It's Exhibit 9, which is your Solvency Letter dated July 11th.
A. Yeah.
Q. Exhibit 9, the binder, let me know when you have that in front you.
A. Yes, I have it in front of me.
Q. And, looking at the first page under "Summary of Opinion", there's a sentence there, which you were here today for earlier testimony, right?
A. Correct.
Q. So you heard Matt read that sentence, right?
A. Correct.
Q. And that sentence is an accurate summary of your opinions, correct?
A. Correct.
Q. And then on the last page, on Page 2 under "Impact of the Filing on Solvency", do you see that?
A. Yes.

Q. That sentence, there again, an accurate summary of your opinion regarding the impact of the filing on solvency, correct?
A. Correct.
Q. You also heard the testimony today. I asked the date of your letter was July 11th, and MVP had filed and served to file an amended filing which reduced their rate from 6.7 to 5.6. That happened just prior to this letter. Did you hear that testimony?
A. I did hear that testimony, yes.
Q. And so your opinion then here related to the 5.6, do you stand by that opinion?
A. Our opinion, we were working on information that was posted to the website. So I didn't receive the notice of the change until after the letter went out.
Q. Fair enough. I'm glad I asked. So, as you sit here today, you've heard testimony now that the 6.7, ultimately, MVP is now proposing 5.1, an additional reduction of .5. You heard that testimony, correct?
A. Correct.
Q. And do you have an opinion that that proposed rate, an increase of 5.1 percent, will likely add an impact to sustaining MVP's current level of solvency?
A. Yes. Our opinion does not change.
ATTORNEY KARNEDY: Thank you very much.

MR. HUDSON: Does the HCA have questions?
ATTORNEY KUIPER: Just a couple.
CROSS-EXAMINATION BY ATTORNEY KUIPER
Q. Good morning.
A. Good morning.
Q. So I just wanted to clarify what your report covers. Is it correct to characterize DFR's stance in your report that, if rates are appropriate, there is no solvency issue for MVP at this time?
A. Correct.
Q. But you don't assess independently whether the rates are set in an appropriate way, do you?
A. We rely on the actuaries. We don't have a health actuary on staff at DFR.
Q. And you don't analyze the affordability of rates, do you?
A. We do not, not in this subject, no.
Q. But you do in other areas that DFR covers, correct? Do you look at affordability in some of your other --
A. With MVP we normally rely on New York as their primary regulator.
Q. Thank you. But you do, DFR considers affordability in some of its other work like when you review long-term care insurance; is that correct?

A. That is not my job area of expertise. That would be someone from Rates and Forms. So I'm more focused on the financial side.
Q. So your part, your report just discusses whether rates are adequate or inadequate from a solvency perspective?
A. Correct.
Q. Would it be fair to say that, if you were to consider affordability, that your, that your report would need to be a little different, a little more balanced?
A. That's kind of beyond the area of my expertise.
Q. All right, that's fair enough. Thank you. But the bottom line is you don't have any concerns at this time about MVP's solvency, correct?
A. Correct.
MS. KUIPER: Thank you.
MR. HUDSON: I know there's at least one question from Chairman Mullin. It sounds like there may be some follow-up.
CHAIRMAN MULLIN: So you talked about your report is based on the initial filing, and then the question was asked that a 5.1, if you had a concern. If it was a filing for a decrease of 5.1 percent, would your opinion still be the same on the solvency of MVP?

MR. LUSSIER: We rely on the actuaries to set the rates. So, if, if the actuaries had determined the rates are not, are adequate and not excessive, then our opinion would generally stay the same.
CHAIRMAN MULLIN: Okay.
MS. HOLMES: Yeah. So I know your opinion is that the rate as proposed will have the impact of sustaining the current level of solvency of MVP. Would a CTR contribution of 1 percent instead of 2 percent also allow MVP to maintain a level of solvency?
MR. LUSSIER: Generally speaking, the Department believes that the filings should stand on their own and that downward adjustments shouldn't be made unless they are actuarially supported. I think, as Matt described before, if there are shortfalls, they may have to be made up in future periods. Does that answer your question?
MS. HOLMES: Well, I guess I'm just wondering if you -- I mean, at some point, you've ascertained a level of solvency that's reasonable. So I'm wondering, What is that range below it if a CTR contribution drops it below the level of solvency that's reasonable? Is it 1.9? 1.8? At some point -- I'm trying to figure out what that number is.
MR. LUSSIER: Okay. Our opinion is, is as to

the, is geared towards the rates as they're filed, and, again, we rely on the actuaries to determine which rates are, are reasonable and, and without, without going, without doing further analysis and maybe possibly discussing with the actuaries, it would be hard to answer some of these hypothetical questions, because, again, my area of expertise isn't setting rates. So we would need an opinion from an actuary to say whether or not those rates are reasonable.

MS. HOLMES: The DFR doesn't do and independent solvency analysis then?

MR. LUSSIER: The, the solvency analysis, for MVP New York is their primary regularity, and, in the context of the filing, we're charged with a solvency letter based on this filing and the proposed rates. Generally speaking, to, to veer off of what has been filed and what the actuaries have opined on might require further analysis.

MR. HOGAN: Noel, I'd like to. I viewed your letter as one of the strongest letters regarding solvency that I've seen in the last six years. Is that fair?

MR. LUSSIER: Strongest? Can you --

MR. HOGAN: As one of the strongest.

MR. LUSSIER: In terms of just how MVP is? I

mean, it's, it's similar to previous, previous filings.

MR. HOGAN: Okay. What is the difference in solvency between MVP and the Blues? What differences are there?

MR. LUSSIER: What differences are there?

MR. HOGAN: In the solvency of those two organizations.

MR. LUSSIER: I'm sorry.

MR. HUDSON: Please proceed.

MR. LUSSIER: Both companies are unique. They both have, they both have different risks that face them. Any company, any insurance company is different. They would have different risks, different considerations. This is kind of a general question. Is there anything more specific you could --

MR. HOGAN: No. I'd just like to know the differences from your point of view.

MR. LUSSIER: Well, again, Vermont is not the primary regulator of MVP, and so we have more information and we have more communications with Blue Cross, so I'm not sure I can fully answer that right now.

MR. HOGAN: Is Blue -- let me put it another way. Are the Blues less solvent than MVP?

MR. LUSSIER: I think that might be outside

of this, this --

MR. HOGAN: No, I don't think it is.

MR. LUSSIER: We're here today, I believe, to just discuss MVP's solvency as it relates to this filing.

MR. HOGAN: This is part of the larger rate-setting hearings.

MR. LUSSIER: So can you repeat the question?

MR. HOGAN: The last question I asked was, Are the Blues less solvent or more solvent than MVP?

ATTORNEY KLINE: I hate to put in an objection, but I do think we're probably beyond the scope of this.

MS. HENKIN: I'd like to clarify a few things, and maybe it will help you out, Con, because I want to clarify what the role is of DFR and where your numbers came in, because some things for the new members in particular may be a little confusing if I could ask a few questions.

MR. HUDSON: I think that's fine.

MS. HENKIN: Yeah, Jesse, you were talking about you rely on the actuaries. What actuaries are you talking about?

MR. LUSSIER: We rely on the Green Mountain Care Board's actuary to review MVP's filings.

MS. HENKIN: Okay. So DFR does not do an actuarial review to see if the 2 percent contribution is appropriate?

MR. LUSSIER: That is correct.

MS. HENKIN: And, as you listened today, did you also understand that our actuaries take data from MVP on what amount they believe is appropriate for solvency, to keep them solvent?

MR. LUSSIER: Yes.

MS. HENKIN: Did you see the exhibit that MVP had that contrasted a 2 percent with a 1 percent contribution to reserves?

MR. LUSSIER: Was that in the rate filing?

MS. HENKIN: I believe it was in Exhibit 4. It's in the book. If you look at Exhibit 4 in the book in front of you and if you look at -- I believe it's on Page 7, actually, Page 6. Go to Page 6. Have you looked at any of these assumptions or these exhibits about what the different assumptions MVP made on the different numbers that they could put into their surplus?

MR. LUSSIER: Not specifically, no.

MS. HENKIN: Okay. Do you understand that the actuaries for the Green Mountain Care Board have looked at these?

MR. LUSSIER: I assumed that was the case.
MS. HENKIN: So, in assuming that the 2 percent is, will sustain, your, your opinion from DFR is basically that 2 percent will sustain the appropriate level of surplus for this, for this carrier?
MR. LUSSIER: Correct.
MS. HENKIN: And that's solely on what you've seen in the L&E report and the actuarial work that went into that?
MR. LUSSIER: Correct.
MS. HENKIN: So, yes, I hope that just clarifies that they did not do an independent calculation, correct?
MR. LUSSIER: Correct.
MS. HENKIN: Thank you.
CHAIRMAN MULLIN: So in your testimony you referred to RBC, and in MVP's testimony they were looking at reserve amount as a percent of premium. Can you tell us, in your opinion, which is a better measure, and do you look at both or just one?
MR. LUSSIER: I don't know that there's a better measurement. We certainly take into consideration several ratios and numbers when we're looking at a company, and I assume that New York does

as well. But they're all good pieces of information to look at, but there are a lot of moving parts, and, there again, each company is different, and so the numbers aren't technically apples-to-apples when you're looking at companies of different sizes or running in different geographic locations.
MR. HUDSON: No further questions from the Board? Well, thank you very much for appearing today. Good to see you.
MR. LUSSIER: Thank you.
ATTORNEY KLINE: Thank you.
MR. HUDSON: So next on the schedule is to hear from the Board's actuary, Lewis & Ellis, and I will turn it to over to Attorney Henkin.

DIRECT EXAMINATION BY ATTORNEY HENKIN

Q. Good morning for five more minutes.
A. Morning.
Q. Could you tell everyone who you are?
A. I am Jackie Lee. I am with Lewis & Ellis, and I work for the Green Mountain Care Board reviewing rate filings in Vermont.
Q. What, who is Lewis & Ellis? Give us just a little background on that.
A. Lewis & Ellis is an actuarial consulting firm. I'm located in the Dallas office, and we have all lines

of business that we provide actuarial services for all lines of insurance, but our practice, Dave Dillon and I, we work on the health side. So we provide health actuarial services for various states, insurance companies, and other people who need actuarial services.
Q. Can you tell us about your educational background and also your professional background, where you've worked since you've graduated from wherever that may be?
A. I graduated from a small university in Texas called Texas Lutheran University. Majored in math with a minor in economics. And then I am also a fellow of the Society of Actuaries and a member of the American Academy of Actuaries.
Q. Where did you work before you worked for L&E?
A. Prior to L&E, I worked at Cigna and HealthMarkets, both of which were health insurance companies, before I moved to Lewis & Ellis about eight, nine years ago.
Q. How long have you done filings for the State of Vermont?
A. We began our work with the Green Mountain Care Board in January 2014.
Q. So right about the time that we had the ACA take effect?

A. Correct.
Q. About how many rate filings have you done, if you can estimate, for the State of Vermont?
A. In the State of Vermont, we have reviewed about 45 filings between the various carriers for QHP all the way up through the large group market filings.
Q. Do you also work in other states or for other states?
A. Yes. We currently do this similar review of rate filings in about seven states.
Q. Have you done -- now, here you're doing the QHP filings for the State of Vermont. Have you done them for other states also?
A. Yes, we have performed a review of Exchange filings in various other states.
Q. And you said seven states this year. Were those were all QHP?
A. Correct, yes, seven states this year.
Q. Speaking specifically about what you do for Vermont, can you just start with the process from when a rate filing comes in, what your office does for the State?
A. Sure. Beginning in mid-May, we receive a, we receive the QHP filings. So I'll talk specifically about that, but the same process happens for all the

filings we receive in Vermont. We receive the filing in May, in mid-May, and when we first get the filing in, we have a team that comprises of three actuaries who review the filing.

The first layer of review is done by Kevin Ruggeberg at Lewis & Ellis. He is an associate of the Society of Actuaries. He's very familiar with the MVP rate filings because he's been reviewing them for the last year, year-and-a-half, and he specifically worked on the QHP filing last year as well. His responsibilities include reviewing all of the documents provided by MVP through SERFF, which is publicly available as well.

Q. And you can tell the people what SERFF is?

A. SERFF is the way that carriers submit their filings to states. So it's online, and they're able to provide general information about the filing as well as very specific documents to support the rates that they are filing.

And Kevin reviews all of the documents which include memorandums, exhibits that support the charts and rates that are provided within the filing as well as an actuarial data set that we utilize internally to have more detailed sort of meat on the bones for the filing as our starting point.

Then we work, I work together with him as a peer reviewer. I review all of the documents, plus we discuss any issues or questions that we may have, and then, as Gary pointed out earlier, we had about seven rounds of questions that were very detailed that we sent over to MVP to understand their data better, understand their assumptions better, and that was all also done through SERFF.

The final level of review is David Dillon. He provides a secondary review as well as helps to keep consistency between this filing and the other filings that we do in the state as well as just kind of generally what we do throughout the rest of the country in other, in other states as well. And so he provides that, and we will discuss the market issues such as risk adjustment as it impacts both filings. So both Dave and I are very familiar with each of the carriers' filings.

Q. Do you just do kind of a mathematical check on what comes in, or do you check on assumptions and other things that might require some more judgment calls?

A. Generally speaking, that depends on the materiality of an assumption and what the assumption is itself. MVP did a wonderful job providing a lot of exhibits detailing how they came up with their rates,

and in that, in some of those instances, we will just review what they have done, but there are other instances such as for utilization trends, and diving into the unit costs and as they relate to the hospital budget, we do perform independent calculations as well to either verify what they've calculated or provide some alternative options or to develop a range of reasonableness about some of their assumptions and the rates in the aggregate.

Q. Do actuaries always agree on the same results with the same information?

A. No, we do not.

Q. And why is that? Could there be different factors or --

A. Different actuaries will have different opinions based on the data that we receive. There are different ways to make a calculation for a particular assumption, and depending on the information at hand and, you know, the market issues or company issues, actuaries will make different assumptions.

Q. You issued a report for the Board. Let's go to Exhibit 10. That's your report. Can you tell me what date that was due this year?

A. We provided this report on July 11th 2017.

Q. And was that the due date for the report?

A. Yes, it was.

Q. A 60-day review period per statute, as you understand it?

A. That's correct.

Q. On Page 2 you give a summary there of a standard of review for the filing. Is that your typical standard of review for every filing?

A. In the State of Vermont, yes.

Q. Okay. And, if you could just look at, maybe start with the last word on the first line, "This letter is to assist the Board", and just read what that standard is.

A. "To assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, provides insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law and is not excessive, inadequate, or unfairly discriminatory."

Q. Do you do an in-depth analysis of things like how affordable something is compared to what wages might be in Vermont?

A. No, we do not. We stick to the more actuarial terms within the standard.

Q. And are those terms the excessive, inadequate, or unfairly discriminatory?

A. Yes.
Q. Do they have actuarial definitions that might be different than a layperson's definition?
A. Yes, we have an Actuarial Standard of Practice Number 8 that relates to health rate filings, and they define these three terms very specifically.
Q. What is excessive? How is that defined?
A. Excessive is defined as when the rates charged are higher than what is needed to make payments for claims, admin expenses, regulatory fees, taxes, and profit or margin or contingencies.
Q. What about inadequate?
A. Inadequate rates are defined as rates that do not charge enough to cover those same items, so payment of claims, administrative expenses, taxes, regulatory fees, and profit margin.
Q. And unfairly discriminatory?
A. Unfairly discriminatory is defined as having rates for a particular rate set of insureds that have similar risk profiles but their rates are not the same.
Q. Let's go to the issues that you pulled out in this filing and pointed out, and, as we heard, there's only one thing at issue here, so I won't belabor too much, but I want to start with, if we look on Page 3 at, under "2016 Actual Projected Claims Experience", what

was the, how much higher was the claims experience?
A. The claims experience was .3 percent higher.
Q. And, if you look at the first sentence on your second paragraph there, what are you pointing out there that what that seems to correspond to?
A. This difference is primarily due to what is called a billback where the company is outlining by statute what they're paying for that's outside of the claims or what they're calling in addition to claims here.
Q. Does that also pay for the Health Care Advocate's office?
A. It does.
Q. So that's all inclusive in this number. Do you consider that part of the claims data normally?
A. No. We typically would outline this as an expense.
Q. If it was moved as an expense, would that make a difference in the medical loss ratio in this that would push this out of compliance with what the limits are?
A. Right. It would change. It would have an impact on the loss ratio, but it would not impact the federal requirements of the loss ratio. So it would never -- it would not dip below such that we would recommend a rate change at this point.
Q. But you could recommend putting this in expenses

instead in the future?
A. We, it is our opinion, and I know we've been working with the Board to try and determine what the right interpretation is of this point with CMS.
Q. If you go down to, I think, the third paragraph there, this is the issue that's still outstanding about membership over 12 months. Can you please explain the L&E's position on this and why you believe it differs from the carrier's position?
A. Yes. So, based on our conversations with MVP, they have assumed that all individuals and small group will be enforced for the full 12 months of a calendar year. However, we do agree with them in certain situations that, looking back to 2016, that's not -- there are some situations that happen in 2016 and 2017 that will not be reflected and will not impact the 2018.
Matt spoke specifically about the open enrollment period being shortened. However, they have assumed 12 months of enrollment for individuals and small groups. We don't agree with this assessment because we feel that there are other forces that would have individuals not have coverage for the full 12 months such as, if they get a job with a large employer, they would drop their individual coverage and move to the large

employer group's coverage.
There has been a lot of discussion about affordability. There may be people who can no longer afford the coverage and will just voluntarily drop coverage, and so it is our recommendation that there be consideration for lapsation throughout the year such that not all policies are enforced for 12 months.
The same could happen on the other side where people aren't just dropping coverage but they could be adding coverage such as they had the special enrollment where people either got married or lost their larger group coverage. They're able to then enroll in the Exchange.
Q. And that, that difference, as you said, was the .3, and that's the only thing that I believe was being contested?
A. That's correct.
Q. If you look at the recommendation on Page 10, the one item was a correction, and that was changed, correct, that half a percentage point?
A. Yes.
Q. As far as the hospital budgets, there was discussion earlier about whether that should be updated. Can you comment at all about how MVP ascertained these and whether they accounted for some

changes such as Rutland Regional Medical Center's decrease that was ordered by the Board?
A. For the 2017 unit cost trend assumptions, we were able to verify that they accurately reflected per the changes and modifications that were made, and we agree with -- MVP agrees with us on this assumption that those need to be corrected. With those modifications, they tie to the 2017 hospital budget numbers which includes the Rutland decrease.
For 2018 they assumed that 2017 would hold true with the exception of those that saw decreases. They would then put them to a more reasonable level that was consistent with other years or other facilities and, at this point, has not reflected either of the letters that were sent to the Board in March and April or what we just recently received as submitted hospital budgets last week for 2018.
Q. You listened to Matt's testimony? He made a statement about their market power in Vermont negotiating and contracting. As someone who sees all of the different filings in Vermont, do you see a large difference between the contracting power, market power and results of negotiations between the carriers?
A. Some of this is confidential, so I'll speak very broadly.

Q. In broad terms.
A. We do not see a difference.
Q. That's very broad. Thank you.
A. You'll ask more questions if you want me to dive in more.
Q. No, no. That's what I expected, so thank you. So the last thing I just want to ask is, Did you review the CTR and the charts that were provided showing that, if it's 2 percent, this book of business would, would meet the New York standards alone, and, if it was not, it was slightly under?
A. Yes.
Q. And do you make an opinion on solvency, per se, on these?
A. We make a very general opinion on solvency. We're not privy to a lot of information that the Department of Financial Regulation is, and so we rely heavily on their analysis, but we do say that we find what they have proposed as reasonable.
Q. And they, in turn, rely on your --
A. Yes, that is correct.
Q. So, if you say that the rate is not, it meets actuarial standards, then is there an acceptance of what that CTR is or how -- I'm, because this is an out-of-state company. Is there any review of these

numbers that were put in Exhibit 4, the projections about what 1 percent does, 2 percent?
A. We did review these, these numbers, and we took those into account when we were determining that we felt that the 2 percent was a reasonable assumption and, at this point, did not have enough information to recommend another number otherwise.
Q. So can you just explain what your ultimate projected rate increase is for this book of business for MVP? There's three things that are bullet points that were accepted other than the hospital budgets, as we know, being a little bit more fuzzy, and there will be more information as requested by the Board. But, with your modifications, what does the rate look like?
A. It is a reduction to a net increase of 4.8.
Q. As modified, do you consider that rate excessive?
A. No.
Q. Inadequate?
A. No.
Q. Unfairly discriminatory?
A. No.
Q. Do you have an opinion whether the resulting premiums are affordable for Vermonters?
A. We do not assess affordability of the premiums.
Q. So your actuarial role is limited to more of a

calculative math without external factors?
A. That's correct.
Q. Do you look at other carriers across the country to see what type of increases are being asked?
A. Yes, we have that information since we do a lot of those reviews. So we do know what they are, and we read, you know, general publications about what's happening in the, in the country for rate increases.
Q. You've been doing this for several years. Has Vermont's rate of growth, is that pretty -- the rate of, the rates of growth here, is that pretty much standard for across the country, or is Vermont higher, lower?
A. I would say that Vermont tends to be somewhat lower due to the nature of the Board itself and the hospital budget process. It's helped to keep the, the rate increases at a lower level.
Q. And your recommendation after what you heard today is still the 4.8?
A. Yes, that remains our recommendation.
MS. HENKIN: Thank you.
MR. HUDSON: Attorney Karnedy, do you have any questions from MVP?
CROSS-EXAMINATION BY ATTORNEY KARNEDY
Q. Can I call you Jackie?

A. Absolutely.
Q. I wanted to just get on the record again -- I heard and I wrote it down -- when you said that MVP did a wonderful job; is that right?
A. MVP did do a wonderful job. Thank you, Matt.
Q. Okay. Now, as to L&E, you heard my opening. You would agree that L&E conducted a vigorous and rigorous review of MVP's rate filing?
A. I would agree with that.
Q. And we have broad agreement on the rate filing this year with only this .3 difference that you just testified about, correct?
A. Agreed.
Q. And you'd also agree that MVP was thorough and responsive to all the interrogatories and the inquiries by L&E?
A. Yes.
Q. So, if you go to Exhibit 10 in the binder and go to Page 10, please, I want to focus on the recommendation bullets. The second bullet, let me know when you're there. You there?
A. I am there.
Q. The second bullet references the decrease of .5. We had an agreement on that, correct?
A. Correct.

Q. And the fourth bullet references a 1.1 decrease based on the risk adjustment. We have agreement on that, correct?
A. Correct.
Q. So let's talk about the other two bullets. On the third bullet relating to hospital budgets, I just wanted to get some confirmation on this. Looking in the bullet, I'm correct you did not make a particular percentage decrease recommendation as to hospital budgets, correct?
A. That's correct. We received that data about the same time as the report was due.
Q. And that's because, until the Green Mountain Care Board has their hearings on the budgets and makes a final decision on the 2018 approved budgets for the hospitals, L&E would only be speculating on what those figures will be and how they'd impact on unit trends, right?
A. Based on the submitted numbers, yes.
Q. That's not really a piece of evidence at this point in the record because it's a future event. Hasn't occurred yet, right?
A. We do have the submitted numbers, but we do not have the approved numbers.
Q. But the final decision yet, the hearings and the

Green Mountain Care Board's numbers, you don't have those yet?
A. We do not have those yet.
Q. And that will happen after August 10th after there's a decision in this rate filing?
A. I will take your word for that. I don't know when the hearings are.
Q. Would you agree with me that L&E is being prudent in not attributing a percent decrease to this third bullet?
A. No. If we had been given more time, we would have, and we hoped to after, during the course of between now and day 90, to hear the response from MVP about the submitted numbers and see how that impacted rates.
Q. Let me ask it a different way. At that snapshot in time on -- this is dated July 11th -- L&E did the right thing in not putting a particular number there because you didn't have enough information?
A. On July 11th we did not have enough information.
Q. Okay. So let's go up to the first bullet if we could. This is where we have a quantified disagreement between L&E and MVP, respectful disagreement, correct?
A. That's correct.
Q. If the Board thinks that your conclusion is

reasonable, it will result in a .3 decrease, correct?
A. Correct.
Q. And, if the Board thinks that MVP's conclusion is more reasonable, then it would stay at the 5.1 and rather than decreasing down to 4.8, correct?
A. Correct.
Q. And this issue relates in large part to the reduction in this open enrollment period, correct?
A. No. I would say that it has to do -- I mean, that's a portion, but it also has to do with just general lapsation throughout the year.
Q. Fair enough. So, as to that portion, I want to ask you some questions about the open enrollment period.
A. Okay.
Q. As I understand it, the testimony, the way this worked it used to be November 1 to January 31st, and next year it's going to be a narrower window, 45 days less. It starts on November 1 and ends on December 15th; am I correct?
A. That's correct.
Q. And, if you go to Page 3, please, of Exhibit 10, and you see there's a paragraph that's, it's one, down the table one, two, three. The fourth paragraph that starts, "The base period", do you see that?

A. Yes.
Q. Would you please read the second and third sentences, the sentence that starts "because", and then there's one that follows that starts with "L&E". Could you read those two sentences, please?
A. "Because policies active for less time are less likely to achieve the deductible and/or out-of-pocket backs, data for partial years tends to show lower utilization than data for complete plan years. L&E agrees with MVP's assessment that this adjustment is appropriate for small group plans which tend to be active for a full 12 months."
Q. Thank you. So it's fair to say you would agree with the logic that folks on small group plans who go the full year are now more likely to go through their deductible and then MVP would have to pay more for their claims?
A. Yes.
Q. Now, I want to get at the where you disagree. MVP -- just correct me if I've got this right. MVP takes the position that there's not sufficient data yet to actuarially predict what people on individual plans will do next year, whether they're somehow different -- and I'll just narrow a window, -- will cause fewer of them to be, you know, last-minute Charlies, not signing

up and having more of a partial year. MVP doesn't think that there's reliable enough data to know exactly how that's going to play out; is that fair?
A. Yes, that's correct.
Q. And you don't think the change in enrollment window shrinking to end up at December 15th, you got to sign up by December 15th, you would agree that that will at least have some impact on individuals overall buying their insurance and whether they'll enroll mid-year versus --
A. Yes, that will have an impact.
Q. And then the difference here is L&E goes ahead and makes some assumptions, a best estimate about what that impact would be?
A. Yes.
Q. And MVP takes the position that they're less unsure of what will actually happen, how many people will do it, how the deductibles will play out, so they're taking a more wait-and-see approach; would you agree?
A. They're taking the approach that they will see 12 months' enrollment. They're not going to wait and see. They assumed 12 months of enrollment for all individuals.
Q. And they're not factoring in the reduction that

you have, correct?
A. Correct.
Q. But you, L&E is making an assumption about next year, correct?
A. Yes.
Q. Okay. So let me ask you a hypothetical if I could. If, hypothetically, more individuals on individual plans start signing up for the whole year rather than mid-year, to the extent that they have claims, they're more likely to go through their deductibles over the longer period of time and MVP would pay more, correct?
A. Correct.
Q. Would you agree with me that a health insurance company should be conservative in setting their rates to make sure that it's charging sufficient premium to cover those claim costs?
A. Yes.
Q. And it should err on the side of caution, correct?
A. Yes.
Q. And, if it guesses wrong, it will likely have to charge higher rates in the years that come after that to make up the difference?
A. Yes.
Q. And you would agree with me that, as it relates to

the health insurance rates and filings, rate filings, actuaries don't like gambling on uncertainty and paying for shortfalls in subsequent rate filings; they like to get it right the first time?
A. I agree.
Q. If you would turn to Page 8 of Exhibit 10, please, go to Paragraph Number 9. So there's a Paragraph Number 9, and then there's a paragraph below it of one sentence. I want to just focus on Paragraph Number 9 and ask you to read the last two sentences in that Paragraph Number 9.
A. Starting with "The proposed"?
Q. Yes, please.
A. "The proposed 2 percent contribution to reserves, while higher than approved last year, is consistent with the assumptions found in MVP's other recent filings. The contribution to reserves assumption appears to be reasonable and appropriate."
Q. So my question, next question is, Whether MVP's final rate is 5.1 or 4.8, as you suggest, do you still agree that the 2 percent contribution to reserves is reasonable and appropriate?
A. Yes.
Q. Okay. If you go to Exhibit 4, please, the General Counsel had some questions. Exhibit 4, and there was a

table attached which is at Page 6, and this was comparing the 2 percent to the 1 percent. Do you see that?
A. Yes.
Q. And, if you go to the front of the exhibit, what's the date of this exhibit on the first page?
A. June 23rd 2017.
Q. Okay. And what was the date of Exhibit 10, which is your final report?
A. July 11th, 2017.
Q. So it was after this, right?
A. Correct.
Q. So, after seeing this information about the 2 versus 1, you concluded that the 2 percent contribution to reserves, while higher than approved last year, is consistent with the assumptions found in MVP's other recent filings, the contribution to reserves assumption appears to be reasonable and appropriate, correct?
A. That's correct.
Q. And then you were asked about affordability by General Counsel, about the general notion of affordability versus the statutory issue we deal with here. If you go to Exhibit 10, Page 2, you were asked about standard of review which is at the top of the page, and you and Judy went through sort of a laundry

list of all the statutory criteria, right?
A. Yes.
Q. And there is, the first question is whether the requested rate is affordable, correct?
A. Correct.
Q. So that's something you considered in the statutory context of this rate filing, right, not the broader question of affordability? You focused on affordable as we consider it in this rate filing, correct?
A. We mainly placed our focus on the final three which are actuarial in nature of not excessive, inadequate, or unfairly discriminatory as defined in the standard.
Q. Let me try it this way. Basically, you reviewed the statutory criteria as an actuary, correct?
A. That's correct.
Q. It's not a philosophical question for you, correct?
A. That's correct.
Q. Actuaries avoid philosophy at all costs?
A. That's correct.
ATTORNEY KARNEDY: If I could just have one second -- okay, thank you very much.
MS. LEE: Thank you.

MR. HUDSON: Does the HCA have any questions?
ATTORNEY KUIPER: I just have a couple.
CROSS-EXAMINATION BY ATTORNEY KUIPER
Q. Good afternoon.
A. Good afternoon.
Q. So, I guess, to focus in sort of where we just left off, so you had testified that, as far as the Board's actuary authority goes, your focus is on the excessive, inadequate, or unfairly discriminatory, correct?
A. Yes.
Q. And you said that you defined those based on Actuarial Standards of Practice, ASOP's, correct?
A. That's correct.
Q. And but would it be -- isn't it true that, that you can only opine on that definition applying to the way you look at the rates and not the way the Board defines their statutory authority, that the actuary standards of practice, you can't opine on whether or not that applies to the Board?
A. Those are what apply to me as an actuary. The Board has a different charge.
Q. Thank you. Excuse me. You also testified that you do an independent analysis of some rate components; is that correct?

A. That's correct.
Q. And I was wondering. Do you note in your report every time you've done an independent analysis? If there's not a note, can one assume that there wasn't one?
A. I would not make that assumption. We will outline if there, if we feel like it is important that we made an independent calculation. I would say, most of the time, we probably do, but I don't want to say that we always comment because we do a lot of work, and we only have, you know, a 10- or 12-page report.
Q. You testified on MVP's growth rate that you do have information on MVP's rate of growth of cost increases compared to other states?
A. Yes.
Q. Would you agree with me that, if one was to use that to look at affordability, you would also need to consider the base cost that you started from?
A. Correct, you would need to know the starting point.
Q. Thank you. In your report you use the terms "reasonable" and "appropriate" often.
A. Correct.
Q. Could you define those terms for me?
A. Reasonable is a hard term to define, but I would

say that we define that as, you know, a number that has, does not fall in being it's excessive, it's inadequate, or it's unfairly discriminatory. So we kind of, that's where we would define it to be reasonable. And then appropriate for the particular assumption based on the data that we, that is available at the time of our statement.

Q. Would it be fair at all to say that -- do you consider for reasonable whether it's a common practice?

A. Yes, we do assess if the methodology is in line with generally accepted actuarial practices.

Q. Excuse me. Coming back to the partial enrollment period questions, in your recommendation did you, did you take into account in that .3 reduction that the enrollment period would be smaller for this coming year?

A. Yes, we did one of those independent calculations for this particular situation.

Q. You don't ask MVP and Blue Cross to use the same methodology to set their rates, do you?

A. No, we do not.

Q. But would you agree with me that the important point is that they use the most reliable data and the most valid methodology available to come to the most accurate rate projections possible?

A. I agree with that, yes.

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

MS. HENKIN: Noel, can I just clarify one question? Going back to you were talking about the individual market and that .3 percent assumption, and you justified testified you did take into account the shorter enrollment. Did you base your calculation also on historical MVP data?

MS. LEE: Yes.

MS. HENKIN: Thank you.

MR. HUDSON: Do I have questions from the Board at this time?

MS. HOLMES: Just one. Thank you so much. It's really helpful. The discrepancy around the .3 percent which revolves around this shorter open enrollment period and these mid-year enrollments, help me just understand. If there is a shortfall in premiums to cover those claims, let's just assume that MVP's assessment is correct which was L&E's, you know, there's always uncertainty whenever you're making predictions, and that's why you have reserves. So wouldn't that be where they would tap into the reserves and sometimes that 2 percent or 1 percent or whatever percentage contribution to reserves? Why does it

automatically have to be assumed that it would lead to increase rates in the next year? Why wouldn't it just be tapping into reserves to cover that shortfall?

MS. LEE: Simplistically speaking, if we were looking at this filing in isolation, if you were to go with our recommendation of 4.8 and the reality hit that it should have been the 5.1, then just kind of looking at this in isolation, that would then drop the CTR from 2 percent roughly to 1.7. That, that would be considered an adverse experience based on what they predicted or were ordered to predict. So, yes, that would, but I can't really speak to -- I think that would be a better question for Matt on how they handle making those types of calculations companywide when those types of things happen. But, looking at this in isolation, that's correct.

MS. HOLMES: Okay. I'm just trying to understand. I mean, some of those reserves are for uncertainties?

MS. LEE: That's correct. It's for uncertainties regarding -- because, if they are incorrect about a utilization trend or their pharmacy trends, it would also come out in that same way.

MS. HOLMES: Thank you.

MS. USIFER: I just have a question on the

hospital piece where I know we didn't roll through the 2018 new budgets for the hospitals, but you mentioned something that, that MVP did use the hospitals that had decreasing rates and adjusted them accordingly up. I mean, you know, there seems a little inconsistency there. Either we use, you know, the rates that carry forward and we don't do anything with 2018, but to take rates that were decreasing and adjust them to a more reasonable rate, you know, seems like we're, we're half baked, we're doing half of the equation versus the other side.

MS. LEE: Right. I think that, to assume a facility is going to continue to have unit cost rate decreases in the future is not the best assumption. So I don't necessarily disagree with them making a change for that. Particularly at the start of the filing, they didn't have any new information. However, now that there's been some submitted numbers, those, or even the letters to reference, those could have been utilized to refine those to see if, in fact, maybe a rate decrease is still appropriate.

I don't -- with no new information, I don't think that that would be prudent to make that assumption, but now that there is a little bit more information that could shape that a little bit better, and given the

hospital budget process, typically, what's submitted is somewhat in line with what's approved. It will go down, but then utilize that to make some estimates about the future.

MS. USIFER: So do we know now, if we used the submitted rates, what that impact would be on this?

MS. LEE: I do not know that at this time. I know Matt's going provide that, and I would prefer to wait for Matt's recommendation, though we can attempt it on our end as well.

MS. USIFER: I just wanted to clarify. We keep talking about mid-year adjustments for the claims. Is it really just to February 1st, you know, that people would have, now can opt in until January 31st, and so, if they started on the program, it would be a February 1st?

MS. LEE: Yeah, I think, to elaborate since there's a lot of questions about it, what our independent calculation looked at was we took -- so in what we had which was data for '16, since we have a full year, there were significant enrollments in January, February, and March, and then it rapidly declined because there people weren't enrolling as Matt testified to earlier, because, if they enrolled within January, they could have had February or March start

dates.

What our analysis did was we took those that were in February and March, and we rolled them into January, and then we assumed roughly .8 percent would have each of the corresponding months later. So we assumed that about 90, roughly, very rough, 90 percent would have 12 months of enrollment experience, and then .8 would have 11 months of enrollment experience, and then .8 would have 10, all the way down. If you add those up, they don't quite go to 100, but I can give you very specifically what it was.

So we just were more assuming that, yes, this special enrollment period would shift people to the, up to January but that you wouldn't lose the fact that there are other external factors that require or that make individuals change coverage throughout the year.

MS. USIFER: Okay, thanks.

MR. HUDSON: Hearing no further questions --

ATTORNEY KARNEDY: I just have one redirect to follow up from the redirect, one question.

MR. HUDSON: A re-cross from the redirect?

ATTORNEY KARNEDY: Re-cross based on the question from General Counsel if that's okay.

MR. HUDSON: Any objections from the HCA or Attorney Henkin?

MS. HENKIN: Haven't heard the question.

MR. HUDSON: We'll wait on objections then. Let's hear the question.

FURTHER EXAMINATION BY ATTORNEY KARNEDY

Q. You were, you responded that on the 3 percent that you did do an analysis based on historical data, correct?

A. Yes, that's correct.

Q. And you just talked about that a little bit, the analysis that you did, and you did calculations that sounds like, based on the month, you made assumptions different months, different percentages.

A. Correct.

Q. But all of that was based on prior years where the enrollment period was from November 1 to January 31st, correct?

A. Yes.

Q. And the year we're talking about is a narrower enrollment period from November 1 to December 15th? It's different, isn't it?

A. It is different.

ATTORNEY KARNEDY: Thank you.

MR. HUDSON: Thank you, Ms. Lee. Nice to see you.

MS. LEE: Thank you.

MR. HUDSON: So there is a --

MS. HENKIN: Can I make a suggestion here? And I'll just do it now. I don't know if it's the appropriate time. There's been a request for some information from the carrier, and I think what I'd like to suggest is that we gather that and you send out a letter, Mr. Hearing Officer, later this afternoon outlining exactly what is needed. Because I think we've taken notes, but we may want to confer on making sure that it's clear what is being asked if that's helpful, and we'll send it to you this afternoon. Is that a reasonable request of you, the Hearing Officer, and others?

ATTORNEY KARNEDY: I think that's fine, and maybe suggest a time when we could talk tomorrow about it.

MS. HENKIN: If needed. I think that we should clarify what the requests are and hopefully when, optimally, we'd like the information by.

MR. HUDSON: Yeah. Given the technicality of some of the requests, that seems like a prudent way to go, and I'm happy --

MS. HENKIN: It was a request, and then somebody else got on the request and made a -- so I want to make sure we get that corrected.

MR. HUDSON: Barring any objections --
ATTORNEY KUIPER: No objections.
MR. HUDSON: Then that's fine. Okay. So, at this point, we're at a place where we can move on to closing statements if the parties wanted to offer them.
ATTORNEY KARNEDY: I actually had one -- we talked about this at the prehearing. One thing I wanted to get on the record if I could at this time.
MR. HUDSON: That's fine.
ATTORNEY KARNEDY: So this is sort of a horse-and-cart issue, and it came up in the testimony, but we talked about it at the prehearing, and I just wanted to get this on the record, and that is the notion of hospital budgets being finalized after your final decision here.

And, if you read Exhibit 10, which is at L&E's -- we've read this -- at L&E's report, they made reference to -- and I'll read the sentence: "L&E recommends the Board consider the impact of 2018 hospital budgets on unit cost trends once the 2018 budgets become publicly available."

So the parties have now completed submitting evidence. The record will be complete. I'm very happy to hear Board Member Holmes asked for some follow-up information. I think that makes sense. So that, by

the time we file our briefs and the Board renders a decision on the 10th of August, the record will be complete and we'll know what the record is.

That said, by Statute, V.S.A. 406 2, 2(a), the Board's 90-day deadline will have run from May the 12th, and that's why we have this August 10th deadline, and the hospital budget hearings, as I understand it, are going to be occurring after you make a decision here, and so my, my concern -- and it's a horse and a cart -- the Board is in a tough spot -- is that the decision be based on this record, and pursuant to Board Rule 2.402, that's what the rule says, findings will be based exclusively on the record. 2.403 lists exactly what the record includes, and it's all these filings up until the point of the Board's decision.

So, just as a matter of procedure, if the Board should consider subsequent budget information after we file what we've been requested to file, that would be after the record's closed, and I just want to make sure and just put on the record that MVP be provided, if you do that -- I don't know if you can by statute -- but, if it happens, that we be provided an opportunity that the hearing gets reopened, we have some fair opportunity to comment on any additional information. So I thought it was important to put that on the record

because we have this horse-and-cart challenge.
MR. HUDSON: And I assume the record will so reflect your statement and request, and, if you want to move on to a closing statement, you may do so.
ATTORNEY KARNEDY: Thank you. In the interests of time, I will say very little other than we think that the evidence has shown that MVP's rate filing as amended meets the statutory criteria. We appreciate the Board's very active questioning of Matt and others, and I think, as a result, we have a pretty good understanding of what the rate filing is. We believe that, on this one issue, it, it does matter. Every dollar matters, and, as an actuary, you know, we get the notion that, Why are you arguing about .3? But what I think is that, in considering the solvency of the company and the rate filing in its entirety, MVP's been more than reasonable in making the proper concessions on that point.

We have a fair disagreement about how you should look at next year, whether you extrapolate month by month making all these assumptions about, What will people do now that the window's closed or the window is narrower? Who knows? And I think MVP is trying to be prudent in not making too many assumptions about that on the side of having to then catch up later and have a

higher rate increase down the road. So that's the reason why we're taking the position. I understand what L&E is saying. We just think, based on relying on historical data, it was different in the past. Next year, who knows how people will react to this? But thank you very much.
MR. HUDSON: Thank you, Attorney Karnedy. Does the HCA wish to offer a closing statement?
ATTORNEY KUIPER: Just a quick one. I'm going to state my main arguments in a post-hearing memo, but I just want to say that there has been talk today about the importance of having conservatism and solidarity, and I just want to point out that it's, the burden of proof is on MVP, and none of the witnesses today could speak to affordability. So I trust that the Board is going to remember the important balance of affordability for consumers when setting rates. Thank you.
MR. HUDSON: All right. We are at a point in the hearing where we can close the evidence for the hearing and move on to the public comment section. It appears at first glance that we probably won't have too much trouble getting through public comment, but there is a sign-up sheet that we may have to adjudicate the order, if any. No?

MS. HENKIN: Is anyone here for public comments?

MR. HUDSON: Yeah, are there any public comments?

MS. HENKIN: So we don't need worry about the order.

MR. HUDSON: All right. Always good not to have fights about the order. So, apparently, the public comment section is unnecessary. Do you, do you want to make a comment about the --

MS. HENKIN: There is a public comment period. We are taking public comment. We expect it to be mostly related to Blue Cross, of course, because that's what we have received more comment on already. It is next Thursday evening from 5:00 to 7:00 at the Second Floor Board Room at City Center.

MR. HUDSON: And, for this specific MVP hearing, there remains an open public comment period that will be lasting until July 28th, and we will be taking public comments by US mail, telephone, email, and by the Board's preferred method of taking public comment through the public comment portal on the rate review website. So, hearing no further business, then this hearing's adjourned.

(Whereupon at 12:47 p.m. the hearing was adjourned.)

C E R T I F I C A T E

I, Sunnie Donath, RPR, do hereby certify that I recorded by stenographic means the Rate Review Hearing Re: Docket Number GMCB-007-17rr, at the Vermont State House, Room 11, 115 State Street, Montpelier, Vermont, on July 19, 2017, beginning at 9:00 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 173 pages are a transcript of the stenographic notes taken by me of the evidence and the proceedings to the best of my ability.

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

Dated at Westminster, Vermont, this 23rd day of July, 2017.

// Sunnie E. Donath