STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-008-18rr

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

July 24, 2018
9 a.m.
---
115 State Street
Montpelier, Vermont

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

P R E S E N T

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

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

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

A P P E A R A N C E S

MVP Health Care

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

Health Care Advocate

Jay Angoff, Esq.
Kaili Kuiper
Eric Schulteis
Tim Fisher

Vermont Department of Financial Regulation

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

I N D E X

Witness	Page
Matthew Lombardo	
Examination by Mr. Karnedy	29
Cross Examination by Mr. Angoff	82
Board Questions	110
Jesse Lussier	165
Cross Examination by Mr. Karnedy	167
Board Questions	171
Jackie Lee	
Direct Examination by Mr. Arduengo	174
Cross Examination by Mr. Karnedy	192
Cross Examination by Mr. Angoff	204
Board Questions	206
Michael Fisher	218
Mr. Karnedy closing comments	223
Mr. Angoff closing comments	224
Public Comment:	
Jill Charbonneau	229
Jeff Hochberg	230
Dale Hackett	233

Exhibits	Page
1-14	21

(9:01 a.m.)

CHAIRMAN MULLIN: Good morning everyone.

MR LOMBARDO: Good morning.

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

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

MR. KARNEDY: My summer associate, Michelle Bennett.

HEARING OFFICER HENKIN: Benny?

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

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

MR. KARNEDY: Yes.

HEARING OFFICER HENKIN: The HCA is

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

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

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

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

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

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

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

Matt Lombardo
Mike Fisher
Jacqueline Lee
Jesse Lussier
Having been duly sworn, testified as follows:

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

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

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

HEARING OFFICER HENKIN: Let's start

with that, get this out of the way.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to have him talk solely about this.

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

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

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

HEARING OFFICER HENKIN: Mr. Angoff.

MR. ANGOFF: Yes. We are aware that

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

HEARING OFFICER HENKIN: Do you have a response?

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

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

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

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

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

MR. ANGOFF: Yes, I have.

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

MR. ANGOFF: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HEARING OFFICER HENKIN: He is not an expert.

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

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

MR. ANGOFF: Very good. Thank you.

HEARING OFFICER HENKIN: Is that understood?

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

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

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

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

(MS. Kessler standing.)

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

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

MR. ANGOFF: Madam Hearing Examiner, stipulated documents.

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

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

MR. KARNEDY: Thank you very much.

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

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

MR. ANGOFF: Correct.

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

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

HEARING OFFICER HENKIN: I was going to

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

MR. ANGOFF: To wait?

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

MR. ANGOFF: Yes, it would.

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

MR. ANGOFF: Yes.

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

MR. KARNEDY: Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much.

HEARING OFFICER HENKIN: Mr. Angoff.

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

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

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

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

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

HEARING OFFICER HENKIN: You may call

your first witness.

MR. KARNEDY: Call Matt Lombardo.

MATTHEW LOMBARDO

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KARNEDY:

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

A. Yup.

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

A. Yup.

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

A. Matthew Lombardo.

Q. And where are you employed, Matt?

A. MVP Health Care.

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

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

Q. And what is your position at MVP?

A. Director of actuarial services.

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

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

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

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

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

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

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

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

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

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

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

Q. Do you review cost drivers?

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes, I am.

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

A. Yes.

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

A. Yes.

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

A. Sounds good.

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

A. Okay.

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

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

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

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

A. Yes.

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

A. Yes.

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

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

that eligible members will feel.

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

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

A. Correct.

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

A. Okay.

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

A. Yes.

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

A. Okay.

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

that?

A. Yes.

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

A. That's correct.

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

A. Yes, we agree with that adjustment.

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

A. Correct.

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

A. We respectfully disagree on this adjustment.

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

A. Yes.

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

A. That's correct.

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

A. That's correct.

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

A. Okay.

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

A. May 11, 2018.

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

A. Okay.

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

A. 10.88 percent.

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

A. $15,734,195.

Q. And the number of policyholders?

A. 8,929.

Q. And the written premium?

A. $144,599,214.

Q. And the maximum and the minimum change?

A. 30.69 percent down to 4.24 percent.

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

A. Okay.

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

A. Yes.

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

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

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

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

A. Okay.

Q. Do you see that paragraph?

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

Q. Green Mountain Care Board as well?

A. Yes.

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

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

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

A. All right.

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

A. Yes.

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

A. Yes.

Q. You agree with that statement?

A. Yes.

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

A. Yes.

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

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

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

card.

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

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

A. Yes.

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

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

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

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

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

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

A. Yes, it does.

Q. So we have a disagreement on that?

A. Correct.

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

A. Yes.

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

A. No. We do not.

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

A. Yes.

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

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

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

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

And MVP did a similar analysis. It wasn't

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

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

A. That's correct.

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

A. Okay.

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

A. Yes.

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

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

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

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

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

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

Q. Does it also consider chronic care?

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

admission, a more severe case.

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

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

Q. So 10 percent, correct?

A. Yes.

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

A. Okay.

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

A. Correct.

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

A. Correct.

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

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

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

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

A. That's correct.

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

A. Yes.

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

A. That's correct.

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

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

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

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

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

A. That's correct.

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

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

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

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

A. Okay.

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

A. Yes.

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

A. That's correct.

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

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

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

A. Okay.

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

A. Yes.

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

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

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

A. That's correct.

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

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

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

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

A. Correct.

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

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

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

A. No, okay. No problem.

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

A. That's correct.

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

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

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

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

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

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

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

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

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

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

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

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

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

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

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

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

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

A. Exhibit 9. Yes.

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

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

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

A. Okay.

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. That's correct.

Q. And that was approved?

A. Yes.

Q. Okay. Why two percent?

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

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

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

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

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

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

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

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

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

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

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

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

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

increasing, we need to also increase the premium rate.

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

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

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

A. I'm there.

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

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

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

A. Yes.

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

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

Q. And read the next sentence.

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

Q. Do you agree with those statements?

A. Yes.

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

A. Okay.

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

A. That's correct.

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

Read the summary of opinion sentence on the first page.

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

Q. You agree with that; correct?

A. That's correct.

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

A. Okay.

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

A. Yes.

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

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

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

A. That's an accurate statement, yes.

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

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

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

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

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

A. Yes.

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

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

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

Q. Do you agree with that?

A. Yes.

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

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

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

A. Okay.

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

A. Yes.

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

paragraph.

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

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

A. Yes.

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

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

proposed in these rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Correct.

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

A. Correct.

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

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

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

A. Yes.

Q. Go ahead.

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

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

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

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

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

A. No.

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

A. I'm familiar with that.

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

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

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

A. That's correct.

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

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

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

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

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

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

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

A. That's correct.

Q. Are there also online health and wellness tools?

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

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

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

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

community-care docs?

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

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

Q. And do those efforts promote quality care?

A. Yes.

Q. Why?

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

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

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

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

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

A. Okay.

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

A. That's correct.

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

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

Q. Do part of our administrative costs include credentialing?

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

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

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

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

A. Yes.

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

A. Yes.

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

A. That's correct.

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. What is that?

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

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

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

A. Yes.

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

A. That's correct.

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

A. Yes.

Q. Do the rates exceed?

A. No.

Q. Okay. So they are not excessive?

A. They are not excessive.

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

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

our rate setting.

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

A. Yes.

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

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

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

A. Yes.

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

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

individual plan being offered.

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

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

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

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

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

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

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

A. That's correct.

Q. Thank you very much, Matt.

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

(Recess was taken.)

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

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Good morning, Mr. Lombardo.

A. Good morning.

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

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

Q. You're his boss?

A. Correct.

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

A. Yes. That's fine.

Q. So what's your position?

A. Director of actuarial services.

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

A. That's New York as well.

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

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

Q. How many actuaries do you supervise?

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

actuaries and indirectly four students that are taking exams.

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

A. That's correct.

Q. And is he a credentialed actuary?

A. Yes.

Q. He's not a fellow; right?

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

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

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

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

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

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

A. Yes.

Q. For how long?

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

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

A. Yes.

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

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

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

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

A. Yes.

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

A. That is correct.

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

Can you tell us what the actual rate is that

you currently have for standard plans?

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

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

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

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

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

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

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

Q. Meaning your rates are lower?

A. Yes.

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

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

MR. ANGOFF: Today. Your current rates.

MR. KARNEDY: Current rates. Thank

you.

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

BY MR. ANGOFF:

Q. Yeah. Your most popular standard silver plan.

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

Q. Between 480 and 520?

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

Q. For your standard silver?

A. Yes.

Q. And what page is that of the --

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

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

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

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

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

THE WITNESS: It's challenging.

CHAIRMAN MULLIN: I'm envious of his eyesight.

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

BY MR. ANGOFF:

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

A. Yes.

Q. Do you know that?

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

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

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

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

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

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

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

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

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

A. That's correct.

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

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

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

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

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

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

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

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

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

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

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

A. It's a possibility.

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

A. Not -- no.

Q. Let me ask you --

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

MR. ANGOFF: Pardon me. I stand corrected.

BY MR. ANGOFF:

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

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

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

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

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

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

Q. Did MVP think that the penalty for not having

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

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

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

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

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

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

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

BY MR. ANGOFF:

Q. Did MVP do any research to determine what the

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

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

Q. So that's a no.

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

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

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

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

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

A. No.

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

A. Correct.

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

A. Yes.

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

A. Correct.

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

Vermont gain in business?

A. Yes.

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

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

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

A. And our rates reflect that.

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

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

Q. Okay. What are those reasons?

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

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

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

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

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

A. Yes.

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

A. I don't recall.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. KARNEDY: I'm going to object. This has been asked and answered.

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

BY MR. ANGOFF:

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

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

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

A. Yes.

Q. And am I correct then in understanding that

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

A. That's an accurate statement.

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

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

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

A. That's my understanding.

Q. But you don't know that?

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

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

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

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

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

BY MR. ANGOFF:

Q. Does MVP have a target RBC ratio?

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

Q. So does MVP have a target RBC ratio?

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

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

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

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

A. Okay.

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

A. Okay.

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

A. Okay.

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

A. That sounds familiar. Yeah. That sounds appropriate.

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

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

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

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

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

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

MR. KARNEDY: Thank you.

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

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

MR. KARNEDY: This goes to my objection.

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

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

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

MR. ANGOFF: I'm sorry?

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

MR. ANGOFF: Exactly right.

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

BY MR. ANGOFF:

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

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

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

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

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

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

MR. ANGOFF: Exactly right.

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

THE WITNESS: I did that equation.

BY MR. ANGOFF:

Q. And does that cause you any concern?

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

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

concerned at all about MVP's financial condition?

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

Q. Could you please turn to Exhibit 13.

A. Okay.

Q. Are you familiar with that exhibit?

A. This is not an exhibit that I prepared.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Correct.

Q. Or inadequate; correct?

A. Correct.

Q. Or unfairly discriminatory; correct?

A. Correct.

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

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

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

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

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

MR. ANGOFF: Sure.

BY MR. ANGOFF:

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

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

The remaining amount we are managing as

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

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

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

Q. Sorry. Go ahead.

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

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

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

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

A. That is not part of the actuarial statement.

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

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

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

THE WITNESS: Yes.

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

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

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

THE WITNESS: That's my understanding. Correct.

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

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

THE WITNESS: That's correct.

CHAIRMAN MULLIN: And what leads you to that assumption?

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

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

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

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

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

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

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

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

average.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE WITNESS: No.

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

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

CHAIRMAN MULLIN: And what about procedures?

THE WITNESS: I'm sorry?

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

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

THE WITNESS: Yup.

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

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

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

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

CHAIRMAN MULLIN: Okay. Thank you.

HEARING OFFICER HENKIN: Member Holmes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE WITNESS: I know we are in

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

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

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

THE WITNESS: I'm not part of that

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

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

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

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

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

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

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

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

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

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

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

BOARD MEMBER HOLMES: Any information

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

THE WITNESS: Okay.

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

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

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

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

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

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

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

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

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

helpful.

THE WITNESS: Okay. Thank you.

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

THE WITNESS: Yeah.

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

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

BOARD MEMBER HOLMES: Okay. What

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

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

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

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

THE WITNESS: Yeah, it would be money

taken out of claim expense. That's correct.

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

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

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

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

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

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

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

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

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

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

THE WITNESS: Okay.

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

THE WITNESS: Okay. Thank you.

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

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

THE WITNESS: Yeah.

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

about 60/40.

THE WITNESS: This -- it sounds right.

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

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

THE WITNESS: Okay.

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

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

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

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

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

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

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

Most of our fixed costs are spread across both states.

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

there is a way to get some of that back.

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

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

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

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

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

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

THE WITNESS: Just individual.

BOARD MEMBER USIFER: Just individual market.

HEARING OFFICER HENKIN: What document was that?

BOARD MEMBER USIFER: The last document. C.

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

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

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

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

that.

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

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

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

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

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

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

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

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

THE WITNESS: Right.

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

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

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

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

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

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

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

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

THE WITNESS: No.

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

HEARING OFFICER HENKIN: Robin.

BOARD MEMBER LUNGE: Hi, Mr. Lombardo.

THE WITNESS: Hello. How are you?

BOARD MEMBER LUNGE: I'm good. Thank you. I was noticing in your CV that part of your job responsibilities include assisting in developing corporate strategic initiatives and managing intelligence. Your CV is in tab 12 if one needs to take a look at that.

I was wondering if you could talk a little bit about what kind of market research you might do.

THE WITNESS: The actuarial team we

analyze competitor rate filings to understand our premium position. So for example, the Vermont Health Connect filings are available on the rate review website. So once those are posted, we analyze our premium position based on where we are in 2018, when we posted on May 11 or May 12, compared to where we expect to be in 2019 on the proposed rates.

Once a final decision is made in a few weeks, we will update that analysis to reflect our final approved premium position. And then we coordinate with our marketing communications team to try to coordinate efforts towards where are we concerning the members that we currently enrolled that we may lose because our premiums are not as competitive, or opportunities that exist because our premium position has improved.

BOARD MEMBER LUNGE: And do you do any or hire any consultants to do market research, or is that an in-house activity?

THE WITNESS: From an actuarial -- from a competitive premium position?

BOARD MEMBER LUNGE: Yes.

THE WITNESS: That's not something that we outsource. Whether it's market intel on consumer behaviors, that would be something that is not

handled by the actuarial department. I know that there are studies done that are outsourced. I understand utilization patterns, what are best practices, how do we navigate care in a correct manner. What do members want, what drives purchasing decisions. Those are items that we do analyze that helps inform our product designs.

BOARD MEMBER LUNGE: I see. Yeah. Thank you. In response to Member Usifer's question you indicated that in your individual mandate analysis you didn't look to the level of the metal level, is that right?.

THE WITNESS: Yes.

BOARD MEMBER LUNGE: And the individual mandate adjustment, if you will, you do that prior to other membership change adjustments, like for example, cost sharing reduction.

THE WITNESS: We are not assuming any membership -- we are only assuming membership shifts in the calculation of the Cost Sharing Reduction. Yes. So to your point, we are not reflecting who's going to drop coverage, so we are not loading up the CSR amount additionally for healthier members that were enrolled in CSR dropping coverage.

BOARD MEMBER LUNGE: Okay. I believe

in your filing you indicated that you were expecting for an individual with a subsidy that your bronze plan would have a near zero premium.

THE WITNESS: Based on the proposed rates, that's what we are assuming.

BOARD MEMBER LUNGE: Thank you. Also related to the bad debt assumption, it's your testimony that that's based on assuming that people will stop paying towards the end of the year.

THE WITNESS: I said uh-huh. Yes.

BOARD MEMBER LUNGE: Yes or no. So it was a clarification. Are you aware that currently prior to the time the penalty was zeroed out that an individual with up to three months of uncovered wasn't charged a penalty?

THE WITNESS: I was aware that there was a two to three-month grace period. Yes.

BOARD MEMBER LUNGE: Okay. Thank you. Got to go back to my tabs. So bear with me. In your filing, this is on page 35. I just want to clarify what a particular term means.

In the summaries experience period non-fee-for-service and capitation amount there is a line that says chiropractic and acupuncture cap. Is that the copayment limitation in Vermont law, or is

that something different?

THE WITNESS: Our chiropractic and acupuncture services are provided from an outside vendor, and it's a capitated arrangement, so we pay them an amount per month up front regardless of how many services are utilized.

BOARD MEMBER LUNGE: Got it. Thank you. I just wanted to clarify what that actually was. And then on page 80 you have a description of some of the capitation and non-fee-for-service medical costs, and those would include, I believe, the Blueprint payments. Page 80. It's the third paragraph.

THE WITNESS: Yes. That's correct.

BOARD MEMBER LUNGE: And it also includes physician incentive payments. Could you explain what those are, please?

THE WITNESS: There are times when we have contracts in place that a physician meets certain metrics in the contract, then there would be a bonus payment provided to them. Maybe that's a quality measure. Certain number of members having a blood pressure screening or certain services such as that.

Those figures come into -- our

financing handles those costs, and to the extent that those costs are continuing in the future, then we reflect that additional cost in our rates.

BOARD MEMBER LUNGE: Got it. To your knowledge are those incentives primarily tied to quality measures or are they tied to other types of incentives?

THE WITNESS: I'm not overly familiar with exactly what is tied -- how those incentive payments are achieved.

BOARD MEMBER LUNGE: Okay.

THE WITNESS: My understanding has been that it's a quality-based metric.

BOARD MEMBER LUNGE: If it's possible to get more information on that, that would be helpful. Would be helpful to see what kind of quality metrics you're linking that to. Give me one more minute. Checking. Some of my questions have been asked, so I can go through the tabs.

In Exhibit 7 on page three these are the responses from July 6. You have projected members based on rate filing assumptions, and you show individual agency only and individual 73 CSR in terms of your projections around where they will move. And you indicate non-silver APTC plans.

Do you have any sense of expectations about whether people -- how many of these will be buying up versus buying down? So buying up to gold, for example, or down to bronze?

THE WITNESS: It's in our rate filing. We are just -- so I guess we are not making specific assumption about where they will go.

BOARD MEMBER LUNGE: Okay.

THE WITNESS: That's a subscriber-dependent decision. And we think they will be based on their health care utilization and what they anticipate to actually spend on health care services in the future. We are working with our marketing communications team to direct the members that are in the 73 and 77 percent plans or individual APTC that are in silver plans towards a better benefit, whether it's through a lower premium rate or a richer benefit at a lower premium rate.

BOARD MEMBER LUNGE: And will you be doing that through direct mailings, phone calls? Can you talk a little bit more about the outreach efforts if you know what the plan is?

THE WITNESS: At this point we are still kind of --

BOARD MEMBER LUNGE: Developing.

THE WITNESS: Developing our strategy, and how we are going to market and communicate that it is definitely something that's very important to us. We understand if we can -- I mean my general feeling is if we weren't doing that, we would be doing a disservice to our members. We should be directing them into the right plan, and that's how you build up trust and hopefully a good, long-term experience for our members so --

BOARD MEMBER LUNGE: Thank you. You're not intending -- it doesn't sound like -- to do anything like auto enrollment or any sort of specific mapping for members to plans in your outreach efforts.

THE WITNESS: At this point, you know, we are focused on the members that will benefit from the APTC increase and trying to just guide them to the right decision-making process. And you know, I know that we are engaged in helping enroll members through the individual mandate penalty being set to zero. That's something we are hoping to retain as many of those members as possible.

BOARD MEMBER LUNGE: Related to the individual mandate what's your company's -- what was your company's position, if you know, on the state

individual mandate?

THE WITNESS: I know Susan Gretkowski participated in that. We supported it because we think that members -- the community will be healthier and members will be healthier if they are enrolled in a health insurance plan. Peace of mind.

BOARD MEMBER LUNGE: Do you know whether your company provided any information to the legislators about the impact of the delayed date to 2020 on premiums?

THE WITNESS: I'm not familiar with what kinds of information has been shared.

BOARD MEMBER LUNGE: If that's possible to follow up on, that would be great. And then one last area I wanted to talk about, which is you had mentioned in response to Member Holmes' questions around One Care Vermont and the APO program that some of your -- that you are participating in value-based payments in New York and Medicaid and in some commercial plans. Do you know what programs you're participating in in New York?

THE WITNESS: In New York there is actually a road map for Medicaid.

BOARD MEMBER LUNGE: Yeah, I'm familiar.

THE WITNESS: So we are working towards achieving those targets. Effectively the -- there is a penalty attached to not meeting those targets through a reduction to Medicaid managed care premium rates that are provided. So if you don't participate, there is certain thresholds for each year. So in 2019, if there is level one, two and three arrangements. Level one is the carriers and the care on the down side. Level two, there is a shared risk arrangement between carriers and the provider system. And level three is just a full capitation almost like the old west coast Kaiser model where you would pay the physician a set capitation rate, and they manage the care and are at risk for managing the costs down below that capitation rate.

So we are on pace to meet those road map targets for 2019 and 2018 at this point. And we are engaged with providers to expand those efforts, and I know we are also engaged with One Care to have conversations about entering into that arrangement with them. The structure and the terms of that arrangement I'm not sure of what's been discussed, but that is something I'm aware that there have been conversations.

BOARD MEMBER LUNGE: And do you know which level you are currently participating in in 2018? Level one, two or three as you described?

THE WITNESS: We have arrangements at all three. Well we have arrangements at level one and level two. And we are working towards a level three arrangement, but it hasn't been finalized yet.

BOARD MEMBER LUNGE: Okay, great. Thank you. I have nothing further.

HEARING OFFICER HENKIN: Member Pelham.

BOARD MEMBER PELHAM: Thank you. Thank you. So I'm new here. I'm a relatively new member of the board. And this is my first rate setting process, and so I've kind of gone back to the basics where my fellow board members are way ahead of me, but just to kind of sort through how this process relates to premiums that Vermonters actually face after they go through the Vermont Health Connection calculator.

THE WITNESS: Okay.

BOARD MEMBER PELHAM: So I took -- and I think the Appendix form, attachment form, is the one called Rate Increase Exhibits 2018, 2019, which I think is this teeny print one that you were looking at earlier. You don't have to look at it now, but

the print was pretty tiny. But I pulled out the magnifying glass and just tried to get a feel for what the premiums that we are talking about now, at the end of this process, and before we go into the Vermont Health Connect calculator process, how this all flows.

And so if you take -- and I did this for 2018 because the 2019 calculator isn't up and running yet.

THE WITNESS: Yes.

BOARD MEMBER PELHAM: Just to get a feel for it if you take your 2018 bronze standard plan at $850 a month for a couple, which is $41,150, 250 percent of poverty, the resulting premium as a percent of income is 24.8 percent. And for a family plan again at 250 percent of poverty which is family of four, 62,750, which is 22.8 percent of poverty.

A couple silver plans in the 250 percent of poverty, it's 21 percent for a couple. It's 31 percent for a family of four. It's 28 percent. And then we kind of get off the subsidy grid so those are kind of hard numbers, harder numbers. At 400 percent of poverty the premium for a standard silver plan is 19 percent, and for a family of four it's 17.8 percent. So that's what we're

talking about here. And I'm just wondering whether or not -- and to me it underscores how important the subsidies are of this process. Do you think these kinds of percent of incomes are affordable?

THE WITNESS: I would just like to address the premium subsidy and how that's actually calculated. So for a double contract which is like a two spouses, if you're eligible for a subsidy I think it's important to understand the premium rate for a double contract is two times the single rate. So it's a 100 percent increase. But if you're looking at the federal poverty level, it's only, I think it goes from about $12,000 to like $16,000. So 33 percent increase from one to two people. The premium -- the way that the premium subsidy is computed is based on a percentage -- a maximum percentage of out of pocket of your income.

The fact that there is a disconnect in the increase in the poverty level versus the premium rate as you go from a single to a double or a family contract, is an issue that is going to always make those rates seem unaffordable for a double or a family contract holder unless you exceed -- your family contract holder and you exceed a certain number of members of your household. That's actually

the only way to offset that impact.

So fundamentally because APTCs are determined based on the Affordable Care Act language, I believe you would actually have to have a change in either the contract tier structure that you're offering in Vermont, if you did that, and you were to make it so it was aligned with from single to double it was more well aligned, the challenge would be that you would have to then add more to your single rates. So your single rates would go up substantially, and it would actually help mitigate that impact that you're talking about right now.

BOARD MEMBER PELHAM: I do understand that it gets very complicated, because as we moved to the calculator and with the advanced premium tax credit, it's actually a winner for some people to allow them to maybe save money and go down to a bronze plan or buy up to a higher plan. So --

THE WITNESS: Yeah.

BOARD MEMBER PELHAM: But I think my question is more pointed in this ball park of, you know, 21 to 28 percent just based on this process. I'm not being critical here. I'm assuming maybe this is a perfect calculation, a perfect world, it's just the nature of the underlying cost of health care

including the cost shift. And that's something we don't talk about.

But in these recommendations are mitigating the cost shift from say Medicare, Medicaid. Would you agree with that?

THE WITNESS: Yeah. I mean cost shifting between from -- cost shifting of costs between Medicare, Medicaid and commercial definitely does have an adverse impact on commercial premium rates.

BOARD MEMBER PELHAM: And in the actuarial process we are not measuring that as a discrete pressure, but it's definitely built into utilization and trends and the pricing of health care.

THE WITNESS: Yeah. It would be -- we are reflecting our best estimates or our known and assumed unit cost increases. And our utilization trend in this filing for medical costs is actually zero, as you know. So we are not assuming an increase in the utilization in our rates. We are just reflecting our best estimate of unit cost increases.

We are doing our best to try to negotiate costs down, but cost shifting when

providers and hospital are feeling pressure in a reduction -- in form of a reduction and fee schedule Medicare or Medicaid business, they are trying to manage their admin costs, what we have discussed earlier, and that it's sometimes creating pressure on commercial rates.

To the extent that the Green Mountain Care Board approved rate increases aren't reflecting any kind of cost shifting, you know, for our Vermont providers which is a large portion of our utilization, then that's not reflected in rates.

BOARD MEMBER PELHAM: And then I took some of your 2018 rates and then ran them through the 2018 calculator at Vermont Health Connect. And you can see dramatic shift toward affordability that most of the bronze plans according to say a standard, the ACA standard are affordable. And then as you kind of move up the middle ladder, they get less and less affordable, but it makes a big effect.

So in this last legislative session there were a couple of issues, there were three issues that I've heard of that kind of affect the situation. One was changes in cost sharing for chiropractic services and for breast cancer screening services. Did MVP participate in those deliberations

in the legislature? I understand you're an actuarial, you may need to look over your shoulder here, but do you know whether or not MVP participated in those discussions with the legislature?

THE WITNESS: Yeah. I'm pretty confident that Susan Gretkowski, our government affairs employee for Vermont, she is involved in all those kinds of conversations. I know that we did do an analysis, and we are not adding to our costs for these two changes. One reason is the chiropractic is a capitated arrangement, so there shouldn't be an impact as of right now on our costs. The breast cancer mandate. We are hoping that that will help manage costs overall. And we are not actually building in any increase for that mandate.

BOARD MEMBER PELHAM: I'm not asking you to either. But so in this same legislative process there is an appropriations bill that was approved in the special session. And there are the appropriations for the state's share of the Vermont premium-assisted program and the cost sharing reductions that are funneled in the calculator and help make your product more affordable to Vermonters. And you know, these are entitlements, as I understand it, but the legislature still has to appropriate

money for it.

And are you aware that the legislature for 2019 appropriated a slightly lower amount than they did for 2018 for these two subsidies?

THE WITNESS: Are you speaking to the 73 and 77 percent cost sharing subsidy?

BOARD MEMBER PELHAM: The Vermont premium assistance which tracks the advanced premium tax credit and the Cost Sharing Reduction.

THE WITNESS: I'm not aware of that.

BOARD MEMBER PELHAM: It's -- and I think as Robin and I have discussed because it's an entitlement, this state has to pay it anyhow. So the actual amount can be fixed in the appropriations bill. But it does seem to be a pattern of growth every year. And then this year it went slightly in a different direction.

But another major to me, as a former state budget guy, area of opportunity maybe here, is the Human Services case load reserve. Are you familiar with the Human Services case load reserve?

THE WITNESS: No, I never heard that.

BOARD MEMBER PELHAM: Well it's -- I'm trying to be fast here.

HEARING OFFICER HENKIN: Try to be

relevant too.

BOARD MEMBER PELHAM: This is quite relevant too. So the Human Services case load reserve was created back in the '90s to kind of set aside money for recessions, when a recession occurs, and it's under the Human Services programs. And this last session there was some statutory changes to that reserve language, and I would like to just read you one of them.

THE WITNESS: Okay.

BOARD MEMBER PELHAM: Which is: Within the reserve sub account for Medicaid-related pressures relating to case load utilization changes, changes in federal participation, could be the individual mandate, in existing Human Service programs and settlement costs associated with managing the global commitment waiver.

So the funds set aside in this general fund reserve are available, in part, to address these types of issues which we are here to discuss today. But the more important part is that the balance in that reserve in 2018 was 22 million dollars. And the balance in 2019 at the Joint Fiscal Office, and the state budget people project is going to be a hundred million dollars. And of that 14 million dollars is

designated toward this language.

So I'm just wondering that as others on the board work to mitigate issues and complications in this filing, like the individual mandate, would you folks be amenable to kind of pursuing maybe an incentive for -- to keep people insured through this year of transition or other types of remediation given the fact that the legislature doesn't have to reconvene to spend this money. It can be appropriated by the act of the emergency board which is the Governor and the two House and Senate legislators of the legislature.

THE WITNESS: Yeah. I'm not too familiar with how those appropriations can be utilized. Whatever is permissible within legal grounds, I think, and will help maintain coverage for Vermonters, MVP is definitely happy to try to participate in any way that can retain members over time. I don't know if we are permitted to supply any type of incentive. That would be something I would defer to our legal team for.

BOARD MEMBER PELHAM: Thank you.

HEARING OFFICER HENKIN: Are we done with this witness?

MR. KARNEDY: I believe we are.

HEARING OFFICER HENKIN: Okay. Let's take a short lunchtime, about 5 minutes until 1. Everybody start. Five minute break.

(Laughter)

HEARING OFFICER HENKIN: Getting back right before 1, and we will get done.

(Recess was taken.)

HEARING OFFICER HENKIN: Okay. I think we are ready to go. We can go back on the record. We can move ahead, and the Department of Financial Regulation has testimony.

MR. LUSSIER: Good morning everyone.

HEARING OFFICER HENKIN: It's afternoon.

MR. LUSSIER: Is it? Okay.

JESSE LUSSIER

Having been duly sworn, testified as follows:

THE WITNESS: Good afternoon. My name is Jesse Lussier. I work for the Department of Financial Regulation. I'm a Certified Public Accountant. I have been with the department since 2011. I am involved in all aspects of financial examination and analysis. Commissioner Piacek yesterday kind of gave a high level summary of what we do in terms of solvency. So if it's okay with everyone, I would like to just skip that to save time. Is that all right?

HEARING OFFICER HENKIN: You're self driving, so go right ahead.

THE WITNESS: I would like to just give a brief statement on insurance regulation in the U.S. generally speaking. In the U.S. insurance is regulated on a state-by-state basis. So that is every state is responsible for their own insurance companies that are domiciled within that state.

(Telephone interruption)

HEARING OFFICER HENKIN: I am assuming that that is Kevin Ruggeberg from L&E who is one of the actuaries, primary actuary on this, and he's

calling in on the line. And it is a public hearing so --

MR. RUGGEBERG: That's correct.

THE WITNESS: Good afternoon. As I was saying, every state is responsible for the insurance companies that are domiciled within their state. And as we have discussed before and as Matt alluded to, New York is the primary regulator for MVP. New York's examination and analysis procedures should be substantially similar to that of Vermont and to all other states in accordance with NAIC guidelines and rules. And Vermont relies on New York to notify us if there are any solvency concerns with any of the companies in their state.

So now if I can just give a brief overview of the solvency opinion. It looks very similar to the previous opinion. The two main factors are because MVP's a relatively small footprint in Vermont, as Matt already discussed, and New York has not expressed any solvency-related concerns to us at this time, Matt read the summary and the opinion, but just to reiterate, the department believes that the rates as filed will sustain MVP's solvency, and that adjustments should not be made unless they are deemed to be actuarially

inadequate.

I'll also echo what Matt said that the department believes that any block of business should stand on its own. That means that premiums should be for paper claims and related expenses. And that's all I have to say. I'll open it up to questions.

MR. KARNEDY: Good afternoon, Jesse, how are you?

THE WITNESS: Good afternoon. Good, thank you.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. So if you would, you were just representing -- turn to Exhibit 10. Do you have a binder in front of you? It's a copy of your solvency letter.

A. Okay.

Q. And that's dated July the 10th; correct?

A. Correct.

Q. And I think you basically just said you've adopted this as your testimony on behalf of DFR; correct?

A. Correct.

Q. On page one, the summary of the opinion, would you read that sentence, please, under summary of opinion?

A. "MVPHP currently meets Vermont's financial licensing requirements for a foreign insurance -- for a

foreign insurer, and DFR believes the proposed rate will sustain MVPHP's solvency."

Q. And you stand by that; correct?

A. Correct.

Q. And would you please go to the next page, and there is a heading that says: "MVPHP Solvency Opinion." Let me know when you're there.

A. Okay.

Q. And would you read, please -- I don't -- I was trying to save time. But I think it's important so the board can understand my question.

Can you read the whole paragraph please?

A. "DFR is not MVPHP's the primary solvency regulator, but it does require MVPHP to meet Vermont's foreign insurer requirements. Currently MVPHP meets these licensing requirements. Further, DFR has not learned of any solvency concerns from the New York Department of Financial Services, MVPHP's primary solvency regulator. Finally, in 2017, all of MVP Holding Company's operations in Vermont accounted for approximately 2.9 percent of its total premiums written. Thus, DFR has determined that MVPHP's Vermont operations pose little risk to its solvency. Nonetheless, adequacy of rates and contribution to surplus are necessary for all health insurers in order to maintain strength of capital that keeps pace with

claims trends."

Q. Thank you. So what you're saying there is that even though Vermont has a smaller percentage of MVP's total premium, you still look at its Vermont premium in this rate filing to determine adequacy; correct?

A. Correct.

Q. And when it comes to solvency, do you believe it's a good idea to kick the can down the road to later years and perhaps have a lower contribution to reserves in one year of say one percent with the hope that you could simply have a contribution of three percent the next year to catch up if you're wrong?

A. No.

Q. Would you please read the paragraph under "Impact of the Filing on Solvency," please.

A. "Based on the entity-wide assessment above and contingent upon 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 MVPHP's current level of solvency."

Q. I have to go back and ask you about my kick the can question I just asked a moment ago. You said no. Why?

A. Can you repeat the question?

Q. Sure. When it comes to solvency, do you

believe it's a good idea to kick the can down the road to later years, perhaps have a lower contribution in one year of say one percent with the hope that you can simply have a contribution of three percent the next year to catch up?

A. No. As I stated before, the department believes any block of business should be adequate, should have actuarially sound rates.

Q. Okay. This letter of July 10th was based on MVP's original filing in May; correct?

A. Correct.

Q. And MVP sought a two percent contribution to reserves which DFR has found to be adequate; correct?

A. Correct.

Q. And you heard testimony here today from MVP?

A. Correct.

Q. And you heard Matt testify that based on L&E's recommendations, MVP has reduced it's average rate increase proposal from 6.4 to 4.6. Did you hear that testimony?

A. Yes.

Q. And the explanations around that.

A. Yes.

Q. Do you have an opinion that a 4.6 rate increase will likely have the impact of sustaining MVP's current level of solvency?

A. Yes. Assuming that my understanding was accurate in that the Care Board's L&E and MVP agreed on certain changes to the rate; is that correct?

Q. Let me ask a more direct question because they agreed on some things. They didn't agree on others. 4.6 percent, do you have an opinion at 4.6 percent rate increase will likely have an impact of sustaining MVP's current level of solvency?

A. Yes, assuming those rates are adequate.

MR. KARNEDY: Thank you very much.

MR. ANGOFF: No questions.

BOARD MEMBER USIFER: I have questions.

HEARING OFFICER HENKIN: Members of the board? Let's start with you for today, this afternoon.

BOARD MEMBER USIFER: I just had a question on you talked about the book of business would stand on its own. And talking obviously of the CTR of two percent. You were here when I was talking before about the administrative costs, and if we look at just this book of business, not dealing with the rest of their world, assuming for sake of argument that claims were all covered under the claims area. When we look at the admin expense, it should have generated about four million dollars more than their

variable costs would have warranted if we did it based on their math.

And so under this book of business that four million would then drop to profits, per se. How do you think about that as far as then relative in -- this business it's about 150 million dollars; right? Of written policy. A little bit less. So a two percent CTR is three million. They generated four million extra on this business in '18.

Just looking at this, not worrying about the fact that the rest of their business may have had less membership.

THE WITNESS: I guess when you say extra income, I'm not exactly sure what that means. It's more of a complex question I think from a solvency perspective, because I would want to see -- we are just taking this filing and talking about income as it gets generated on this, I would want to see also other factors such as if the number of insureds increased and how that would affect surplus supporting the underlying lives. So it depends.

BOARD MEMBER USIFER: Okay. Thanks.

CHAIRMAN MULLIN: So you talked about reciprocity between states as far as regulation of the adequacy of the reserves. Do you have any

concerns as a regulator about the way New York calculates reserves?

THE WITNESS: No. I have no concerns. They haven't expressed any concerns to us.

CHAIRMAN MULLIN: Thank you.

HEARING OFFICER HENKIN: Tom? Nothing else. Congratulations. Very nice to see you and hear from you. Thank you very much.

MR. BOYLES: Thank you.

HEARING OFFICER HENKIN: Next our staff Attorney Sebastian Arduengo will be leading the direct examination of actuary Jackie Lee. And Jackie, you were here to get sworn in, I believe.

MS. LEE: Yes, I was sworn.

JACKIE LEE

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. ARDUENGO:

Q. Good afternoon, Jackie.

A. Good afternoon.

Q. We did a lot of this with Dave yesterday --

A. Yes.

Q. -- but so for that reason, we are going to go through this first part pretty briskly.

Could you tell everyone who you are?

A. I'm Jackie Lee.

Q. And where are you employed?

A. I'm employed at Lewis & Ellis.

Q. And what is Lewis & Ellis?

A. Lewis & Ellis is a consulting firm based in Allen, Texas.

Q. And what business is Lewis & Ellis primarily engaged in?

A. Primarily engaged in actuarial consulting to all types of insurance; health, life and property and casualty. We do have some other smaller lines for compliance.

Q. Okay. And what is your educational

background?

A. I graduated from Texas Lutheran University with a bachelor's of science in mathematics. And I've taken the exams as well from a professional standpoint, so I'm also a fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

Q. How long have you been an actuary?

A. I have been an actuary for over 15 -- I have been working in the actuarial field for over 15 years. I have been a credentialed actuary for a little over 10.

Q. How long have you been retained by the board to provide actuarial services to the State of Vermont?

A. Since 2014.

Q. And in that time how many Vermont health insurance rate filings have you worked on?

A. I worked on every single one that has come through the Green Mountain Care Board, and I think it was a little over 60.

Q. And in what market segments have those rate filings been?

A. They have been in the QHP segments as well as small group and large group.

Q. So you would say that you're quite familiar with the Vermont health insurance marketplace then?

A. Yes.

Q. Do you work on health insurance rate filings in other states?

A. Yes.

Q. How many would you say?

A. Lewis & Ellis is currently contracted with eight to review for the QHP filings effective 1/1/19.

Q. And in your work with other states do you do a comparative look at the nationwide health insurance market?

A. Yes. The states are varied throughout the country, and so we get to see a wide range of the various rates, the rate practices, and also just some of the different -- how the different states handle their role as far as an effective rate review.

Q. What do you do in your work to keep up with changing health care reform issues?

A. Well we do a good job at Lewis & Ellis because we work with so many states. I personally also volunteer a lot with our society. I co-wrote an article for a strategic initiative for the Health Section Council on the individual mandate. I'm also currently the secretary and treasurer for the council itself, so I'm on the leadership team there and on the track to become the chair of the health section for the entire actuarial community.

Q. You've kept up well with the changing

regulatory landscape and the health insurance market?

A. Yes. A lot of our continuing education also promotes that. There are a lot of actuaries that put a lot of time in that. So it's -- I'm part of that driving force. But also we have got a community within our actuarial world to help keep us up.

Q. So generally speaking how is the health insurance rate filing reviewed?

A. Generally speaking, we have a lot of guidance that we have to follow. We have got state regulations. We will have guidance from the federal government as well such as instructions. And our profession also has guidance through actuarial standards of practice and sometimes practice to help us formulate how we go about reviewing and pricing health plans.

Q. And what's the process for reviewing a Vermont rate filing in particular?

A. So we have three credentialed actuaries that work on every filing. We keep them consistent from filing to filing by carrier so that we can become familiar with what's happening with the carrier.

So for this filing and all MVP filings we have Kevin Ruggeberg who is a society -- in the Society of Actuaries. He is the primary reviewer so he gets on SERFF and holds down the filing and has correspondence with the

carrier itself.

Q. Could you briefly explain what SERFF is?

A. Sure SERFF is the platform in which we communicate through rate filings, and so a carrier can file their rates that way and forms, and most states use that as a platform to get their information.

Q. Do you do any peer review in your work at L&E?

A. Yes. I peer reviewed Kevin's work, and then Dave who works on the Blue Cross filing as well also peer reviews the work so that we are consistent across both -- we try to be as consistent as possible between both carriers on their practices in Vermont.

Q. And when you review a filing are you performing an independent analysis and calculation, or are you just checking whatever calculation or assumption you received from the companies?

A. That answer depends on the assumption we are reviewing. If the assumption is large enough where the great impact associated with that assumption is large enough, then we will do an independent review on our own. If the company has methodologies or process in place either for smaller or even sometimes larger, we will in addition review what they have performed to see if there are any flaws in their methodology or the numbers that they have used for those assumptions.

Q. And do you have a process for getting additional information from the company if you need it?

A. Yes. We usually put together an inquiry letter, and in SERFF, the system that I talked about, making sure that the carrier's aware that there is a letter. And we ask questions, and generally they respond within a week or sometimes a tighter time frame depending on where we are in the process.

Q. And did you do that with this filing?

A. Yes.

Q. And how long do you have to review a filing from the time it's submitted to the board?

A. We have 60 days to provide a formal report to the board.

Q. And is it your understanding that that's a statutory deadline?

A. Yes. It is.

Q. Are you familiar with the filing that's under review here today?

A. Yes.

Q. Did you write an actuarial report with respect to that filing?

A. Yes. We did.

Q. I believe that report is Exhibit 11 of the binder. Could you turn to that, please?

A. Yes.

Q. On page two of the report is a standard of review. Is this your standard of review, or is it the board's standard of review?

A. This is the board's standard of review for our work.

Q. What is your standard of review?

A. Well we comply with what the board has requested on us, plus we use our actuarial standards and practice to supplement that. But our standard of review is to determine if the rates are actuarially sound.

Q. Are there terms that are in the board's standard of review that are defined in the actuarial standards of practice?

A. Yes. There are.

Q. What are those terms?

A. Excessive, inadequate and unfairly discriminatory.

Q. So we have heard some testimony today about affordability. Is that the same thing as excessiveness?

A. No. We are -- we are opining on whether or not the rate is excessive which means that the benefits and admin in relation -- or the benefits in relation to the premium and admin are not more than what they should be.

Q. And what about adequate? What is the definition of that according to the actuarial standard practice?

A. We want to make sure that the rates are sufficient, meaning that they -- the rates being charged are able to handle the benefits and other costs that are being administered by the carrier.

Q. And how is the term unfairly discriminatory defined in the ASOP?

A. We have -- we want to make sure that the rates are equitable for the same type of individuals that have similar criteria, rating criteria, so that there is not a -- people that same group that have a rate that differs for reasons that are not appropriate.

Q. And when you say that given assumption in your report is reasonable and appropriate, what does that mean?

A. It means if falls under the standards that we just reviewed, those definitions, it meets those criteria.

Q. So did you make any recommendations to the filing?

A. Yes.

Q. Can we turn to your recommendation regarding the company's claims experience, in particular issue of meet your enrollment?

A. Yes. We made a recommendation, which is on

page 11, that the carrier modify the mid-year enrollment termination factor to adjust for only small group policies, and that result was a decrease in rates of .3 percent.

Q. What did the carrier assume when it made its with -- with it's filing?

A. So the carrier assumed that for this particular factor, particularly they called it the average duration factor, they assume that all policies would be in force for a full 12 months. And that's what the adjustment was to increase their claims in the base period experience to account for the fact that not all policies were in force for the full 12 months. You have deductibles and such that lower it.

Q. And did you agree with that assumption?

A. We did not agree with that assumption.

Q. And why not?

A. We asked the carrier for their claims experience -- or their -- we asked the carrier for the number of policies that have 12 months of enrollment versus all the rest, you know, versus the rest of the duration time period. And in their response to us they provided that it's I believe in Exhibit 3 page six, and it's clear for 2016 and 2017 that there are enrollments throughout the year, that not all policies have a full 12

months.

We did agree that open enrollment is different for 2018 and '19. But that to assume all policies will be in force for 12 full months is -- is not a logic -- or is not a reasonable expectation.

Q. And you said this was based off of the company's own data; is that correct?

A. Yes. This Exhibit 3 page six of their response is based on MVP's data.

Q. And what reasons would people either enroll or terminate their coverage mid year?

A. There are a lot of reasons. I would say a good example, special enrollment periods. If you have a change in your job, let's say you lost your job in the middle of the year, then you lost your large group coverage potentially, and then you could enroll as an individual. Or let's say that you jumped on with a small group, changed jobs, then you could jump on to the small group.

Q. Do individuals voluntarily lapse coverage mid year as well?

A. Yes, they do.

Q. So for those reasons, your opinion is that MVP's assumption that all members will be enrolled for the full 12 months is unreasonable?

A. Yes. We think that that is unreasonable.

Q. Okay. Let's move on to the next recommendation which had to do with risk adjustment. Could you briefly explain what makes the risk adjustment calculation so complicated?

A. The risk adjustment is complicated mainly due to the timing of data received as well as needing to know information about other carriers in the market that is proprietary or confidential. So it requires a carrier to understand the health risk and the risk scores of those in the entire market which means that, for instance, MVP would have to understand Blue Cross's entire risk profile in order to calculate this.

Additionally, used to be on June 30th but this year it was roughly July 9th, CMS puts out their report of the adjustment payments, and because of that falling in the middle of our review period that, you know, puts the carrier at a slight disadvantage because they don't have that before the filing. So they have to make an educated guess.

Q. So did you update the calculation with the updated numbers from the federal government?

A. Yes. That was our recommendation was that MVP use the report that came out on July 9 as -- and those numbers as their starting point -- rather than the number

in which they used prior to having that knowledge.

Q. And is it your understanding that the company agrees with that modification?

A. Yes.

Q. Move on to your final recommendation which relates to unit cost trends and hospital budgets. Could you explain your recommendation, please?

A. Yes. We recommend that most up-to-date information regarding the hospital budgets and unit cost trends be considered during these filings. Again, there is a disconnect in the timing of this filing and the hospital budgets, and that midway through our review process draft budgets come out.

And in the past, we have incorporated changes based on these -- this new information.

Q. Now these are draft -- these are budget submissions. These aren't the final order; is that correct?

A. That's correct. I believe the final order happens sometime in August, September which is definitely after the board makes its order. At least it has been in the past.

Q. Have you had the opportunity to review these submissions?

A. Yes, I have reviewed the draft submissions.

Q. And have you reviewed hospital budget submissions and draft orders for past years?

A. Yes.

Q. For say the last three years what's been the relation between the budget submissions and the final budget order?

A. I don't have them all memorized. But roughly for the last -- the last two years there's been a slight decline in what was submitted versus what was approved. Prior to that, they were roughly equal to one another. So there's been a small averaging pattern, but definitely not very conclusive.

Q. Okay. And have -- did the company make an assumption regarding the hospital budget submissions?

A. Yes. In the original filing MVP set their unit cost trends for 2019 equal to their 2018 unit cost trends. Based on this updated information they have updated the 2019 trends to reflect the new budget submissions that we have been discussing. And they have proposed that in the most recent objection and response.

Q. Do you have an opinion as to the company's updated assumption?

A. We are still reviewing their assumption. Right now they have put in the values that were in the submission and that resulted in about a half a percent

increase in rates, but we have not presented a formal opinion on that at this point because we were still reviewing it.

Q. What is your initial assessment?

A. Our initial assessment is that it was -- we do feel it's appropriate that updated budget information be incorporated but that it's possible to consider the fact that the last two years it's gone down slightly. So one of the things we are going to look at is we are assessing this facility by facility, if there are any patterns between what was submitted versus approved specifically in the last couple of years, but we have not formalized that at this time.

Q. Okay. So with the recommendations that you've made to the filing, what will be -- incorporating those recommendations, what would the average overall annual rate increase look like?

A. The average rate increase for the first two bullet points that we have recommended, not including the proposal of the updated trend at this point, that turns the -- our recommendation would be an 8.5 percent rate increase or what's felt by Vermonters of a 3.8 percent increase.

Q. You said what's felt by Vermonters. Could you explain that?

A. Yes. Because of the unfunding of the CSRs, there have been the opportunity of the silver reflective plans to be offered in Vermont. And because of that, there were able to be some varying premiums such that people who did not need the subsidies could move over to these plans or not meet the cost sharing requirements.

And so therefore, the rates are lower in this environment for Vermonters.

Q. The rates are lower because of the reflective silver plans?

A. Yes.

Q. And is it your understanding that a significant portion of the rate increase proposed by the company will be borne by the federal government in the form of premium subsidies?

A. Yes.

Q. Let's talk about some other aspects of the filing that you didn't give recommendations on, but there was some testimony today.

Did you review the company's medical trend?

A. Yes.

Q. The company chose a zero percent utilization trend; is that correct?

A. That is correct.

Q. Did you find that assumption to be reasonable

and appropriate, and why?

A. When reviewing the utilization trend we took into account -- we asked the carrier to provide us data on utilization trend, and they did. It was -- there was no clear pattern in their -- in this data that they provided to us. We do know that there have been other carriers in the state that have seen some utilization trends, but we felt that MVP had enough information, and based on their block of business that the zero percent trend was reasonable and appropriate.

Q. And did you review the company's pharmacy trend?

A. Yes.

Q. And did you find that reasonable and appropriate, and why?

A. Yes. We did. We -- MVP as well as many other carriers rely on their PBM to help predict the pharmacy trends for the future year. It's a prospective look by the PBM taking into account any changes in the drug mix, between, you know, brands coming off patent and utilization of that particular carrier that was used in this. And so they relied on this data. We did ask for the historical pharmacy data, and that indicated much higher trends than what the PBM was projecting. And we know it's not as -- not as good of an analysis because

it's retrospective versus prospective. So we agree with the use of the PBM's trends.

Q. Okay. Now let's pivot a bit to another one, one of the more significant changes in this filing over last year which is the increase in premiums resulting from the removal of the individual mandate penalty.

Did you review MVP's assumption as to that change?

A. Yes.

Q. And did the company rely on its own assumption or on the analysis that was commissioned by the board and the Department of Financial Regulation?

A. Their memorandum states that they used the report done by the board and the DFR.

Q. Do you recall when you prepared that report?

A. L&E, I believe, dated that report February, 2016 or 2018.

Q. Vermont passed a state-based individual mandate. Was that passed before or after you submitted your report analyzing the effect of the removal of the individual mandate penalty on the market?

A. After.

Q. So you did not incorporate that into your report?

A. We did not incorporate that into our report.

No.

Q. So let's just briefly turn to contribution to reserves. In your analysis for your report do you review for solvency and contribution to reserve?

A. Yes. DFR handles the vast majority of the solvency over MVP, but as part of an effective rate review, we do consider it and look at it as far as the rate's development.

Q. And do you also look at confidential information reviewing the company's solvency?

A. Yes.

Q. And did you find that the company's assumption of a 2.0 percent contribution to reserve to be reasonable and appropriate?

A. Yes.

Q. So with the recommendations that you outlined, is this filing excessive?

A. No.

Q. Is it adequate?

A. Yes.

Q. Is it unfairly discriminatory?

A. No.

Q. All right. Thank you. I have nothing further.

HEARING OFFICER HENKIN: Attorney

Karnedy?

MR. KARNEDY: Thank you.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Can I call you Jackie, Jackie?

A. Yes.

Q. You heard when I was talking to Matt, and you just went over, if you look at Exhibit 11, please, in your binder, your opinion. The three bullets. And you were a moment ago testifying about the hospital budgets, so I would like to talk to you a little bit about that.

Would you read -- well I guess we can cut to the chase. You say in that bullet that L&E recommended updated information about the hospital budgets should be considered by the board; correct?

A. Yes.

Q. And it's your opinion that that information is important and should be considered in the board's consideration of our rate filing; correct?

A. Yes.

Q. Okay. Go to Exhibit 9, please. There is a binder in front of you. And if I understand this is an objection letter where MVP responded to a question that was posed by L&E; correct?

A. Yes.

Q. Okay. And you pose that question because it was an important question to L&E in doing your job on this filing; correct?

A. Yes.

Q. And can you read the question, please, number one?

A. "Please address whether the recent information regarding the hospital unit cost increases for 2019 are anticipated to have an impact on the proposed rates. If so, provide updated trend build-up by facility and an explanation of the sources of any updated assumptions."

Q. Okay. So as you sit here today, you would again reiterate to the board that you're asking this question because it's important information the board should consider, right?

A. Yes.

Q. And you asked -- if you look at the letter you received, the first paragraph, you received the request on July 16th. Right? Do you see that in the very first paragraph?

A. Yes.

Q. And then we responded on July the 17th, one day later; correct?

A. Correct.

Q. Very prompt, right?

A. Yes.

Q. Okay. And that was all triggered by the hospitals filing their budgets; correct? The proposed budgets?

A. Yes.

Q. Do you know when that was roughly?

A. July 2? Don't quote me.

Q. Okay. So early July. Right?

A. Before July 16th.

Q. Okay. Excellent. Excellent. I asked for that, didn't I? But it was after your July 10th opinion, because you would have talked about it in the opinion if you had known; correct?

A. I don't know that that's necessarily true.

Q. Okay. You're saying because who knows when you have actually learned it, et cetera. Not that it's not important, right?

A. Right. And we submit the report on the 10th which I believe was a Monday. And so there were a couple days the Green Mountain Care Board could have thrown that up on the website, and even if it had been posted Friday, we wouldn't have had enough time to digest it and incorporate the report.

Q. Plus we have got the whole time difference between Texas and Vermont. It's a whole hour.

A. In fairness I was in Europe at the time, so it was much greater.

Q. Do you recall last year that this same issue came up of whether the board should consider the hospital budget proposals as opposed to the final decision?

A. Yes.

Q. And do you recall that the board determined that they would consider that information even though they weren't final hearings with the hospitals; correct?

A. Yes.

Q. Do you think that was appropriate?

A. I do.

Q. Do you think that's appropriate this year?

A. I do.

Q. If you go to Exhibit 9. You'll see a paragraph -- I want you to read the first sentence. It's 1, 2, 3, 4 paragraphs down. Can you read that first sentence, please?

A. Starting with "MVP analyzed?"

Q. Yes, please.

A. "MVP analyzed the effect of the proposed trends on premium rates in the filing and found that they would increase the originally proposed premium rates by approximately 0.5 percent."

Q. Thank you. And if I understood your testimony

on direct examination, you don't necessarily disagree with the .5 percent increase. You just haven't fully analyzed it yet; correct?

A. I will say we have analyzed what MVP did, and that yes, they incorporated those numbers properly. But I have not determined if all -- if that's appropriate given the submitted versus approved and taken that into account.

Q. You haven't fully yet come to a decision on it?

A. Correct.

Q. That's not because MVP wasn't prompt. It's sort of that calendar we were talking about, right?

A. Correct.

Q. Okay. And I think I heard you say you don't recall exactly what happened last year in terms of you think it might have ultimately been slightly less, the amount that was approved, the hospitals versus what they proposed, but you don't remember the exact numbers, right?

A. For 2018 it was on average .3 percent according to the chart I looked at before I walked up here.

Q. Well --

A. I didn't memorize all the years. That was just '18. I think it went from 2.2 to 1.8 percent.

Q. So if -- let's just make this hypothetical

because you don't recall exactly. So if it were like 2.2 they knocked it down three points or something. Is that what you're saying?

A. No. Point 3.

Q. But this chart you're talking about, do you have that chart?

A. Back there I think.

Q. I want to move along, but it's fair to say whatever it is, it is. Right?

A. Correct. Yes. whatever it is, it is.

Q. And --

A. It was slightly lower.

Q. And would you agree with me that MVP requesting an increase based on this issue, you don't disagree but you might disagree as to the amount, but there should be some increase given what the hospitals proposed; correct?

A. Yes.

Q. Okay. So that was bullet number three. The hospitals. Now let's talk about the mid-year enrollment. I think you and I had this discussion last year.

A. Yes.

Q. And you won. But I'm going to try again. Actuarial, respectable approach, right?

A. Correct.

Q. Both approaches are reasonable, you think yours is superior; correct?

A. I think mine is superior.

Q. Fair enough. Okay. Go to page three.

A. Of Exhibit 11?

Q. Yes, please. Okay. So you have your paragraph numbered one. I'm just getting to this because we are going to talk about it in case you wanted to reference it. That is paragraph number one that goes page three to four, right?

A. Correct.

Q. Your first full paragraph on four, third sentence, I'm going to read it to you. "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." Do you see that sentence?

A. Yes.

Q. So we have agreement on that; correct?

A. Yes.

Q. The area of disagreement is on MVP using the 12-month period on the individual; correct?

A. Correct.

Q. And L&E's estimating mid-term terminations and enrollment, right?

A. Yes.

Q. That's based on some data you got from MVP?

A. Yes.

Q. So the dispute is, is there enough reliable data there. Should we do it the way you've suggested or do we take what we would call a more conservative approach and just figure the whole year for everyone, right?

A. Correct.

Q. If Charlie is a mid-year enrollee, he will presumably be less likely to achieve the deductible and/or the out-of-pocket maximum than he would if he were in for the whole year; right?

A. Yes.

Q. And he would also generate lower utilization and claim costs in contrast to if he were in the plan for the whole year; right?

A. Correct.

Q. None of us know actually exactly what's going to happen in 2019. Correct?

A. Correct.

Q. And that relates to who is going to enroll, who is going to terminate, when they were going to do it during that year; right?

A. Right.

Q. We don't know whether Charlie is going to terminate in July or October; do we?

A. No.

Q. Or at all?

A. Correct.

Q. We also don't know if it could be one person or it could be thousands of people who terminate in July for some reason; right?

A. That's right.

Q. And your job as an actuary is not guess?

A. That's correct.

Q. Make conservative estimates; right? Assessments based on good data; right?

A. That's correct.

Q. And you would agree with me that having adequate rates is important. Better to be safe than sorry.

A. I would say adequate rates are important. I wouldn't say that having adequate rates is necessarily safe versus sorry. If they are adequate, they are adequate.

Q. Fair enough. I was just -- not using actuary language. I'm sorry.

If MVP's rates are inadequate though they may need to charge more next year to make up for it; correct --

A. Yes.

Q. -- if the board allowed them to do that; right?

A. Yes.

Q. Your preference as an actuary though is to have your 2019 rates line up with and be adequate to cover the claims for 2019; right?

A. Yes.

Q. And you would agree with me that as it relates to health insurance rates, actuaries don't like to gamble on uncertainty. You want to pay for what you're going to pay for in that year; right?

A. Yes.

Q. Get it right the first time; correct?

A. Yes.

Q. Okay. Let's go to the third paragraph on page four of your report. It's the third full paragraph. It starts "L&E recommends." Do you see that?

A. Yes.

Q. Okay. Can you read that sentence? It's a couple sentences down which has the 91.6 in it. Could you read that, please?

A. "Based on L&E's analysis of MVP's data, our best estimate of the 2019 enrollment is that approximately 91.6 of members will enroll in January with .76 percent of members enrolling in each of the other 11 calendar

months."

Q. And then read the next sentence, please.

A. "Additionally, we have assumed that approximately 3.8 of all members lapse their coverage in any given month."

Q. And the data you looked at didn't show that things were spread out across the months evenly; did it?

A. I would have to go back and look. But I would assume it was not uniform. No.

Q. Fair enough. This is your best estimate, but it's not exactly what's going to happen next year; correct?

A. No.

Q. And is it fair to say that the board should take with a grain of salt attributing these particular numbers to each month. They are going to be different, aren't they, in actuality?

A. I think they should give a little more than a grain of salt to it, because they are based on data. So I just -- I agree with you that maybe it's higher in one month than another, but across it should be averaged.

Q. Okay. Thank you. Next I want to talk about contribution to reserves, if I could. Exhibit 11, page nine, paragraph nine, please, to acclimate yourself. See that numbered paragraph where you talk about contributions

to reserves?

A. Yes.

Q. Okay. So you found MVP's recommended contribution two percent to be reasonable and appropriate; correct?

A. Correct.

Q. You indicated while recommending that you consider what DFR said on the issue?

A. Correct. Yes.

Q. And you heard Matt's testimony first adjusting to the 6.1, then agreeing to the 2.9 percent for the risk, and then adding .5 percent for the hospital budget proposals. You heard all that testimony, right?

A. I think you mean 1.9 for risk adjustment, but yes.

Q. I meant 1.9, yes.

A. Yes.

Q. Numbers matter.

A. Numbers do matter.

Q. So the amount, as you understand it, you've heard that we are talking about today is a 4.6 percent rate increase; correct? And L&E's recommending 3.8?

A. Yes.

Q. Okay. So whether MVP's final rate is 4.6 or 3.8 as you suggest, you still agree that the two percent

contribution to reserves is reasonable and appropriate?

A. Yes.

Q. Thank you very much.

HEARING OFFICER HENKIN: Attorney Angoff.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Ms. Lee, you said that you assume that people will drop policies during the year, right?

A. Yes.

Q. Okay. And did you say that MVP disagreed with that?

A. Yes. For the individuals they assume that 100 percent of the policyholders will have 12 months covered, so that means no one's coming off, and no one's coming on.

Q. That's what MVP told you?

A. That what their assumption was, yes.

Q. Could you turn to Exhibit 1 page 40. And look at the second paragraph there. Headlined bad debt expense.

A. Yes, I see it.

Q. Okay. Isn't MVP there itself saying that people are going to drop out during the year?

A. Yes. That is what the bad debt expense assumption is stating.

Q. That's right, and they are charging policyholders for that; aren't they?

A. Yes.

Q. .6 percent?

A. Yes.

Q. When you found that a two percent contribution to reserves was reasonable for Vermont, did you know that MVP had filed for a 1.5 percent CTR in New York?

A. No.

Q. Knowing that now, would that change your opinion as to whether or not a two percent CTR for Vermont is reasonable?

A. I'm not sure that that would have impacted my decision, because we don't review in New York, or I just look to Vermont. And I think that with the uncertainty of the risk adjustment payments, that's a risk to them as well as other factors.

I still think two percent is appropriate, and especially because they filed the same last year, and it was approved. I felt like no change seemed reasonable.

Q. Did you know that MVP when you assumed -- when you found that two percent CTR for Vermont for 2019 was reasonable, did you also know that in the 2018 the New York Department allowed MVP only a 1.5 percent CTR?

A. I did not know that.

Q. Okay. Knowing that now, would that change your opinion as to whether a two percent CTR is reasonable for Vermont for 2019?

A. Again, I don't really know what the -- what was involved in the New York review. I don't know if they proposed two percent, knocked it down to one and-a-half. Or if they came in with one and-a-half. I think that would be information I would like to understand before making an opinion, changing my opinion to match New York's.

Q. It might change your opinion, but you don't know now?

A. I don't know.

MR. ANGOFF: I have no further questions.

HEARING OFFICER HENKIN: Okay. Kevin, you're already.

CHAIRMAN MULLIN: I just wanted to follow up on that last line of questioning because I was somewhat confused.

MVP has the healthier population when it comes to QHP.

THE WITNESS: Yes.

CHAIRMAN MULLIN: So why would changes in the risk adjustment be a risk to them?

THE WITNESS: Well just saying that it could, you know, they -- on a PMPM basis the risk adjustment payment or receivable, either one, is much more impactful for them on a PMPM basis because while their membership has been growing, it is small, a smaller subset of the Vermont market. And so any change in that has a direct impact. It may be more favorable because they are healthy, but it can also go the other way.

CHAIRMAN MULLIN: Okay. CTR, you said eight states. I think David said nine. So one of you is right. But however many states that you are in, is it common to see different CTR levels among different plans?

THE WITNESS: When you say plans, do you mean carriers? Or do you mean like products within the --

CHAIRMAN MULLIN: Products within an individual company.

THE WITNESS: Sorry. Want to clarify one more. Do you mean like gold, silver, bronze or between large group, small group? Sorry.

CHAIRMAN MULLIN: Okay. So this particular case Vermont has a merged market.

THE WITNESS: Yes.

CHAIRMAN MULLIN: Okay. I believe the testimony we heard from Mr. Lombardo is that there is a difference between 1.5 and two percent between the small group and the individual in New York.

THE WITNESS: Okay.

CHAIRMAN MULLIN: And likewise, is it common by companies in different states to have a different level of a CTR in a rate filing based on what that plan is?

THE WITNESS: Yes.

CHAIRMAN MULLIN: Okay. You have testified that it was reasonable for a two percent in this particular rate filing.

THE WITNESS: Yes.

CHAIRMAN MULLIN: Would it also be reasonable for a 1.5 percent in this rate filing?

THE WITNESS: I think if they had filed 1.5, I don't think that would have changed my response. I think that would have been okay.

CHAIRMAN MULLIN: Thank you.

HEARING OFFICER HENKIN: Ms. Holmes.

BOARD MEMBER HOLMES: If the hospital budget submissions came in below the assumptions made by the carriers in the filing, is it fair to say with near certainty that the carriers' assumptions would

be wrong and should be adjusted downward? That is, the board doesn't generally increase the commercial rate above that which the hospitals have submitted.

THE WITNESS: Yes. That's what happened last year.

BOARD MEMBER HOLMES: Right.

THE WITNESS: Right, yes.

BOARD MEMBER HOLMES: So it's fair to say that the assumptions made by the carriers in the situation last year were wrong because the hospital submissions came in lower than their assumption?

THE WITNESS: Right. That is correct.

BOARD MEMBER HOLMES: Okay. If the hospital budget submissions come in above with the assumptions made by the carriers in the filing, is it fair to say that the carriers' assumption may still be right because there is some uncertainty about what the board is going to do and by how much the board is going to reduce potentially those commercial rate asks?

THE WITNESS: Yes. And that's why we wanted to take more time to review and have discussions with the staff, and that's why I was looking at how the past years have gone. A couple of years ago most of the time submitted was approved.

However, the last two years, as I've testified earlier, they have been on average .3 percent lower than what was submitted.

So I recognize that there is a difference, and that's why our report doesn't say go with the hospital budget figures but with updated information. And to me that would -- that is why we want to take more time to assess, because broad scope I could say it's a .3, but it does depend on the facility. And I know the facility mix even just between the two carriers are very different.

BOARD MEMBER HOLMES: So it would be reasonable for there to potentially be some asymmetry in how the board handles what's submitted and how we then deal with the filing depending upon whether what's submitted is above or below what the carriers assumed?

THE WITNESS: I think that's possible. I would like to advise the board to attempt to be consistent where, you know, again, what my process was going to attempt to do over the next couple of days is to make sure that if I don't go all the way to that number, that it's consistent with, if possible, to find a pattern for let's say UVMMC. If they always -- it's always dropped a certain

percentage or amount to apply that and then consider that.

Because it is fair to say that there is a pattern there.

BOARD MEMBER HOLMES: Yeah. I would just caution that is an entirely new board, so whatever patterns are emerging are also board dependent.

THE WITNESS: Yes.

BOARD MEMBER HOLMES: That's all my questions.

BOARD MEMBER USIFER: I would just add to that a little bit when we look at the hospital budgets in total, in some of the guidance that we gave, and it's very preliminary right now, but in total the budgets came in under the overall guidance that we gave. So we had given a 3.2 percent rate. It came in at 2.9 percent.

So even with rates that may not get approved, the commercial rate increases that are higher, so you know, it tends to only go down rather than go up from there. So how do other factors like utilization, and things like that, there has to be other factors that are driving that number down, if in fact right now those submissions have a higher

rate.

So I guess when you're looking at that kind of looking at the totality of understanding what are some of the other assumptions that might be in there.

THE WITNESS: Can you ask your question differently? I'm not sure I'm following.

BOARD MEMBER USIFER: So if rates are coming in at a certain percent, and that's driving up the top line, but utilization is going down, for instance, and utilization maybe was assumed to be flat, you know, that's another factor potentially. If we came in, and they said insurance -- the average rate is X, I don't know what the blended average rate is, three percent or something, two percent, but the overall budget increase is even less than that, that means other things are going on in that budget.

THE WITNESS: I'll have to take your word for it. We only generally see the weighted average at a very high level. We don't really dig into all of those. I just know that we can't rely on the weighted average number, whether up or down, because even the distribution by facility, as I said, between the two carriers can be very different.

But I will say I know that when these

budgets came out that there was one facility in particular that was supposed to be flat, but then the budget came in and it was much higher, and so we would hope that the board is going to bring that down, but that wasn't a red flag to us when we originally saw it.

BOARD MEMBER USIFER: Just one other question. When we are talking about a business that's growing, and may continue to grow because the premiums are different between MVP and Blue Cross, so I know the assumptions are based on the number of lives from last year at 25,000. And there may be continued growth. And the discussion about admin costs, and then how would we get the benefit from that. And is there a way -- any factors that L&E would ever put in to say if there were a growth in membership what that would do to rates?

THE WITNESS: I think we generally rely on the carrier to provide that kind of information to us. Typically, if you see a growth in enrollment, your point is we would like to see a benefit in the admin costs going down, because you can spread it across the entire, a larger portion of membership.

I think in MVP's case which they have testified to is that they have a portion that's in

New York that's -- that they are having to bridge this across, but that's not an uncommon practice to have that happen across multiple lines of business, even across states for larger plans.

I know you're comparing it to just Blue Cross Blue Shield of Vermont, but they only do business here in Vermont. So it's not that uncommon, but like you -- I mean I think it's a little disappointing that it didn't go down further. Because I know that was something that the board wanted, and I'm sure even too MVP wanted it because it would have made their rates even lower which would have drawn more members to them.

So I mean I think that based on what I've seen, they are trying to be competitive, and they want the market share, and it was something that I wasn't even sure they could achieve, but they have. And they really continue to have lower rates and to kind of answer a question earlier, they do have the lower rates across the board with the exception of the catastrophic plan.

BOARD MEMBER USIFER: It still seems -- I mean Vermont's only 2.9 percent of their business. And yet our business went up from 10,000 lives to 25,000 lives. So we went up 15,000 lives. The rest

of their business went down overall 10,000 lives. So still the three percent of Vermont can't carry that burden for the whole business. I mean even if you're going to readjust, you have to align that across all the lives, and there has to be about 8, 900,000 lives there. So --

THE WITNESS: Good challenge for MVP to consider for the future. But, you know, that's not my business, so I don't know how they do it. And I know that Matt did talk about it more extensively than I can. But I do think that's a good challenge, because I agree, that could benefit Vermonters especially as that enrollment growth continues, which it should, because rates are even lower relative to Blue Cross's.

BOARD MEMBER USIFER: Okay, thanks.

BOARD MEMBER LUNGE: I just have one question. Jackie, in your report on page seven you have a description as to the individual mandate analysis that L&E performed in February. And yesterday your colleague, Dave, testified that the report was based on financial impacts related to the mandate. However, the report indicates financial and non financial. Does that need to be corrected?

THE WITNESS: I believe that would need

to be corrected. I think that it was based on financial only. Yes.

BOARD MEMBER LUNGE: Thank you.

THE WITNESS: Should we issue an amendment for that?

HEARING OFFICER HENKIN: You can do that on the record right now. I think that will be accepted. I believe that you acknowledged there's an error in the report and recorded here.

THE WITNESS: Okay. Thank you.

BOARD MEMBER LUNGE: Thank you.

BOARD MEMBER PELHAM: I have no questions. I have no questions.

THE WITNESS: Thanks, Tom.

HEARING OFFICER HENKIN: Just looking around to make sure that everyone is done. Thank you very much, Jackie.

THE WITNESS: Thank you.

HEARING OFFICER HENKIN: I have public comment here. Will you be offering anything else?

MR. ANGOFF: We have Mr. Fisher's rebuttal testimony.

HEARING OFFICER HENKIN: I did offer you that, but you did not make it clear if that was going to happen.

MR. ANGOFF: Oh, yes. Absolutely.

HEARING OFFICER HENKIN: Okay. Mr. Fisher, take the witness stand.

MR. FISHER: Good afternoon.

HEARING OFFICER HENKIN: Now you did take the oath also this morning?

MR. FISHER: I did take the oath. And I'll just -- it's good to be here. You guys throw a great party.

MICHAEL FISHER

Having been duly sworn, testified as follows:

MR. FISHER: I will start with --

MR. KARNEDY: Object just as to form. What's happening here?

HEARING OFFICER HENKIN: Well I said that he could be a rebuttal witness. As to form, I assumed there would be -- he would be lead in questioning, but that does not appear to be happening. I am not prohibiting his testimony unless there is an objection to its contents as he's presenting it right now.

MR. KARNEDY: So would you like me to -- without knowing what he's going to say -- I'll have to interrupt him at times.

HEARING OFFICER HENKIN: I do not know what he's going to say either, but I would hope that his attorney has prepared him to stick within the bounds of rebuttal and not to venture into the inadmissible materials we talked about today nor outside of the record as presented.

MR. ANGOFF: That's correct.

MR. KARNEDY: I'll be polite, but I have to speak up.

THE WITNESS: And I will do my best to live in the bounds with whatever it is rebuttal witness means. I'm sure I'll be corrected.

HEARING OFFICER HENKIN: I hope your attorney explained that a little to you.

THE WITNESS: So I want to start by just recognizing where it is I come from as the health care advocate. And to just say out loud that as I sit through a day-long proceeding like this, I am receiving emails from people who -- for whom it's not working so well. And I'm not going to tell you -- I could give you an example, an email that came to me during today. I'm not going to. But I just want you to know that the passion that I come to this with comes from the experience of listening to Vermonters for whom this great, complex system of paying for health care isn't working.

I have a few, I think, fairly high level comments about what I've heard today. And so first off, I heard a discussion about quality improvements that MVP was making and their attempt to direct people to primary care. And I appreciated Member Holmes's focus on that. I do want to turn to the page, it's tab five, page seven. It's a little bit of irony for me to be focusing on this question

here. I don't bring it up and ask you to open it up because I have anything in particular to say about this filing today regarding these numbers, but I want you to know that I found these numbers important. And I plan to ask these questions every year. I think that they provide a benchmark for us to measure something that I think is important.

So the second issue is there's been a great deal of focus on a report called -- report or a study -- that was commissioned by the board and by DFR with regard to individual mandate. I don't know whether the board has seen that study or that report. I don't know whether the carriers have seen a more detailed analysis of that report than I've seen. But I want to report to you that in the commissioning of that study there was a discussion of not wanting to spend too much money, a high level understanding of the lay of the land. And I'm not an expert to tell you whether it's efficient to direct the carrier to increase the rates by two percent, but I will ask the question -- I will ask the board to consider that question as you're entertaining it.

I'm just aware that it was a high level attempt to get a picture of the lay of the land, not a detailed analysis. I've heard executive --

insurance executives say today and previous days, that their companies are as lean as possible. And I heard insurance executives say that there is a great deal of the health care spending that's beyond their control. There is not a lot they can do about it, and it leaves me, as the Health Care Advocate, to want to say that it can't be true. If that's true, there is no role for us here to do anything about it.

I am as -- I will be as strong a supporter. I would agree with much of the testimony you've heard about the importance of solvency. I agree an insurance company needs to be solvent. It is a primary consumer protection. But I also would assert with as much strength as I can, that affordability is equally important.

I've heard many times in -- I don't know, it doesn't matter whether the topic is how many people are going to come on and off a plan during the calendar year. And how many people are going to turn 65 on any other day than January 1, I'll put it that way. How many people are going to -- is it reasonable to put this amount in a reserve or that amount into a reserve. I've heard again and again this concept of it's better to say safe than sorry from the insurer's perspective.

And I think the main point I want to make is that there is a cost to being safe, being more safe than sorry. That that decision to be -- to err on the side of insurer solvency means people will not be able to afford the care.

So I think I could have a couple of very brief comments in response to some of the things that have been raised, but I think I'll stop. Happy to receive questions.

MR. KARNEDY: No questions.

HEARING OFFICER HENKIN: Does the board have any questions?

(No response)

HEARING OFFICER HENKIN: Thank you, Mr. Fisher. Did you want to say anything to close?

MR. KARNEDY: Well, being a lawyer, I would say that I'm happy to waive closing if my brother is as well. If not --

HEARING OFFICER HENKIN: I thought you were going to say I feel compelled to say something.

MR. KARNEDY: But if he's going to talk, I'm going to talk. Jay, if you are -- do you want to do a closing? If you do, I want to do a closing.

HEARING OFFICER HENKIN: You can say

anything brief, not at all.

MR. ANGOFF: I appreciate the offer, and I hate to not accept it unconditionally. I would just like to do a short closing. Two minutes tops.

MR. KARNEDY: Then I will be brief.

HEARING OFFICER HENKIN: Go right ahead, Mr. Karnedy.

MR. KARNEDY: MVP requests a rate increase of 4.6 percent as amended from our original May 11 request of 6.4. Those numbers are the numbers felt by Vermonters. This reduction recognizes a decrease from an actuarial adjustment on silver loading of some three percent, a risk adjustment reduction of 1.9 percent, and an increase of .5 percent based on the hospital's proposed budgets. MVP has met its burden. I'll leave you with a quote from now retired Justice Dooley, one of his last decisions was in our case in re: MVP Health Insurance, where he questioned -- no, where we questioned what to do about these non-actuarial terms. And this is what he said. "That these terms are general and open ended reflects the practical difficulty of establishing quote, more detail, narrow or explicit standards, end quote, in this field. A difficulty due to the fluidity inherent in concepts

of quality care, access, and affordability given advancements and setbacks in technology, medicine, employment and economic well-being. Accordingly, flexibility is required." It goes on from there.

So I read that because I dismissed the notion that we have heard that we are sort of at sea without an oar, or a life boat when we talk about these concepts of affordability, quality of care, and access. What Justice Dooley is saying that we don't need to look to Webster's Dictionary to understand what those words mean. What he's saying is whether the rate is affordable or not, he's saying it's up to the Green Mountain Care Board to determine that. You're your own Webster's dictionary. You can decide that.

And MVP has provided sufficient evidence that will fall into the various buckets, some not actuarial, some actuarial, but I think this is not a problem. I think you have plenty of evidence to find in MVP's favor and approve the rate filing as amended. Thank you.

HEARING OFFICER HENKIN: Mr. Angoff.

MR. ANGOFF: Three points. First, this business about MVP charging Vermonters more or treating Vermonters less favorably than New York

residents I think is not only fundamentally unfair, both having a higher CTR for Vermont residents and not allocating the administrative expenses that should be allocated to Vermont. Not only is that fundamentally unfair, but it hurts Vermonters a lot without benefiting New Yorkers much, because New York is so much bigger. So it just doesn't make sense. That's number one.

Number two, as far as the RBC issue is concerned, you know what MVP's RBC ratio is. You know you heard the Commissioner testify yesterday that the no action level is 300. My only point is that I think MVP's RBC ratio is fine. The board does not need to be concerned about it, adding an additional contribution to reserves. It's really surplus. The board doesn't need to add a contribution to raise RBC -- MVP's RBC ratio.

Third and final point, I essentially agree with Mr. Karnedy that, yeah, the board has tremendous discretion. This is a unique or near-to-unique statute. That I'm told it's based on Rhode Island's, but I don't think Rhode Island -- Rhode Island has done too much with it. You're the only regulatory board in the country that goes through this process and has got to determine what those

words mean. And you do have discretion to do that.

And I think that there's the plain meaning of those words and that the board -- the board should take the unfair, excessive and inadequate standards very seriously, but it should take all the other standards equally seriously.

The board has a very difficult job in balancing those standards. Thank you.

HEARING OFFICER HENKIN: A few matters in closing. There were some questions that were presented to MVP where we were going to get responses from you, from the appropriate folks. I think we can reduce that to a writing and get it off to you hopefully by the end of tomorrow so you'll have those questions available. There is no extension on times for memo or anything else in this matter. We have, I believe, other than these responses, all the testimony. There's been no amendment. I believe we will stay right on schedule with this which means that memos will come in -- public comment closes tomorrow -- tonight or tomorrow. Today's the -- tomorrow.

We have been receiving a lot of public comment. We have a public comment period open tonight. We will take some public comment. Today

there is a few people who signed up. And as I said, we will send those questions out very promptly.

MR. KARNEDY: May I ask a question?

HEARING OFFICER HENKIN: Yes.

MR. KARNEDY: The questions -- we have to prepare a brief. We will meet the deadline, but when will the responses to the questions be due? There were a number of fair and good questions.

HEARING OFFICER HENKIN: I think some of them are very direct, and they shouldn't be, you know, if you can quantify the traffic on your website, for instance, on your consumer website. These type of things, I think, should be pretty direct.

I would like to have those questions all back by no later than Monday. And --

MR. KARNEDY: I wonder if it's possible given that the brief is due on Monday, could we get the responses to the questions sometime later in the week next week?

HEARING OFFICER HENKIN: Let's take a look once I quantify these, and I'll take a look in house. I have been very pleased with the fact that Matt tends to do things before they are actually due. If I can stress that that would happen again, I would

give you a few extra days.

BOARD MEMBER HOLMES: His mother is very proud.

HEARING OFFICER HENKIN: I don't know as that will happen. Please, I will try to work with you on that. We want to get the answers as quickly as possible, but we want them fully answered, so I will consider that. But I'm not going to, as I said, I do want to look at these closely and make sure we can ask pretty pointed questions that will be relatively -- I won't say easy -- but they will be something you can answer and don't demand Matt to do a huge essay which we are going to grade him on.

I think some of these he has to get the information, or you have to get the information from other persons at MVP.

MR. KARNEDY: It sounds like you'll fairly work with us on that, which we appreciate.

HEARING OFFICER HENKIN: I will work with you on that.

MR. KARNEDY: Thank you.

HEARING OFFICER HENKIN: Okay. We do have a few people that signed up today to comment. And again, there is a comment period this evening. David Hills is the first person, if you could come up

and have a seat.

MR. HILLS: I'm going to withhold my comments for now.

HEARING OFFICER HENKIN: Okay. Jill Charbonneau.

CHAIRMAN MULLIN: You didn't bring doughnuts.

MS. CHARBONNEAU: I didn't come to the bakery this morning. I'll remember that.

My name is Jill Charbonneau. I'm president of the Vermont State Labor Council, AFL-CIO. Listening to some of the discussion here today I'm not sure that my comments fit in, but obviously stop me if you don't want to entertain what I have to say.

I spend a lot of time in the legislature, and I hear the term affordability a lot. And also on the even years I spend a lot of time on the doors, and I hear the term affordability a lot. And one thing that I think Vermonters find is that their health care is unaffordable. And I recognize that medical insurance is not the same as health care. But still, it is unaffordable to Vermonters.

I mean I hear stories of people working less because they can't afford to work more and still

receive some of the benefits of health care through the Affordable Care Act. I hear Vermonters going to their doctors and getting prescriptions. One of the solutions was, you know, we will give you a larger dosage. It will be more affordable to you, but you'll have to cut the pill in half. That's a great solution when it works, but most of the time there are many Vermonters where this doesn't work. So when you examine what rate setting can do and whether an insurance company needs two percent or 1.5 percent or whatever it is that they may need, also reflect on what it's going to cost Vermonters when they try to receive medical care that they can't afford. Because for many Vermonters health care is unaffordable. And that's what I wanted to share.

HEARING OFFICER HENKIN: Thank you.

MS. CHARBONNEAU: Thank you.

HEARING OFFICER HENKIN: Jeff Hochberg. Just because of apportioning this evenly with the evening folks, I'm giving everyone three minutes. I'm only kidding. Please.

MR. HOCHBERG: I'll be brief. My name is Jeff Hochberg. I'm the president of the Vermont Retail Druggists, also the director of the pharmacy group. I wanted to bring attention to something that

may or may not be present in the binders, the information you received from both Blue Cross and MVP. It's certainly something that was discussed about pharmacy trends and how cost of pharmaceuticals are going up.

A lot of attention was directed at specialty drugs. So I want to add some clarity for the board on what a specialty drug is. It's a term that's broadly applied to high-cost drugs. This term does not have any federal, state or professional regulatory rule definition. Loosely put, even insulin can qualify for a specialty drug.

In 2018 MVP required all Vermont beneficiaries on the exchange to utilize CVS Caremark pharmacy solely for the distribution of specialty products. This is a mail order pharmacy, not a residential. And again, CVS Caremark had in its sole discretion to define what drugs qualified under this category of specialty drugs.

It may or may not be evident in the binders that this is going to be -- this practice is going to continue. I have been indicated by Brian Murphy of Blue Cross Blue Shield that Blue Cross Blue Shield of Vermont does intend to do the same thing with its mail order pharmacy owned likewise by its

PBM, Accredo Pharmacy, owned by Express Scripts DSI.

So when I sit here and I listen to comments about increasing access, and I appreciate the efforts you're doing on the provider level, but they are not -- frankly they are doing quite the opposite on the prescription level. So at this point if these plans were to exist, all the business potentially could be forced to mail order. And Vermonters would have very little access to community pharmacies, to help drive costs down, to help encourage lower cost substitutes, to help coordinate benefits within the various providers. This impacts both communities for retail pharmacies and hospital outpatient pharmacies, particularly the hospital pharmacies in relation to the 340b practices which is a very significant portion of their budget items.

And quite frankly, we take the position that this is a violation of state statute. In the 2013-'14 session the statute under Title 8 Section 4089(j) section B reads: A health insurer and pharmacy benefit manager doing business in Vermont shall permit a retail pharmacist licensed under 26 V.S.A. Chapter 36 to fill prescriptions in the same manner and at the same level of reimbursement as they

are filled by mail order pharmacies. With respect to quantity of drugs, days supplies of drugs suspends under each prescription. There is no financial windfall for any consumer to receive the product via mail versus a retail pharmacy as per the statute.

So I don't understand why it thinks this. That was my comments. Thank you.

HEARING OFFICER HENKIN: Thank you. Dale Hackett. Is there a Dale Hackett here?

MR. HACKETT: I have no idea who he is. Okay. I wrote it as a consumer, is that okay?

CHAIRMAN MULLIN: That's fine.

HEARING OFFICER HENKIN: Have a seat.

MR. HACKETT: I'm a little concerned like with all these do's, don'ts, and so forth.

CHAIRMAN MULLIN: We are in a public comment period. You don't have to worry about it. Those rules of evidence you don't have to worry about.

MR. HACKETT: Oh shoot. That's not my world. If I'm convinced of nothing else, it's that I don't want to live in that world. And it's just a tough world. That's all I'm saying. It's not my world.

So my comments are simply from the

consumer perspective. What sounds good isn't what looks good when you're the consumer doing the purchasing. Actuarial can't tell you what you can afford. They tell you what the company can afford. There is very little in their discussion that is what's in my head when I'm looking at what I have to consider when I'm deciding what to buy for health care.

Life is not data. It has emotions, there is art, there is uncertainty, there is love, there is aging, there is family, there is children, school, housing, some of these things have expenses. Food, education, day care. And you cannot escape the consequences.

A consumer has to consider their solvency when buying a health care plan that goes well beyond the cost of the plan itself. It includes the affordability of the utilization of the plan and not just the premium cost. You have to consider how often you use it, why are you going to use it, what's the copays, far more than they ever discuss.

They do get at it. I'm just saying it's more than they discuss. When we consider a cost we think solvency and resiliency of our household financial status as a consumer. What we think about

next is where we, as consumers, can disagree with any insurance company and probably do as costs go up. Where do we ever have the ability other than public comment right now where we can actually listen to this and come back and say, you know what, that's not our world.

The services good health care requires to be delivered is required of the plan, I have but always not -- oh, of the plan I have, but not always available. Do I need to repeat it or did that make sense? Because I want to try to not take too long. What a plan does not deliver does have a cost. You've heard that before. We face that all the time up here. It's not in the equation. Out there, it's in the equation. These are what we call the consequences.

What bothers me about the rate reviews is the lack of focus on the affordability or just what I have been talking about as we see it. For all our regulations affordability of a social need by society is not assured by an insurance company. That's part of the problem. Their performance, insurance companies, always fall short of needs by society, they don't have to conserve. That, I think, is a fact denied too often that we all if we just

stop and think about it realize that as soon as we walk out that door, it is reality.

I'm done almost. Consumer solvency is different in context than insurance companies validate. I ask the board to validate consumer solvency and health care expenses. At least consider our point of view and what we live with. Most plans' policies do not account for life experience, except when they talk about risk adjustment. We need to find respectful common ground. Sorry, long winded, but at the same time, thank you for letting me say that.

HEARING OFFICER HENKIN: Thank you, Dale. With that, I will turn it back over to the Chair to close the meeting.

CHAIRMAN MULLIN: Is there a motion to close?

BOARD MEMBER LUNGE: I move to adjourn.

BOARD MEMBER PELHAM: Second.

CHAIRMAN MULLIN: All in favor.

BOARD MEMBERS: Aye.

CHAIRMAN MULLIN: Any opposed?

(No response.)

CHAIRMAN MULLIN: Thank you everyone. I know it's been a long couple of days.

HEARING OFFICER HENKIN: And it's not over.

CHAIRMAN MULLIN: 4:30 at Montpelier City Hall.

HEARING OFFICER HENKIN: In the Memorial Room.

(Whereupon, the proceeding was adjourned at 2:34 p.m.)

C E R T I F I C A T E

I, Kim U. Sears, do hereby certify that I recorded by stenographic means the hearing re: MVP Health Care 2019 Vermont Health Connect Rate Filing at the Vermont State House, Room 11, 115 State Street, Montpelier, Vermont, on July 24, 2018, beginning at 9 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 237 pages are a transcript of the stenograph notes taken by me of the evidence and the proceedings to the best of my ability.

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

Dated at Williston, Vermont, this 25th day of July, 2018.