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GREEN MOUNTAIN CARE BOARD

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VERMONT HEALTH CONNECT RATE REVIEW HEARING (MVP)

July 28, 2015
9 a.m.
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89 Main Street
Montpelier, Vermont

Hearing held before the Green Mountain Care Board, at the City Center, 89 Main Street, 2nd Floor, Montpelier, Vermont, on July 28, 2015, beginning at 9 a.m.

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CHAIRMAN GOBEILLE: Good morning, everyone. Welcome to day one of Vermont Health Connect Rate Review festival.

(Laughter.)

CHAIRMAN GOBEILLE: Thank you, Con. At this point I will turn the hearing over to our Hearing Officer, Judy Henkin. Judy?

MS. HENKIN: Thanks, Al. Good morning everybody. Preliminary, please turn off your cell phones if you have a ringer on your cell phones. I would appreciate that as a starter.

Also if you did not sign up, please do so, even though we know you, it would be good to have a record of who has come to the hearing.

This morning we are going to hear for the third time MVP's case for the exchange in re: MVP Health Care 2016 Vermont Health Connect Rate Filing, Docket Number GMCB-007-15. And we are going to hear -- we have attorneys in the room with Gary Karnedy representing MVP. Good morning. And we also have the office of the HCA here, and I think both of you will be presenting today or --

MS. KUIPER: It will be mainly me.

MS. HENKIN: Mainly Kaili. We are going to start right away. I don't think there is much I have to explain. I am going to give everybody an opportunity to do a small opening statement, and then we will move on with the witnesses. We will have the company present first. We will hear from also the Department of Financial Regulation following the company's presentation and cross examination. And then we will hear from an actuary from L&E who is here from Dallas, Jackie Lee, who will be testifying about this. And we will close with Donna Novak for the HCA. And I believe that will conclude the day except for public comment which will be at the end.

Mr. Karnedy.

MR. KARNEDY: Thank you very much. My name is Gary Karnedy, I'm from the Primmer law firm, and we have been coming each year to represent MVP Health Plan, Inc. in these filings. We are here again for this 2016 rate filing.

We would like to thank the Green Mountain Care Board for your consideration. We also would like to thank the actuaries at L&E for their review and collaboration with our actuaries in suggesting modifications to the MVP 2016 rate filing.

Now that we have a bit of a track record, over the years I found first with DFR then when we moved here to the Green Mountain Care Board, this rate approval administrative process has really evolved and improved. What we found this year was I hope will be a pretty predictable and fair process and hearing for all the stakeholders. Your professionals and your staff, including the actuaries, that would include MVP's actuaries in that, really worked hard to discuss and narrow issues before the lawyers got involved. That's a good thing. I've also enjoyed working with opposing counsel to again narrow the issues for this proceeding.

This year the process has resulted in what I think is what will be a pretty straightforward hearing today. I think that there is one issue, we have had in the past years many issues, but there is just one material difference, I believe, in the opinions that L&E has, the opinions that we have, and that amounts to a .3 percent difference. So that's, I think, marked contrast to prior years.

MVP initially proposed an average increase of only three percent this year for our 2016 rate filing. L&E's recommended a reduction of three, 2.7 based on four modifications. After reviewing L&E's recommendations, MVP has found agreement with them on nearly all the issues, save one issue which is a demographic single conversion factor adjustment which we will be talking about today in the hearing. So that one issue just so happens that this year L&E is proposing a .3 percent increase on that issue. And consequently, MVP we were at three percent. L&E's come in at 2.7 percent. We are actually now at 2.4 percent. We are looking for a 2.4 percent increase over last year's rates. So we are .3 percent lower than what L&E is proposing.

We believe the evidence will support and show that the 2.4 percent increase proposed by MVP meets all the statutory criteria. It's affordable, promotes quality care, promotes access to health care, protects against insolvency, and is not unjust, unfair, inequitable, misleading or contrary to law. It's not excessive, inadequate, or unfairly discriminatory. Those are the things we need to prove.

In short, we believe you'll conclude after you hear the evidence that the 2.4 percent increase is actuarially sound and is the best proposal for Vermont to have MVP here as another insurance option for our citizens. Thank you very much.

MS. HENKIN: Thank you. Kaili.

MS. KUIPER: My name is Kaili Kuiper, and I'm here with Lila Richardson. We are staff attorneys for the Office of the Health Care Advocate.

CHAIRMAN GOBEILLE: You can move that closer if you want to.

MS. KUIPER: Is it on?

MS. HENKIN: I think it's on. Excuse me for a moment. Susan, I have your coffee. Can I give you this now?

MS. KUIPER: In order to ensure that Vermonters receive a fair rate for health insurance, Vermont requires health insurers who sell individual and small group policies to justify any rate changes before they can impose them on consumers. Our expert, Donna Novak, will testify today that there are two areas where MVP did not meet that burden to justify their rates. First, in agreement with L&E, Ms. Novak will testify that MVP should have used 2015 demographics to project their rates, and instead they used 2014 demographics.

Second, MVP overstated its paid to allowed ratio, and on this point they failed to demonstrate that their rates development meets the ACA requirements. Ms. Novak will recommend on the first point that MVP be required to use 2015 demographic information. And on the second point Ms. Novak will recommend that MVP be required to show their calculations for their benefit paid to allowed ratio, by following the federal rules so that it can be determined whether their overstated paid to allowed had any impact on their rates.

The HCA asks the Board to ensure that MVP's rates are justified by adopting these recommendations. Thank you.

MS. HENKIN: Okay. We can call your witness.

MR. KARNEDY: MVP would call Kathleen Fish.

MS. HENKIN: Sorry for the truck noises here. It's one of our standard morning sounds here. The beeping in the backup will start shortly.

KATHLEEN FISH

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KARNEDY:

Q. Good morning, Kathleen.

A. Morning.

Q. How are you?

A. Great.

Q. Why don't you pull that microphone a little closer. Okay. Now say something.

A. Hello.

Q. Can everyone hear her okay?

CHAIRMAN GOBEILLE: Yeah. It's pretty good.

MR. KARNEDY: Terrific.

BY MR. KARNEDY:

Q. Would you please tell the Board your name?

A. Kathleen Fish.

Q. And where are you employed?

A. MVP Health Care.

Q. And this filing is on behalf of the MVP Health Plan, Inc.; correct?

A. Correct.

Q. And if you would turn, please, to Exhibit 11, in the binder of the Exhibit 11. I understand this is your CV, your resume; correct?

A. Correct.

Q. And you prepared it, right?

A. Yes.

Q. And I see you went to UVM?

A. I did.

Q. What did you major in at UVM?

A. Mathematics.

Q. That's related to what you do today; isn't it?

A. It is.

Q. I won't ask you when you were at UVM. But it was sometime ago, right?

A. Yes.

Q. What is your position at MVP, please?

A. I am Vice President and Chief Actuary.

Q. And last year MVP had Pete Lepaca (phoenetic) testify who was in that position. You replaced Pete; is that right?

A. That's correct.

Q. And how long have you been at MVP?

A. A little less than 10 years.

Q. And are you a certified actuary?

A. I am.

Q. And what are your job duties as chief actuary?

A. I am responsible for all rate setting and reserve setting and risk analysis at the company.

Q. And have you worked on the MVP Green Mountain Care Board filings in past years?

A. I have.

Q. You worked with Pete on those?

A. Yes.

Q. And didn't you, in fact, sign some of the rate filings in the past years?

A. I have.

Q. So you're very familiar with the issues that Vermont's had in the past and this year as well; correct?

A. Yes.

Q. Thank you. Now I've got some housekeeping to do with you. If you turn to the front of the binder please. The very front. You'll find an exhibit list. Tell me when you're there.

A. Okay.

Q. And you'll see a list of exhibits that we have marked. Exhibit 1 is the rate filing. Correct?

A. Correct.

Q. And Exhibits 2 through 7 and also 13, those are the Q and A, the questions and the responses that the Health Care Advocate had in -- excuse me, the Green Mountain Care Board, L&E's questions, their actuary's questions to MVP; correct?

A. Correct.

Q. And our responses?

A. Correct.

Q. And those exhibits contain that, right?

A. Yes.

Q. You're familiar with both the content of the rate filing and the content of those responses, and -- correct?

A. Correct.

Q. And you would adopt those as part of your testimony in this case; correct?

A. Correct.

Q. Thank you.

MR. KARNEDY: So I move for the admission of 1 through 7 and 13, please, which I think have been stipulated to.

MS. KUIPER: Yes.

MS. HENKIN: No objection to those?

MS. KUIPER: No objection.

MS. HENKIN: We admit into the evidence it's Exhibits 1 through 7 which were stipulated to by the parties.

MR. KARNEDY: And 13 as well.

MS. HENKIN: And 13. Sorry.

(Exhibits marked MVP-1 through 7 and 13 were admitted into the record.)

BY MR. KARNEDY:

Q. And would you go to Exhibit 6 please. In the binder. Exhibit 6. Again housekeeping.

A. Okay.

Q. And do you see there is a handwritten "not" down under number 2, a handwritten not?

A. I do.

Q. Can you explain that, please?

A. It was a typo.

Q. And that's been corrected, and everyone has stipulated to the word not going into the letter, right?

A. Correct.

Q. And would you go to Exhibit 8 please. In the binder. Exhibit 8.

A. Okay.

Q. And what is this please?

A. This is the solvency opinion.

Q. From the Department of Financial Regulation, right?

A. Correct.

Q. And you're familiar with that?

A. Correct.

Q. And would you go to Exhibit 9 please. Exhibit

9.

A. Okay.

Q. And what is this please?

A. This is the opinion from L&E.

Q. And you're familiar with that?

A. Yes.

Q. Would you go to Exhibit 10 please. Exhibit 10.

A. Okay.

Q. And what is that please?

A. This is the opinion from Donna Novak.

Q. And you're familiar with it?

A. Yes.

Q. Thank you. And then we already talked about Exhibit 11 which is your CV, and you're familiar with that, right?

A. Correct.

Q. And then I would note all these exhibits that have been stipulated to that we just identified have little handwritten numbers on the bottom right-hand corner. Do you see that?

A. Yes.

Q. And that's to help witnesses identify the pages as we work today, right?

A. Right.

MR. KARNEDY: So I would move for admission of Exhibits 8, 9, 10, and 11, please.

MS. HENKIN: Any objection?

MS. KUIPER: No objection.

MS. HENKIN: Exhibits 8, 9, 10 and 11 are admitted into the evidence.

(Exhibits marked MVP-8, 9, 10 and 11 were admitted into the record.)

MR. KARNEDY: Thank you very much.

BY MR. KARNEDY:

Q. Okay. Kathleen, first I want to start with sort of a high level explanation of the rate increase. Okay, before we dig into the issues in dispute. So let's start at a high level. If you go to Exhibit 1 that's MVP's original rate filing; correct?

A. Correct.

Q. If you would go to page nine of that exhibit. It sort of summarizes things.

A. Okay.

Q. In the first paragraph the third to last sentence let me read it to you: The proposed rates reflect an average rate adjustment to prior rates of three percent, comma, ranging from negative 1.8 percent to 27.3 percent.

Do you see that language?

A. I do.

Q. So MVP originally filed a rate that's -- filed for a rate increase of three percent, right?

A. Correct.

Q. Would you explain that last clause, the ranging from language, what's that about?

A. We had to make some adjustments to the particular products, the benefits underlying those particular products due to requirements from the federal government in certifying our plans by metal level. So the adjustments reflect some modifications to the benefits as well as some changes to how we applied administrative expense to our products.

Q. So is the three percent a weighted average of the span of products then?

A. It is.

Q. Okay. And then if you go down below under market/benefits. There is -- the very last sentence, would you read that sentence underneath there? It starts: The book of business.

A. The book of business affected by this rate filing reflects 3,324 policyholders, 4,227 subscribers, and 6,417 members.

Q. Okay. So that's the universe of insureds that we are talking about with this rate filing; correct?

A. That is correct.

Q. And that was current as of the information we had at the time of this filing on May 15?

A. Correct.

Q. Okay. Would you next go to Exhibit 9 which is L&E's report, please.

A. Okay.

Q. Go to page 10 of their report. The very last sentence. Let me know when you're there.

A. I am there.

Q. That summarizes L&E's view on the rate increase, right?

A. Correct.

Q. And what do they say?

A. After the modifications, the anticipated overall rate increase will reduce from three percent to approximately 2.7 percent.

Q. And above there is some bullets where they did various additions and subtractions on various issues, right?

A. Correct.

Q. And then the net of all that is 2.7 percent, right?

A. Correct.

Q. If you go to Exhibit 12, please, which is marked for identification, Kathleen, we will be talking about this some, but I'll be pointing at things. But you can look at your copy and talk more to the Board so they will able to hear you.

A. Okay.

Q. Let's just start again. We are at a high level here. At the top we show the net impact of the rate increase, L&E is at 2.7 percent, right?

A. Correct.

Q. And we are at 2.4.

A. Correct.

Q. .3 percent add-on by L&E, right?

A. Correct.

Q. Now after reviewing all the filings, we just went through the various actuaries, do you believe that the 2.4 percent, and we are going to explain this later, but you believe that the 2.4 percent increase is superior to the 2.7 rate increase suggested by L&E and anything else that might be suggested by the HCA actuary, and meets the statutory standards such that it's adequate, fair, just, equitable, affordable, not excessive and promotes quality of care and access?

A. I do.

Q. So let's talk a little bit about this disagreement that we have respectful disagreement on, the

.3.

First, the exhibit's entitled Single Conversion Factor. What is a single conversion factor?

A. It is a -- a factor that is applied simply to translate a per member premium requirement to a per contract premium requirement. We are required by the State of Vermont to charge per contract premium rates. Those for single policyholders, double policyholders, parent-child policyholders, and family policyholders.

As actuaries we develop revenue requirements, premium requirements on a per member basis. So that factor translates those on an equivalent basis to per contract rates.

Q. And when you say per contract, do you mean insurance policy that would cover one person or cover a family?

A. That's correct.

Q. That's the contract?

A. Yes.

Q. And how do you charge premium rate? Do you charge to individual members or to subscribers?

A. No. To subscribers.

Q. And what you just described this conversion is that something that's required by the state to be charged in that way?

A. It is.

Q. Over the years has MVP consistently used a particular calculation methodology in determining the single conversion factor and the demographic factor?

A. Yes.

Q. And has L&E similarly been consistent, might be different, but it's been consistent. They do the same thing each year?

A. Yes.

Q. And our method -- what do the New York regulators think about MVP's method?

A. They require us to use this method.

Q. And what's your opinion regarding the method used by L&E versus MVP? Are both actuarially reasonable?

A. Yes.

Q. It's just a question of which in your view respectfully is superior, right?

A. Correct.

Q. Now it just so happens in this year MVP's calculation on this issue resulted in a .3 percent increase over us, right?

A. That's correct.

Q. Last year what happened when they used the same method on this issue?

A. It resulted in a three percent decrease.

Q. A three percent decrease. Okay.

MR. HOGAN: Three percent or .3?

THE WITNESS: 3.1 percent to be exact.

BY MR. KARNEDY:

Q. So same method each year by both actuaries, but the results can vary each year depending on what's being input into the methodology, right?

A. That's correct.

Q. So I would like you to take a little time and explain the difference in the two methods and the data that's used.

All right. Let's start with the data that's used. What does MVP use for data in contrast to L&E?

A. We are using our census information that is the base of our 2014 claim experience. So the membership and the subscribers that make up our 2014 experience.

Q. And when you say 2014, do you mean for the entire year?

A. Calendar year. Yes.

Q. So you use census information and then claims information as well?

A. Yes.

Q. And could you explain what data -- membership census data L&E used?

A. They are using a snapshot as of a point in time, March 2015.

Q. And then both actuaries for L&E and MVP at the end of the day they are making an estimated guess about what will happen with experience in 2016, right?

A. They are adjusting the claim projection by a demographic factor. So they are introducing an assumption about how our claims will change.

Q. But both are making educated guesses, right?

A. Yes.

Q. Would you explain why you believe MVP's data is superior to L&E's data?

A. We are using our 2014 experience to project our 2016 premium rates. That is a complete, full, mature year of claim experience. And we believe that that is a better projection of our claim expense than trying to make an assumption about how the membership and the demographics of that membership has changed from '14 to '15. Using that demographic adjustment is speculation about how those claims will change.

Q. But they say it's more recent in time, you should use more recent in time, even though it's one month, you should use more recent in time information. What do you say to that?

A. It's only more recent as it relates to the membership. It is not more recent as it relates to the claims.

Q. So there is two issues then. There is the census membership data; right? And then you said there is this other issue about claims. So explain that please.

A. The claims, as actuaries we have to use historical claims to project future claims. And we would use at least 12 months of claims to do that projection. So the underlying membership that is driving those claims is the same membership that we are using to convert our per member per month revenue requirement to a per contract.

So those are aligned -- the membership and the claims and the census is all aligned to do that 2016 projection. Introducing a demographic adjustment factor and the 2015 census information is simply making additional assumptions about our projection that we don't believe are necessary.

Q. And actuaries like to avoid making additional and additional and additional assumptions, right?

A. That is correct.

Q. Thank you. So let's go through this then and crunch the numbers a little bit.

I believe based on your testimony that the method that MVP used you believe is reasonable and actuarially justified; correct?

A. I do.

Q. So I think we have already talked about the .3 percent add on. I've said that enough that I think we get that.

The enrollment data used you talked about. MVP used 2014 actual, one whole year of data, right? And L&E used a one-month snapshot; correct?

A. Correct.

Q. And the demographic factor 1.583 is what we used, and they used a 1.614. Can you explain why those numbers are different and the basis for that?

A. The 1.583 is simply the average demographic factor using an actuarial-based age, sex cost curve. That represents the average factor for our experience per membership, compared to that same age, sex curve applied to a snapshot of the membership, the distribution of our members as of March 2015. The age distribution.

So we have a slightly older population in March 2015 relative to our experience period, and that's why that factor is slightly higher. If you take the ratio of those two, that is a two percent adjustment based on an aging population.

Q. So this is where they did an additional assumption that we didn't do, right?

A. That's correct.

Q. And then the single conversion factor, these numbers MVP has a 14.5 percent and 12.6. Is there a difference in data that drives those different numbers?

A. The data that drives our calculation of 14.5 is our distribution of members and contracts between single, double, parent-child and family over that experience period versus the 12.6 is the distribution of the single -- distribution of subscribers and members by contract type as of that snapshot in time.

So the single conversion factor is simply a formula that's comparing the average contract size to the average load ratio that's used, and we simply are using two different census.

Q. Okay. And we have a math example. Going to use your math degree now. We have a math example. This is based on $100 a premium, right, per member per month. Can you walk us through this and just show how the math comes out for MVP and L&E starting with the projected claim cost. We just said a hundred dollars. We used that as an example, right?

A. Yeah. So --

Q. Go ahead.

A. The hypothetical example is saying that we have $100 per member per month as our average claim expense in 2014. We are making a statement that we are not adjusting that. We are taking that claim expense and we are projecting it forward based on trend and other adjustments. We get our --

Q. Let me stop you there. So you're talking about a demographic adjustment now?

A. Yes.

Q. So we take the $100 and we just multiply it by one because we are not making any change, right?

A. That's correct.

Q. And then so that comes out to a hundred dollars, right? And then explain from there.

A. So in this example we are effectively assuming that we have no trend. So our $100 is our required premium. We are not making any adjustments for demographics, so our projected claim expense remains at $100.

And then we need to multiply by the single conversion factor to translate that member premium for a single premium. And --

Q. That's the multiplication here?

A. That's correct.

Q. And that gets us to 114.50 right?

A. Correct.

Q. Let's walk through L&E then. One hundred dollars again. And then explain this multiple and where it derives from?

A. So L&E is using the ratio of those two demographic factors. The 1.614 divided by the 1.583. So they are using an age curve to project how the claim expense will change due to the changing demographics of our population. So they are resetting that projected claim expense effectively to $102.

Q. And that's the additional adjustment we talked about, right?

A. That's the additional adjustment, correct.

Q. Additional assumption, right?

A. Yes.

Q. And that gets you to a dollar 2, and then the multiplying by the single conversion factor?

A. So they are now calculating their single conversion factor based on that same snapshot of membership in March of 2015 that they used as the basis for their demographic adjustment. So it's important to make those two adjustments together. If you're going to use a current snapshot for the single conversion factor, you need to make that adjustment for the demographics. So it's a reasonable approach.

However, we don't believe that it is giving a better answer.

Q. And the delta between those two approaches is the .3 percent, right?

A. That is correct.

Q. You come in at 2.4; they are at 2.7, right?

A. Correct.

MR. KARNEDY: I would like to offer Exhibit 12 into evidence.

MS. KUIPER: No objection.

MS. HENKIN: No objection. We will admit Exhibit 12 into evidence.

(Exhibit MVP-12 was admitted into the record.)

BY MR. KARNEDY:

Q. I'd like to pivot to the solvency if we could. In this year's filing what does MVP assume in terms of a contribution to surplus?

A. Zero.

Q. And last year what was -- what percentage of contribution to surplus did the Board approve for MVP?

A. One percent.

Q. So why the difference this year? Why the change?

A. MVP is very concerned about premium rates and affordability and wants to be a player in Vermont. We want to have a presence here. We want to grow our membership. So we are doing what we can to keep premium rates affordable.

Q. What's our market share now roughly?

A. Our market share relative to the Blues is a little less than 10 percent is our best estimate at the moment.

Q. So in your opinion, and this is on solvency, will the .3 percent difference in the rate increase between the 2.4 percent offered by MVP and the 2.7 adjusted by L&E adversely impact the solvency of MVP Health Care, Inc.?

A. No.

Q. Does the 2.4 still reflect a break even premium rate?

A. Yes.

Q. Can you explain that?

A. So the 2.4 represents MVP's best estimate of the required premiums based on the actuarial assumptions that we needed to make to set those premium rates. Because we are adding zero percent surplus margin, we are effectively saying that we expect our cost to equal the premiums that we are filing. So therefore it's a break even premium rate.

Q. So that zero percent contribution that was with our original filing, we are suggesting here for the 2.4, and no solvency issues from your perspective, right?

A. That's correct.

Q. Let's go to, please, Exhibit 9. Exhibit 9. Go to page nine, there is a section nine. Exhibit 9 page nine section nine. Let me know when you're there.

A. I am there.

Q. Okay. Would you read -- there is an "in light," I think it should be in light of. In light MVP. Read that sentence please?

A. In light MVP not making a modification as a result of CMS's 2014 risk adjustment payments reported and this zero percent contribution to reserve assumption, we strongly recommend that no reductions outside of those proposed within this report be made to MVP's rates.

Q. Do you agree with that statement generally?

A. Yes.

Q. Why?

A. Because it's important that the premium rates that carriers are filing are respected and approved as filed because they represent our best estimate of our cost structure.

Q. So in your opinion is the .3 percent difference going to 2.4, is that material and thus contrary to L&E's cautionary statement here?

A. It is not in contrary to their statement.

Q. Why not?

A. Because it is simply a respectful disagreement in actuarial assumptions. So MVP is claiming that a 2.4 percent rate increase is still a reasonable and actuarially sound rate. And it doesn't change our position that we are still pricing to a zero percent surplus margin. So it is --

Q. So do you think was the method -- was the message from L&E on this relating to just having an actuarially sound opinion?

A. I believe so.

Q. And we have one; correct?

A. Correct.

Q. If you would, go to Exhibit 8 please.

A. Okay.

Q. So this is already in evidence. And this is DFR's solvency analysis, right?

A. Correct.

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

A. I have.

Q. Do you see Summary of Opinion on the first page? Do you see that? Would you read the sentence under Summary of Opinion?

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

Company.

Q. What are those two companies please?

A. MVP Health Plan is our HMO company for which we write this business. MVP Holding Company is simply the parent.

Q. And you agree with this opinion; correct?

A. I do.

Q. And then if you go to page two, please. At the bottom there is an impact of the filing on solvency, do you see that paragraph?

A. I do.

Q. And would you read the last sentence please?

A. Based on the entity-wide assessment above and contingent upon GMCB's actuary's finding that the proposed rate is not inadequate, DFR's opinion is that the proposed rate will likely have the impact of sustaining MVP Health Plan's current level of solvency.

Q. And you agree with that statement, right?

A. Yes.

Q. And you agree with that statement as it would apply to the 2.4 percent increase, right?

A. I would.

Q. Now this letter that was prepared by DFR, this related to our three percent increase, right?

A. I believe so.

Q. And has MVP provided additional information to DFR as it relates to the fact that we are going for a lower rate increase?

A. Have I provided additional information?

Q. Have we?

A. Yes.

Q. Let's use the royal we.

A. Yes.

Q. And you understand you're coming here today to testify about that; correct?

A. Yes.

Q. So they have approved, it says no solvency issues as the three percent increase, but we will hear from them today on the 2.4 percent increase, right?

A. Yes.

Q. Now I would like to ask you an issue -- ask you about one issue that was raised by Ms. Novak the HCA actuary. What is URRT?

A. That stands for Unified Rate Review Template. It is a federal spreadsheet that is required to be populated and submitted as part of a rate filing.

Q. So it's a federal form; correct?

A. Correct.

Q. If you go to Exhibit 1; please. The very back of it.

(Cell phone ringing.)

MS. HENKIN: Just reminders; cell phones off. And if you haven't signed in, please do so.

BY MR. KARNEDY:

Q. On page 133 and 134. Let me know when you're there. 133, 134.

A. Yes. I'm there.

Q. So is this the URRT form we just talked about?

A. It is. Yes.

Q. And the Health Care Advocate, I'll tell you they blew this up so we could see it better. If you go to HCA-A which is Exhibit A in the binder.

A. Okay.

Q. So this is -- this is a blown-up version of that, right?

A. Correct.

Q. But it's something that we put in our rate filing; correct?

A. Correct.

Q. That's a federal requirement.

A. Correct.

Q. So was this form completed by MVP in compliance with federal law and regulations?

A. Yes.

Q. What was Ms. Novak's issue was your understanding?

A. Her issue relates to a ratio that is shown on worksheet one that reflects the paid to allowed ratio of our claims.

Q. Okay. And what's a paid to allowed ratio?

A. The numerator is the projected medical expense, on a paid basis, so MVP Health Care's liability. An allowed claim expense is the denominator, and that reflects the total cost of care. So the difference between those two is what the member pays.

Q. Okay. And did she have a concern that we didn't use paid amounts?

A. She said that if we used paid amounts that our rate filing was fine, and there wasn't an issue with the rate.

Q. And did we use paid amounts?

A. Yes, we did.

Q. So is this concern that Ms. Novak has about the URRT a valid concern that the Board should be considering today?

A. Not in my opinion.

Q. And what's the difference between the data that was put into this table and the balance of our rate filing? All that was filed with the Green Mountain Care

Board.

A. There isn't really any difference. It's just a different display of our data.

Q. And the data that was put in this table and in our filing is justified and reasonable, right?

A. Yes.

Q. And it was based on actuarial opinions, right?

A. That's correct.

Q. And is MVP reporting data accurately on this form?

A. Yes.

Q. Okay. Now I need to just go through some statutory elements to prove my case. Are MVP's rates excessive or unfairly discriminatory?

A. No.

Q. Why not?

A. Because they were priced to be actuarially sound.

Q. And are the rates inadequate in your opinion?

A. No.

Q. Do they cover claims costs?

A. Yes.

Q. And do they cover the expected cost of delivering health care for those products?

A. Yes.

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

A. No.

Q. They are actuarially sound?

A. Correct.

Q. And they are fairly charged premium for services covered?

A. Yes.

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

A. Yes, we do.

Q. Do you believe it's important that Vermont insureds have options, more than one carrier in the exchange?

A. We do.

Q. And MVP's been in Vermont for awhile; correct?

A. Yes.

Q. We have a proven track record, would you say?

A. Yes.

Q. And do MVP rates meet the standard of affordability?

A. Yes.

Q. Again they are actuarially justified; correct?

A. Yes.

Q. Just one last piece. Every year we ask about administrative savings, what MVP's up to. We try to innovate and save monies. Could you tell us a little bit about that this year?

A. MVP is always trying to reduce the overhead that we have to add into our premium rates. So we are always looking for ways to maximize, you know, how we do business from a technology perspective and from a people management perspective.

Q. Okay. And would you go to Exhibit 4 please. Exhibit 4. Page two of Exhibit 4.

A. Okay.

Q. And this is again -- this letter is one of the responses to questions from the Green Mountain Care Board's actuary; correct?

A. Correct.

Q. And on the second page you see under five they actually ask us about administrative costs, don't they?

A. Yes.

Q. And there is seven items listed?

A. Yes.

Q. Would you go -- going through all the items fair to say that's a good list of ways that we are trying to save on administrative costs?

A. It is.

MR. KARNEDY: That's all the questions

I have.

MS. HENKIN: Kaili?

CROSS EXAMINATION

BY MS. KUIPER:

Q. Hello.

A. Hi.

Q. I just have a few quick questions. First of all, all the objection letters are signed by Matt Lombardo; is that correct?

A. Yup.

Q. Do you stand by the responses that were given in the objection letter?

A. I do.

Q. Could you turn to Exhibit 5. Template. Are you familiar with this, the questions and responses in this letter?

A. I am, yes.

Q. As far as question one goes, which relates to the paid to allowed issue that Ms. Novak is going to bring up, do you stand by the response that was given?

A. I do.

Q. That the difference is based on a calibration factor and induced utilization?

A. Yes.

Q. Okay. Thank you.

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

THE WITNESS: Okay.

MS. HENKIN: I'll turn to the Board for questions. I'll start today with Mr. Hogan at the end.

MR. HOGAN: Well mine's more of a comment. This was the clearest set of presentations that we have ever had. So thank you.

MR. KARNEDY: Thank you.

MS. RAMBUR: I have one question mostly for my own edification. I'm curious how, although these products are relatively new, I'm curious about the pattern of demographic churn that is expected quarter by quarter.

THE WITNESS: I guess I don't know that we expect demographic churn. I'm not sure I understand your question.

MS. RAMBUR: My question is are the demographics usually fairly stable over a period of time? Because obviously one of the questions here is a 2015 snapshot that has a different demographic pattern. So I'm just curious in general if there was a long time line we would have a sense of how much there is up and down, so I'm just curious if that represents more of an anomaly or a trend or if it's too early to tell.

THE WITNESS: I think it's -- I don't think we could assume that it represents a trend. One of the challenges with the market right now is it's new, and it's evolving. So 2014 was the first year, as you're aware, of the exchange. We had our membership entering into that product portfolio as well as some new membership from outside.

2015 we continued to have some of our existing products and membership moving into the exchange for the first time. So we had some grandfathered policies that people are coming off of. So the book of business is far from stable. It is going to continue to ramp up as people come off of old products that are being discontinued and into this new market.

So the change in the demographics wasn't that material. It amounted to a year or two in average age. So based on actuarial cost curves, you know, as you get older the expected claim expense goes up. However, because there is people coming from all different products and people have different reasons for buying insurance, just because the average age went up does not mean that necessarily the costs will go up, when you're talking about small populations.

MS. RAMBUR: And one other very brief question. I know it's not an issue in this particular hearing, but I'm just very curious about the calculations of the incurred but not reported paid claims, because that seems like it's a very complicated science, and I would just like to very briefly hear you talk about how that's done.

THE WITNESS: So incurred but not reported is simply an adjustment that carriers have to make -- insurers have to make to project what the ultimate claim expense will be. So if we are using 2014 claim experience, we only had two or three months of run out, so we took a snapshot of that 2014 claim experience as of March 2015.

We know that there is lag in health insurance claims. So we know that that experience that we are using is not complete fully, and that we will continue to receive claims for dates of service that were incurred in 2014.

So that IBNR factor is simply ratioing that experience period claim up to an expected fully mature claim level.

MS. RAMBUR: Thank you.

MR. HOGAN: Can you come back to me?

MS. HENKIN: I can.

MS. HOLMES: Sure. I don't know if you can hear me. This is actually just building a little bit on Betty's question about the demographic factor and the single conversion factor. I'm wondering -- maybe this happened a couple years ago, but does the impact of the Affordable Care Act's allowing people up to age 26 to be under their family's policy, does that have any impact on the single conversion factor or the demographic factor at all? Now this infusion of 20 to 26 year olds who tend to be healthier, younger but are now counted as family members, does that affect it at all?

THE WITNESS: It affects it to the extent they are changing the census --

MS. HOLMES: The age.

THE WITNESS: -- that we are using.

MS. HOLMES: Okay. So -- and that wouldn't have anything to do with the discrepancy between L&E and MVP at all?

THE WITNESS: No. This whole conversation is simply about just the average age and contract distribution from one period of time to the other.

MS. HOLMES: Okay. Thank you.

CHAIRMAN GOBEILLE: So my question has more to do with the process and improving it than your presentation today, because I think you're right, that the presentation has improved over the years. And I would echo Con. This is very straightforward and well done.

But my question is maybe a larger one or looking down the river one. We have two regulatory processes that are sort of ill timed. And have you put thought into how we could improve hospital budgeting and rate review? Where it seems that you almost have to submit your rates before you know what they are submitting. And how we could do that better. Or is how we do it now fine?

THE WITNESS: We would love to have that information in advance of our rate filing. So to the extent you're able to change the time line of hospital budgeting to be more in line with the deadlines of rate filings, that would be terrific.

CHAIRMAN GOBEILLE: And when you looked -- if you have had an opportunity to, and I'm probably betting you haven't, because they just came out on Thursday, if you have had an opportunity to look at the hospital budgets, what we are seeing this year is a lower commercial ask than we have seen in other years. And that's just our high level view of it. That may not affect you in a linear way.

But would it be fair to say that knowing that could have impacted this submittal, and so somehow fixing that in the future, as you've said, may be better for the Vermonters buying these products.

THE WITNESS: Yes.

CHAIRMAN GOBEILLE: Okay. Thank you.

DR. RAMSAY: I'm -- Ms. Fish, I'm a family doctor. I suppose you know, you might have heard this from last year, so I constantly come back to the issue of what the role of an insurer is in the health care system as to collect a premium which we are talking about today and to pay a claim based upon the medical decisions that go on between me and my patients.

That being said, I want to go back to the administrative costs. If we go to Exhibit 1 page 17. And go down to category -- I'll wait for you all to get there. So under the category of general administrative expense including QI component, it appears that MVP has allocated out of its 35 dollar PMPM administrative load, three dollars or about nine percent of that to quality improvement initiatives. And you know, I'm thinking about a system that we are focused on called an integrated system of care where we have a blueprint NCQA that's, you know, mentioned in this filing. We have the Accountable Care Organization model, both Medicare shared savings, commercial and Medicaid, we have coalitions that we are building, Home Health, designated -- all of which are really focused on improving the quality of care for my patients.

And I know this is not something that you would be able to specifically answer, but it intrigues me that almost 10 percent of the administrative load is going to quality improvement initiatives. And it's hard for me to know how those are actually helping my patients. I know when I see Medicare shared savings program that have performance and quality measures that I have to attain, that that at some point is helping my patient because it's making me perform better. But -- and it's not, you know, I'm not focused just on MVP. I'm going to ask all of -- both of our qualified health plans this very question. Specific examples of how that nine percent of your administrative load is actually helping my patients' outcomes, helping my patients be healthier.

It's really hard for me as a family physician to connect those dots. So I just wanted this to be on the record. I think it's something that we need to talk about as more -- other entities in this state through an integrated health care system are doing quality improvement initiatives. I would take you back to Exhibit 4. Let's go to Exhibit 4, where MVP's response around past several years -- MVP, this is page two, has taken every opportunity to try and reduce administrative costs. This includes a list of seven things that we have already heard about.

Unless I can be reassured that the quality improvement three dollars and 16 cents per member per month increase that MVP is applying to its administrative costs is actually going to help my patients, their experience of care, or the outcomes of care I provide, I've got to see number eight on here; reduced investment in quality improvement initiatives that are also being done by other actual provider entities in this state as we move towards an integrated health care system.

I'm just -- I'm making the statement to get it on the record. Because I believe it's an important thing to have on the record as we review these rates.

THE WITNESS: Okay. Thank you.

MR. HOGAN: I would like to hear your thinking on that.

THE WITNESS: I guess I'm -- I didn't quite follow your punch line, which you're saying number eight on here you want us to illustrate or you want us to state that we are making efforts to reduce?

DR. RAMSAY: What's the return on investment for my patient for your quality improvement program as opposed to what I know to be the return on investment for other entities, mainly providers that are actually focused on quality improvement programs. Okay. That's the punch line.

THE WITNESS: Okay. And so I mean MVP is making every effort to be nimble and to be good stewards of the expenses that we are loading into premium rates. So our efforts are always around how to have the lowest administrative expense built into our premium rates.

That being said, the QI component of it is not one that we would focus on reducing per se as that is focused on quality improvement which is what

MVP health plan is all about, serving the member and making our communities healthier.

So I can follow up with some more specifics. I'm not an expert on quality improvement initiatives at MVP, so I can't really speak directly to your question. But we can certainly follow up with that.

DR. RAMSAY: That's all I ask. Because when MVP, the HMO product and Blue Cross, I mean this is a new era. We did not have NCQA requirements for the Blueprint patient-centered medical home not many -- five years ago. We did not have quality and performance measures three years ago. We didn't have a coalition of willing providers that are evolving in the state to focus on the triple aim. We didn't have any of those things.

When you all -- Blue Cross and MVP felt the need to make big investment in quality improvement, I understand that. But I'm asking you to look forward into this new world that we are in, especially in Vermont which has tools now in place that most other states don't have.

THE WITNESS: So you're saying that MVP shouldn't have to spend that much money on quality improvement any more because these other programs --

DR. RAMSAY: Has to be really what return it is getting in the new era on that three dollars and 16 cent per member per month. Just like Blue Cross/Blue Shield is going to have to look at that. It's going to have to look at how much money you spend on utilization control. When the shift in financial responsibility goes from you to me, okay, when I am at risk for the total cost of care, you're going to have to look at how those tools that you've used to control utilization become less important, and they become less a part of your administrative burden.

So I don't want to lecture you. I'm just saying it's a new era. I mean I agree with everything else that's been said. This is a hearing that has advanced and gotten better. Thank you, Gary. Thank you, Ms. Fish, for doing this and putting this together, and especially thank you for -- you're going to make a lot of my patients very happy when they see this kind of a rate structure for the first time in many years.

Whether or not this changes your market share, that's to be determined. But these are the kind of things we like to see.

MR. KARNEDY: Dr. Ramsay, if we might,

we have a written briefing, a filing that we need to do by Monday. We can include more details to respond to your question.

MS. RAMBUR: It would be helpful hearing this conversation to understand which pieces of the quality improvement are directed at quality improvement within MVP, which are at the level of the health system, which are at the level of individual clinical organization, not integrated, but just to understand the different piece of that. Because it seems like there is probably, I'm assuming, a lot of different levels of QA, I'm assuming.

THE WITNESS: Yes.

MS. HENKIN: Anything else from the Board? Board counsel?

MR. DONOFRIO: No.

MS. HENKIN: Thank you, Ms. Fish.

THE WITNESS: You're welcome.

MS. HENKIN: I understand that's your only witness.

MR. KARNEDY: Well I guess I would like to rely on DFR's testimony.

MS. HENKIN: We will bring DFR up next. Did let them know this was their time slot, and I think Attorney Chieffo is here to testify I believe.

Are you going to just testify -- ask yourself questions and go through?

THE WITNESS: I suppose I can ask first if you would like, or I can just speak.

MS. HENKIN: We'll get you sworn in.

RYAN CHIEFFO

Having been duly sworn, testified as follows:

MR. CHIEFFO: My name is Ryan Chieffo. C-H-I-E-F-F-O.

Good morning everybody. My name is Ryan Chieffo. I'm an Assistant General Counsel for the Department of Financial Regulation. And I'm Commissioner Donegan's designee today for this hearing.

I would like to speak for just a few minutes, and then I'm happy to take questions from anybody that has. DFR's role here today is to give the Board, all of you, our analysis and opinion of how MVP's rate as filed might affect its solvency. And this role is statutorily defined for this purpose, and it's also consistent with DFR's larger and statutorily defined role for all insurers that operate in Vermont, which is to ensure the stability and solvency of the insurers and of the market, which is a vital consumer protection function.

Now DFR has been in this role as a solvency regulator for many, many years and it is exceedingly rare to see a Vermont insurer become insolvent. For our purposes today, MVP and MVP's parent company are New York companies, and so like all foreign companies, out-of-state companies, DFR relies heavily on its counterparts in New York for the information and the data and the analysis that goes into understanding and monitoring solvency of MVP. DFR then supplements that with its own foreign company licensing framework which itself is solvency based. And regardless of the state Department of Insurance that is the primary regulator for a given company, for solvency purposes the idea is the same, which is that solvency is a complex, dynamic and prospective function. Prospective part is key. Simply because it's a very limited utility to Vermont consumers to -- after their insurer is in financial trouble, to look back at the data and confirm for them that, yes, your insurer is in trouble, which is not to say that past data and experience doesn't play a role in solvency analysis. It plays a very large role.

However, that being said, to simply isolate a single past data point such as a risk-based capital ratio from a previous year's financial statement, is itself inadequate to serve as a proxy for solvency of a company on a going-forward basis. On a going-forward basis, to adequately regulate for solvency, it's DFR and DFR's counterparts in other states that receive exclusive access to a myriad of otherwise very confidential information that informs an understanding and an ability to monitor, and if needed, to intervene to improve a company's solvency outlook.

So that all being said is a kind of where we are coming from. You all have our solvency opinion which was drafted and submitted with MVP's initial three percent average increase rate. Our conclusion at that point was that the rate would serve to maintain the current level of MVP's solvency as you've heard. Since then while we didn't produce a new solvency opinion, we were informed and we were -- we have been in contact with MVP about a 2.4 percent average increase rate rather than a three percent. And the conclusion remains the same, which is to say that it's DFR's opinion that an average 2.4 percent increase to MVP's rates should operate to maintain its current level of solvency.

And so I would be happy to take any questions from anybody that would like to ask.

MS. HENKIN: Attorney Karnedy?

MR. KARNEDY: No questions. Thank you very much.

THE WITNESS: My pleasure.

MS. KUIPER: I don't have any questions either. Thank you.

MS. HENKIN: Board members? Any questions?

MR. HOGAN: So the only thing you added to your solvency letter is the fact that at the 2.4 level they are still solvent.

THE WITNESS: That's correct. Yes.

MS. HENKIN: Nothing else. Thank you.

DR. RAMSAY: I have a question. So given the fact that this book of business is five percent of MVP's total holdings, would there be any rate increase low enough that would threaten their solvency?

THE WITNESS: You know, I couldn't speak to that right now, for a specific one-time rate, even an exchange rate. However I can say that, you know, as a function of time, you know, it's important that insurance companies have adequate rates to maintain their level of solvency. And given rate here, we would have to dive into further analysis.

MS. HENKIN: Others? Thank you.

THE WITNESS: All right. Thank you

very much.

MS. HENKIN: We will continue with the next witness and get moving. I believe you're all complete here, and I'm going to allow -- Attorney Donofrio is going to take testimony from L&E at this point. So Jackie Lee, if you would like to take the stand.

JACKIE LEE

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DONOFRIO:

Q. Good morning, Ms. Lee.

A. Good morning.

Q. You have been -- well not in this room, but you have been in this chair before so to speak, right?

A. Yes, I have.

Q. You provided similar testimony at last year's rate review hearing; correct?

A. Yes. I did.

Q. Nonetheless I'm going to go over some of the same ground we did last year just to kind of establish your background and your expertise, and then just ask you to briefly walk through the work that L&E did related to this case. Okay?

A. Great. Thank you.

Q. Sure. So what's your current job title?

A. I'm a Vice President and consulting actuary with Lewis & Ellis.

Q. Briefly what's your educational background starting with college?

A. I went to college at a small university in

Texas called Texas Lutheran University. And I studied mathematics.

Q. And what did you do from there?

A. After college I went to Connecticut and worked for Cigna from 2005 to 2006, and then went back home to Texas to be warmer. And resided in Dallas where I worked for a smaller insurance company that did -- that provided health care for individuals and small groups called Health Markets, that does business under Mega Insurance and Midwest Life Insurance.

And then from there in 2008 I joined Lewis & Ellis focusing my entire -- most of my career on health insurance. At L&E I have been exposed to pricing projects, doing filings. I did the same at Health Markets, my prior employer, filing with states. And then with the adoption of the Affordable Care Act we have just continued to work on rate filings but from a different angle which is working with states. Our firm works with several states doing rates.

Q. So you do this type of work -- the type of work you do here in Vermont you do with other states as well?

A. That's correct. Our firm -- our particular office which is the Dallas office has contracts with eight states this year. And we have been fairly consistent with that number for the past three years doing rate review analysis. And then our other office in Kansas City does four to five states as well.

So in general our firm handles a lot of states doing rate review analysis on the state's behalf. Now our role in each state varies greatly. Some we are very similar to this situation where we provide a full recommendation. However, there are others where we have a lesser role where we are more of a peer review or provide suggestions, and then we work with actuaries on staff.

Q. Thank you. When did you begin working with the Green Mountain Care Board here in Vermont?

A. Our contract began January 1, 2014.

Q. And could you briefly describe your role under that contract?

A. Sure. Our role with the Green Mountain Care Board was fairly broad. However, over the last two or one and-a-half years, we have handled all rate filings that have come to the Green Mountain Care Board. We analyzed all the rate filings, the details, assumptions and final recommendations from the carriers. And after that we provide a report to the Board with our recommendations. And then we are on standby for hearings. We did the exchange hearing last year. And we answer any questions that the Board may have regarding our recommendations or the filings themselves.

Q. And about how many filings have you reviewed for the Board?

A. In 2014 we handled 25 filings. And in 2015 we have completed six, and we have three currently ongoing.

Q. Can you describe a little bit the process of how -- let's stick with the case at hand and use this as an example, the process you used to review this filing beginning with how did you staff it.

A. Sure. We have a several tier or level in which we review this filing. We start with -- we assign an associate of the Society of Actuaries, and we assign them as a primary reviewer. For the MVP Health Care filings we have assigned Rita Tansen who is an associate with the Society of Actuaries. She has worked on every filing that MVP has submitted to help develop a relationship with the carrier, understand their dynamics, and really be familiar with all of their exhibits and how they price their products. So she is involved on a day-to-day basis working with the carrier, speaking with Matt and Kathleen of MVP.

Then the next level of review is me. I am a peer reviewer for the filing. I work very closely with Rita. I'm generally on most phone calls with MVP, however, a lot of times Rita and Matt now have a working relationship where they can handle a lot of the day-to-day back and forths. But I review all of the filing documents, questions and answers, help come together with her regarding our reports and what our recommendations are going to be, and answer any questions of the Board.

And then our final is Dave Dillon. He holds a similar role that I do. But he oversees -- I mean I oversee both filings as well. But he also oversees both filings as well as every single filing that is in six of the states that our office works on and makes sure that we are having consistency between the carriers in Vermont, plus just industry-wide standards across all of the group -- of the states and making sure we are consistent with federal requirements. That's the general process.

When we are doing our analysis, we look very -- at the very fine level of detail of all of the filings presented, the carriers do a fantastic job putting together lots of exhibits and lots of reports that we look through. But we make sure to also take a step back because sometimes there are assumptions when you look at them in isolation that can appear to be okay, but once you take a step back and look at it in the aggregate, it may not be. So we definitely try to take a step back, look at the final rates, and understand all of them combined and make sure that the final result also makes sense.

Q. Thank you. Have you had a moment to review the exhibit book in front of you?
A. I have.
Q. So you don't need to flip to the exhibits I'm about to reference. But --
A. Okay.
Q. Exhibit 1 is the rate filing itself, right?
A. Yes.
Q. And you've reviewed that?
A. Yes, I have.
Q. And Exhibits 2 through 7 are a series of letters reflecting MVP's responses to questions posed by L&E. And are you personally familiar with all of that information as well?
A. Yes, I am.
Q. Exhibit 8 is the DFR Solvency Analysis. Have you reviewed that?
A. I've read that.
Q. Exhibit 9 is the Lewis & Ellis actuarial opinion. I assume you're quite familiar with that?
A. I helped write that, yes.
Q. And Exhibit 10 is Ms. Novak's report. I assume you've reviewed that as well?
A. Yes, I have.
Q. Thank you. Let's move to -- one more question

about the process. You mentioned you referenced conversations between L&E and MVP's actuaries. Can you describe what role those conversations play in the review process?

A. The actual verbal conversations?

Q. Yes.

A. In general our verbal conversations are more regarding clarifications of written language that they have provided to us, or to just give us a better understanding of an exhibit. Because of the wide breadth of material that we receive and the detail that is provided, sometimes it's just easier to get on the phone and have them walk us through an exhibit rather than spend hours trying to figure out what their approach was. If anything within our verbal conversation we feel needs to be documented such that either the Health Care Advocate or the Board needs to see that, then we will follow up with an objection, an official inquiry, an objection letter, so that that can be documented.

So in general, if there are quote unquote, back door discussions, that we are having, they have no impact on this filing unless we have then followed up. That's partly why there are so many letters back and forth. Generally we follow up and make sure we understand versus asking a lot of clarification questions that could just add to the confusion among these filings.

Q. Thank you. At this point could you flip to Exhibit 9 which is the L&E analysis.

A. Okay.

Q. Now when Lewis & Ellis performed this analysis for the Board you understood that your role is to assist the Board in determining whether -- I'm going to read a bunch of statutory elements here. The proposed rates are affordable, promote quality care, promote access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading or contrary to the laws of this state. And are not excessive, inadequate or unfairly discriminatory.

A. Yes, we understand that's our role.

Q. And you're familiar with that standard; correct? Because it's the standard that has applied in all of the filings you've reviewed here in Vermont?

A. That's correct.

Q. Thank you. What was the overall proposed rate increase?

A. For MVP their proposed rate increase was 3.0 percent.

Q. And when we refer to an overall proposed rate increase, what does overall mean in that --

A. There are several products that were filed within this particular exchange filing. There are various product offerings that have differing benefit structures, different deductibles and co-insurance that a consumer can choose from. And depending on the changes and assumptions that are made, the effect on an individual plan will be different.

And so to understand what that means is they do a weighted average of all their plans with how many members are enrolled in each plan to determine the overall rate increase of 3.0.

Q. Thank you. Could you flip to page 10 please, and down towards the bottom there is a list of your recommendations. Do you see that?

A. Yes, I do.

Q. Just generally, how does Lewis & Ellis arrive at its recommendations in the course of reviewing the filing?

A. In general or for the specific filing?

Q. For this filing. Sorry.

A. Okay. So after our review, several of our recommendations came about through either a change that happened during the course of the review that MVP felt should be reflected in their rates, and had they known this information prior to submission, that would have been reflected. And another was an error that was found that

MVP had made.

So they recommended -- in the course of our questions they noticed that they had referenced an incorrect cell. So those were two of the four bullet points.

The other two bullet points are consistent with prior recommendations that we have made in regards to a demographic factor adjustment and the single conversion factor that we made a recommendation for changes to.

Q. Okay. So let's get specific and talk about each one now.

A. Okay.

Q. Which of the four recommendations resulted from, as you described, an error that MVP recognized in one of their -- one part of their submission?

A. They inadvertently referenced the wrong cell when adjusting for the average policy duration for the 51, 2100 large group. So they made that adjustment and it was a minus .1 percent change.

Q. Next could you explain there is the second bullet -- there is an adjustment for Blueprint payment charges. Could you explain that adjustment?

A. Yes. During the course of the review the Blueprint payment changes came into effect and were notified to -- through the Green Mountain Care Board to all of the carriers and to us, and so we asked if they were planning to -- each of the carriers were planning to make an adjustment for that. And they did, which resulted in a decrease of .4 percent.

Q. Okay. Now so the remaining two bullets, one relates to an increase in the projected index rate related to demographics. And the other is the single conversion factor.

Are those together kind of the Exhibit 12 issue that we heard testimony about?

A. That's the exact issue that it is. Yes.

Q. Could you first explain Lewis & Ellis's recommendation that the projected index rate be increased in order to account for changes in demographics.

A. The indexed rate is a term that the federal government has coined. And it is in general, what the definition is is that the -- this is the anticipated projected claims cost for the population that they are pricing the plans for.

And so when you are doing projections forward you're making a lot of assumptions, you start with a -- your experience period which is -- for MVP is calendar year 2014. And then you make any adjustments that you feel will be more or better reflected of a 2016 population.

Those items can be a trend. If you expect your provider contracts to change, you can make that adjustment at that point in time. If you have changes in your PBM which MVP has had in the past you can make those adjustments at that time as well, anything that is different from your experience period that you foresee happening or changing in the future, that's where you make these adjustments to get your projected amount.

And here we feel like that if you anticipate a change in your demographics that is another place where you would make that change. MVP has stated that they think that their population will be similar to that of their 2014 enrollment. And our difference of opinion is that we feel like a better snapshot of that would be to use the most recent census that they have, because demographics are constantly changing, especially in light of the Affordable Care Act. And we feel like that should be reflected in your anticipated population.

Q. Is the approach that Lewis & Ellis recommends consistent with the -- your review of MVP's rate filing last year for Vermont Health Connect?

A. Yes, it is.

Q. Was there a similar adjustment made last year?

A. Yes. There was a similar adjustment. The same -- it was very similar where they used a -- the experience period census as what they anticipate their census to be rather than what the most recent snapshot of the prior -- the most recent month that they had complete as of the filing submission.

Q. And looking back on page 10 of your -- of the L&E document, this change results in a plus 2.0 percent change; correct?

A. Yes. That's correct.

Q. And now kind of at least in my limited understanding, kind hand in hand with that comes the third bullet; correct?

A. That's correct.

Q. Could you -- first of all, could you just explain what that -- the change is reflected in the third bullet there?

A. Yes. This is the change for the single conversion factor. Kathleen did a really good job explaining this earlier where companies use a per member per month approach to project their claims cost, and in Vermont it's required to switch to a per contract. And so that's what this factor incorporates. And the adjustment and the underlying data needs to be consistent with the demographics that you have used. And that's why in Exhibit 12, they have coupled them together here because it does not make sense to have two separate -- two adjustments that are on two different census projections.

So in the past we have always recommended a demographic change and a single conversion factor change because we need to be -- if you're anticipating a census, that needs to be consistent across both of these factors.

Q. So using Exhibit 12 for the moment, the 12.6 in the lower right box.

A. Yes.

Q. That's the figure that results from L&E recommending -- using the demographic assumption that we talked about a moment ago; correct?

A. That's correct.

Q. So with respect to each of the four bulleted recommendations on page 10, was it L&E's conclusion that each one is actuarially reasonable?

A. Yes.

Q. And taken together would it be actuarially reasonable to do all four?

A. Yes. We do agree.

Q. And in doing so would that result in a rate that meets that statutory -- that lengthy statutory standard of review that I read to you earlier?

A. Yes, it does.

Q. And very briefly you mentioned that you reviewed Ms. Novak's report; correct?

A. Yes, I did.

Q. Is there anything in Ms. Novak's report that would lead you to change or alter the conclusion you just made?

A. No, there isn't.

Q. And same question with respect to the DFR solvency report.

A. No. There is nothing in that report that would make us change our recommendations.

MR. DONOFRIO: Thanks. I have no further questions right now.

MS. HENKIN: Attorney Karnedy.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Welcome back.

A. Thank you.

Q. I just -- first I just have a question on one word and you used it twice. About the data.

A. Yes.

Q. March 2015 you used the word snapshot; right?

A. Yes.

Q. So the data that L&E used is a snapshot for 2015; correct?

A. For the enrollment. Yes.

Q. And you would agree that MVP used a whole year of data 2014, right?

A. That is what Kathleen said. I would have to go back and read through. But sure. Yes.

Q. Okay. Great. This URRT issue that's been raised by Ms. Novak, you had a chance to review her opinions; correct?

A. Yes.

Q. And you heard the testimony of Kathleen on that issue on behalf of MVP, right?

A. Yes.

Q. And would you agree with MVP and Ms. Fish that the URRT issues raised by Ms. Novak have no material impact on the rates as proposed and considered in this case and are simply not material to the Board's consideration of MVP's rate filing?

A. It's my understanding that the URRT issues will not affect rates.

Q. Need not be considered by the Board; correct?

A. And not considered by the Board for this hearing.

Q. Would you agree that MVP aggregately reported its data on the URRT form?

A. Sorry. Would you rephrase the question?

Q. Would you agree that MVP reported accurately on the URRT form?

A. Yes, I believe the URRT is accurate.

Q. And the 2.7 versus the 2.4, you heard Ms. Fish testify regarding MVP's proposed 2.4 percent rate increase, right?

A. Yes, I did.

Q. Is she correct that L&E and MVP used different data methodologies to calculate the single conversion and demographic factor?

A. I would say we used the same methodology but we used different underlying data.

Q. Fair enough. And would you agree with her statement that both approaches, although different, are actuarially reasonable?

A. I believe they are both actuarially reasonable.

Q. And then on solvency you would defer, I think you said to DFR, on their solvency opinion, right?

A. Yes.

Q. And that conclusion on the 2.4 percent increase, right?

A. The DFR?

Q. In other words, DFR testified today -- they filed a letter on the three percent, but they testified today on the 2.4, and you agree with that?

A. Yes.

MR. KARNEDY: Thank you very much.

THE WITNESS: Thanks.

MS. KUIPER: I have no questions for Ms. Lee. Thank you.

MS. HENKIN: Thank you. I'll open it up to the Board then, and I'll start over here.

MS. HOLMES: I don't have any questions.

CHAIRMAN GOBEILLE: All set.

DR. RAMSAY: I just have one question and it is related to Exhibit 12. Particularly around the two different models for enrollment data used and demographic factor. And I just remember from managing the finances of our department over the years about how -- how much variability there was in claims.

I mean November, December nobody wanted an elective procedure done. In July and August all the doctors went on vacation. So can you kind of just explain to me how they can be -- as a non mathematician -- how they can be equally actuarial sound to take a snapshot versus a year?

THE WITNESS: Well in general we -- I think your idea of having a full year and year to year should not change that much unless there is a reason to suspect that. And in our case, we have the Affordable Care Act. And the Affordable Care Act has shaken things up for the last several years.

So what you're referencing I think with doctors going on vacation, and all of those, that affects your claim dollars.

DR. RAMSAY: Right.

THE WITNESS: It doesn't really affect enrollment. I mean I guess technically you could, but enrollment is not really going to be affected by the fact that doctors are going on vacation. So looking at the -- from an enrollment standpoint, I think that with the Affordable Care Act you want to use the most up-to-date information that you can.

With claims -- you can't use claims through 2015 because of IBNR, which is incurred but not yet reported claims, what was brought up during Ms. Fish's testimony.

So it is very common to take a step back and use claims that are a little bit older to ensure that they have had ample amount of time to complete, and you don't have to make as many assumptions about it. However, you do know enrollment numbers. And those you can know at any point in time, you can -- in general subject to systems, you can pull up who's covered right then and there. And I think that one of the reasons this year -- it was brought up earlier that this year the demographic change is not very large whereas last year it was. But last year it was based on -- and I'm -- I had an -- I don't remember this exactly, but it was roughly 2013 calendar year information. And then we, the Board, ruled to make them use 2014 info. And the reason there was such a huge difference was because you had pre-ACA population, and now you're in ACA world. Whereas here even the approach used by MVP it does incorporate some ACA or virtually all.

However there were some issues with Vermont Health Connect enrollment. It was delayed to around April 2014. So there were some issues with that that didn't allow members to enroll as quickly as they would have liked. And so there are still ongoing issues that have happened with the Affordable Care Act, not to mention the fact that even if you had your exact same block of business replicated one year later, everybody got one year older.

Now the assumption could be taken that, okay, some people leave and some people come, and you can just in general keep it the same. And I think that lends to why our recommendation and change is not all that much different whereas last year it was much greater. And the two percent that we have referenced just solely isolating the demographic, that's a fairly normal aging adjustment.

Did that answer your questions?

MS. HENKIN: Anyone else?

MR. HOGAN: Yeah. We have heard really solid testimony from everybody, at a very detailed level.

THE WITNESS: Yes.

MR. HOGAN: But if the Board, and I'm not trying to predict what we will do, but if the Board agreed with the 2.4, that's a 20 percent reduction in their rates. Does that still feel okay to you?

THE WITNESS: Where is the 20 percent coming from?

MR. HOGAN: From 3.0 to 2.4.

THE WITNESS: Okay. I would say in general that the .3 percent difference that we are negotiating here should be okay. However, as we noted in our report, MVP has made strides to be more competitive in this market.

MR. HOGAN: Right.

THE WITNESS: And they have chosen to

make some assumptions that were aggressive, and by aggressive I mean that they, you know, took the lowest that they could to be actuarially sound. And I don't want to retract. I think that their rates are actuarially sound. I think they are sufficient. But that any further decrease could just affect their overall CTR, which in their filing is zero, which means that if there are any assumptions that are incorrect, it could go negative.

However, it's possible that there are some assumptions that they are, you know, have overestimated, and therefore it goes the other way. So there is two sides to this. But I will say that we want to caution the Board on any decreases to these particular rates because it is possible that they are -- for this product they could go negative.

MR. HOGAN: Decreases beyond the 2.4 or the --

THE WITNESS: Beyond the 2.7 that we recommended.

MR. HOGAN: Okay.

DR. RAMSAY: Do you know of any national data, this would -- because you're doing these actuarial assessments all over the country --

THE WITNESS: Right.

DR. RAMSAY: -- that suggest that the sicker people get in sooner, and the healthier people get in later?

THE WITNESS: When you say get in, do you mean to the doctor or get insurance?

DR. RAMSAY: No. Into insurance. Into the affordable care --

THE WITNESS: I would agree if you're sicker you're more likely to enroll as soon as possible.

DR. RAMSAY: Yeah. Okay.

MS. HENKIN: Anything else from the Board?

MR. DONOFRIO: No further questions. Thank you.

MS. HENKIN: Anything else from Mr. Karnedy?

MR. KARNEDY: A follow up if I could.

THE WITNESS: Sure.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. When I asked you on cross exam whether you deferred to the Department of Financial Regulation, you said yes. And you agreed -- also went on you agree with their opining that the 2.4 percent rate increase wouldn't impact the solvency; correct?

A. Yes.

Q. That was your testimony. You just said a moment ago you would caution the Board about the decrease, but you stand by your earlier testimony on the issue of solvency. DFR has spoken and 2.4 is fine in their perspective; correct?

A. Correct. They are the experts in the solvency.

MR. KARNEDY: Thank you very much. That's all I have.

MS. HENKIN: Any questions?

MS. KUIPER: No, I have no further questions.

MS. HENKIN: The Board? We are going to take a 10-minute break at this time. And that will put us back in this room at 10:47.

(Recess was taken.)

MS. HENKIN: Okay. We are going to get started. Go back on the record. Continue the hearing. We have, I believe, only one more person to testify. If anyone here has not signed in, please do so. If anyone here would like to give public comment at the end of this hearing, there is a sign-up sheet. Kelly and Jamie have it in the back of the room, so just get their attention, and you can get your name on the sheet if anyone is interested.

Okay. I think we are ready to continue. HCA, would you like to call your witness?

MS. KUIPER: I would like to call Ms. Donna Novak.

MS. HENKIN: You'll have to speak up, Kaili.

DONNA NOVAK

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. KUIPER:

Q. Could you please state your name and address?

A. Donna Novak. 156 West Calle Guija, in Sahuarita, Arizona.

Q. Thank you. Could you please turn to the document labeled Exhibit 10 in the binder. Could you turn to page 15. Do you recognize this document?

A. Yes, I do.

Q. Can you identify it?

A. It's my CV.

Q. Does your CV provided here include a description of your educational and professional background?

A. Yes, it does.

Q. What is your profession?

A. I'm an actuary.

Q. Do you have an area of specialty in your practice?

A. Yes, health insurance.

Q. What did you have to do to become an actuary?

A. I took a series of exams. And then to retain my credentials, I have to do continuing education.

Q. Do you have any professional certifications?

A. I'm an ASA associate of the Society of Actuaries. I'm an MAAA member of the Academy of Actuaries, and I'm an FCA, a Fellow of the Conference of Consulting Actuaries.

Q. And how long have you been certified as an actuary?

A. Since 1990.

Q. What is your educational background?

A. I have an MA in mathematics, and an MBA in finance and Health Care Administration.

Q. Do you participate in any kind of continuing education? You mentioned that before.

A. Yes, quite a bit.

Q. And could you describe that a little bit?

A. Well we have a requirement of hours, but I typically go over significantly. I think most years I'm over a hundred hours of continuing education.

Q. Are you employed?

A. Yes, I am.

Q. And where are you employed?

A. At a company I founded, NovaRest Consulting.

Q. And how long have you worked there?

A. We founded the firm February of 2002.

Q. What is your experience with actuarial review of health insurance filings, specifically ACA or in total? Just in general.

A. In general, I have been reviewing filings well probably since before I started my firm. But definitely since I started my firm. I review Medicare supplement, I review Medicare filings, I review Medicaid certifications, I've reviewed rate filings, commercial rate filings prior to ACA. And since ACA I review ACA rate filings as well as transitional rate filings and grandfathered rate filings.

Q. And how many -- can you estimate how many ACA filings that you have reviewed?

A. We actually went back and counted them. I've reviewed since 2013 for the first filings, 156 including the Vermont filings.

Q. Your CV says you helped create and review the rate process in two states; the District of Columbia and Puerto Rico?

A. Also -- Minnesota also.

Q. And could you describe that experience?

A. Sure. We interviewed stakeholders and looked at transparency and what was important to different stakeholders; physicians, brokers, insurance companies, consumer advocates. We also interviewed actuaries from states that we thought had very good rate review process, had been doing it prior to ACA, and what their process was, what they thought they were doing well, what they wanted to improve with ACA.

And we developed a process to review the rate filings as well as a template because this happened before the federal template came out. So we developed a standardized template that would standardize the way rate filings were submitted. And we developed a rate filing manual for insurance companies to follow, to again standardize.

Q. Thank you. Have you ever worked for a regulatory agency? Or done work for a regulatory agency?

A. Almost all of my clients are regulatory agencies. Either federal or state.

Q. Do you have experience reviewing the solvency of health care insurers?

A. Yes, I do.

Q. Could you describe this experience?

A. Yes. First, I did the modeling for the medical portion of health risk-based capital as part of an Academy of Actuaries project. The Academy of Actuaries developed the health-based risk capital formula for the NAIC that the NAIC made some changes to and later implemented.

Q. Could you explain what the NAIC is?

A. Sure. National Association of Insurance Commissioners. I've supported state insurance departments in financial exams including exams here in Vermont of Blue Cross Blue Shield of Vermont and MVP. Not MVP, sorry, TVP.

Q. TVHP?

A. Thank you. I headed the work group at the Academy of Actuaries. It was called the solvency work group that helped the National Association of Insurance Commissioners look at potential changes to the risk-based capital formula or other regulatory means of dealing with some of the additional risks that ACA created.

Q. Do you have any other professional experience that you believe is particularly relevant to what you'll be discussing today?

A. As I said, I have done some work in Vermont, as far as with Blue Cross/Blue Shield of Vermont as well as one of my employees has been reviewing the Medicare supplement filings in Vermont.

Q. How much time did you take to prepare for your testimony today?

A. 36 and-a-half hours. As of last Sunday, not including yesterday.

Q. Okay. And do you work for free?

A. Not on purpose. No, I do not.

Q. Is the rate that you received for your work today typical of what you receive for similar work?

A. Yes. The rate review work that I do.

Q. And to the best of your knowledge is the rate you received for your work today typical of what most actuaries would receive for doing similar work?

A. I think our hourly rates are lower than many of the actuarial firms.

Q. I would now ask that the Board qualify Ms. Novak as an expert witness.

MS. HENKIN: Do you have any objection?

MR. KARNEDY: No objection. No.

MS. HENKIN: I don't know if it's necessary, but we will qualify her as an expert actuary witness.

MS. KUIPER: Should I continue?

MS. HENKIN: Yes.

MS. KUIPER: Thank you.

BY MS. KUIPER:

Q. So could you tell us what you did to prepare for your testimony today?

A. I reviewed the original rate filing. I prepared a list of issues, questions that I had around the rate filing. I reviewed the Lewis & Ellis questions as they came in. Objections. The answers from MVP as they came in. I submitted additional questions that were unanswered from the first -- at least the first round, maybe the first two rounds of questions. Those were then submitted to MVP.

We received answers from those objections. I submitted some additional objections. And I believe that the Health Care Advocate also submitted some objections as part of those sets. And then I reviewed the solvency reports -- I'm sorry -- Financial -- Vermont Financial --

Q. Department of Financial Regulation?

A. Thank you. Solvency report. Lewis & Ellis's report came in slightly before I finished mine, and I looked at that also.

Q. Okay. So can I refer you to the exhibit list at the beginning of your binder? Are you familiar with all of the exhibits that are included in the binder?

A. Yes, I am.

Q. And to the best of your knowledge, are the questions that you submitted that were passed on to MVP, are they included --

A. Yes.

Q. -- in the objection letters that are in this binder?

A. Yes.

Q. Is the data and information that you relied upon for this testimony the type reasonably relied upon by actuaries working to review health insurance rates?

A. Yes.

Q. And do you have a peer-review process for your work when you evaluate filings?

A. Yes, I do. One of the other senior actuaries at the firm, I always have a peer review, and this particular case, the other senior actuary at the firm that reviewed it is Rick Diamond. He peer reviewed this.

Q. Could you just speak a little bit to his qualifications?

A. Rick is an FSA. He was the chief actuary at the Maine Bureau of Insurance for many, many years. And has been working along with me and some other actuaries at the Academy of Actuaries trying to help HHS improve their instructions, and ask questions of HHS to see what their instructions for the rate filings, interpretations of those instructions. And --

Q. All right. Thank you. Can I refer you back to Exhibit 10. Do you recognize this document as a whole?

A. Yes, it's my report.

Q. It's your report. Okay. And did you come to any conclusions regarding MVP's filing?

A. Yes, I did.

Q. And what were they?

A. Well actually there were four points. Two had been covered in the objections and objection letter, I think one due to an objection that the Health Care Advocate had asked. And another one was an error that MVP found when they went back and did some review. And then we had asked some questions about average ages and average factors, age factors. And I found that although MVP used 2014, if they used 2015 enrollment, there would be a change in the rates as well due to the change in the factors.

And also I found that although the documentation is so superior this year than -- really was good documentation, there were still some things where I could not tell how some factors had been developed. I asked a question about that, an objection, and the answer still didn't quite line up. And so I felt that any rate filing should include detail -- enough documentation that the reviewing actuary actually understands how all the assumptions and factors were developed. And if there is any deviation from the Federal Unified Rate Review instructions, that that be documented. And it wasn't totally in this case.

Q. Okay. Could I refer you to page 10 of your report.

A. Yes.

Q. And does page 10 on to page 11, does that represent your recommendations?

A. Yes, that's my conclusions.

Q. What are the impacts of your recommendations to the Board?

A. It would be in total, my recommendation as in addition to the -- would be a .3 percent reduction in the rates. Increase in the rates. I'm sorry.

Q. Could you break that out by recommendation?

A. The two that had been previously indicated, Lewis & Ellis report included that as a .5 percent decrease. I recalculated that, and found I agreed with that .5 percent.

The issue of not being able to recreate all of the assumptions is a documentation issue. It doesn't affect the rates at all. And then the demographics, the net effect of that is a .3 percent change.

Q. Okay. Thank you. Did you hear Ms. Lee's testimony regarding her recommendation on this filing?

A. Yes.

Q. And you read L&E's report?

A. Yes, I did.

Q. Is your recommendation regarding demographics, the demographic change the same as Ms. Lee's change regarding demographics?

A. Yes. I got there a little bit different because I focused a little bit more on the age factors than the age. I included both in my report, but the result is exactly the same.

Q. Thank you. And in discussion today that the information used for 2015 demographics is a snapshot, would you expect enrollment to change from the first quarter of 2015 to the full year?

A. Not significantly. You know, people will come in and out of the pool. They will leave Vermont or they will come into Vermont. But I wouldn't expect a huge variation from the first quarter to the full year, now that we have a little bit more stable ACA enrollment process and population.

Q. Okay. Thank you. Are you aware that L&E did not specifically recommend that MVP reproduce its rates according to the federal instructions for the URRT?

A. Yes.

Q. Were you aware of that before you submitted your recommendations?

A. Yes.

Q. Why did you decide to continue to submit that recommendation even though you knew that L&E did not adopt it?

A. As I said, the Academy of Actuaries, we have done a lot of work with HHS to create instructions that would help the filing actuaries and would help the reviewing actuaries understand the rate filing without a lot of additional questions.

I headed up a group that rewrote ASOP 8. The ASOP, Actuarial Standards of Practice, that covers rate filings and rate review. And we also did a -- I participated in the development of a practice note on rate filing and rate review. Pretty consistently it is advantageous that any assumptions that deviate from normal be well documented, and also that documentation be presented that shows that the federal instructions, but more importantly that only the adjustments to the indexed rate that are allowed are being used.

Rates can be developed any way an actuary feels it is appropriate. But then they have to be documented in such a way to show that the federal instructions, and only the adjustments allowed under the federal instructions and the federal law, are included.

Q. Okay. Thank you. Your report uses both the terms paid to allowed and actuarial value or AV. Could you explain the relationship between those terms?

A. Yeah, they are basically the same. They are basically the same.

Q. So they are synonyms?

A. Yes.

Q. So could you explain in a little more detail your analysis on the paid to allowed issue or AV issue?

A. In answer to our question on what was included, because the AV, including a note in the federal instructions, but from my experience also, the AV, that is the benefit AV, the one that is based on the experience of the company, not the standard federal claims distribution, is usually not very different from the weighted average of the federal -- federally calculated actuarial value. So paid to allowed which is based on the company experience is usually not that different. When we ask a question about that difference in the case of MVP --

Q. I'm sorry. Let me back you up. What are the numbers that -- the specific numbers that you were looking at that you were comparing for similarity?

A. Okay. The weighted average actuarial value that comes from the actuarial value calculator is point 70, about 70 percent. And the value that MVP used which is in worksheet one is point 81 or about 81 percent. So quite a bit higher. 81 percent is quite a bit higher than 70 percent and a bigger difference than we would expect.

Q. Okay.

A. And being higher it increases the rates.

Q. All right. Thank you. So in your report on page seven you state that the actuarial value calculator uses a standard set of claims distributions, and therefore company specific paid to allowed ratios will be different but should not be very different.

Could you explain that statement?

A. Sure. The company's claims distribution, although different than the standardized one that's used by the federal government, is typically fairly close unless there is something very unusual about the company's block of business or their provider contracts, which I didn't see was the case with MVP.

Q. Okay. And what are you basing your statement on that they should be -- that they are generally pretty close?

A. Two things. As I say, my experience, but also it's actually in the federal instructions. And on page 53 if I remember correctly there are instructions on the paid to allowed ratio. And it indicates that although they can be different, they should be essentially -- it doesn't say the same. We could quote it if you would like.

Q. Let's first start by talking about your experience, how much of a discrepancy between those numbers do you normally see in your experience of reviewing rate review filings?

A. As I say, a few percentage points at the most. We do have one other filing this year that was significantly lower which means the rates are lower, that we are questioning and asking the carrier to increase the rates.

Q. Just to review, what's the percentage discrepancy that you're seeing in this filing?

A. In this filing? It's the difference between 70 percent and 81 percent.

Q. So that now that you mentioned that the federal instructions are another reason -- are part of your analysis here.

A. Right.

Q. So could you turn to what's marked as Exhibit C.

A. It's not here.

Q. Okay.

(Handing document)

BY MS. KUIPER:

Q. Sorry about that. Are you familiar with Exhibit C?

A. Yes. That's the Unified Rate Review Instructions for 2016, that Department of Health and Human Services publishes.

Q. And does this document provide any

instructions relevant to the issue, the paid to allowed issue?

A. These instructions are instructions for filling out the Unified Rate Review Template or the URRT. But also for all of the adjustments that can be made to the index rate, and specific order that they are made in. And so it's not only filling out the template, but also the rate development.

Q. Okay. Could you point us to any specific instructions on the paid to allowed issue?

A. It's at the bottom of page 53. 4.4.6.

Q. Could you read that section aloud?

A. Sure. So this says: Provide support for the paid to allowed factor in the projection period for the market shown in worksheet one, section three. Demonstrate that the ratio is consistent with the membership projections by plan included in worksheet two. The ratio for each plan should be relatively consistent with the metallic AV, and that's the federal AV from the actual value calculator, for the plan to which the actuary is attesting. However, it's recognized that there may be -- may not be exactly the same due to differences between the insurer's experience, and that's the claims distribution, and the experience underlying the AV calculator.

So it says they should be relatively

consistent.

Q. All right. And do you believe that the difference in MVP's paid to allowed of 81 percent and their weighted average of the federal AV calculator of 70 percent qualifies as relatively consistent?

A. No.

Q. I would now ask that exhibit HCA-C be admitted into the record.

MR. KARNEDY: No objection.

MS. HENKIN: HCA-C is admitted into the record.

(Exhibit HCA-C was admitted into the record.)

MS. KUIPER: Thank you.

BY MS. KUIPER:

Q. All right. Now could you please turn to Exhibit 5. Are you familiar with this letter?

A. Yes, I am.

Q. And does this letter address that paid to allowed issue that you're concerned with?

A. Yes, it does.

Q. All right. And question one, did MVP's answer here help you understand why there is a discrepancy between those two -- the two numbers that you're --

A. In answer to the question we submitted, they indicate that part of the difference is a four percent induced utilization, and part is due to a calibration of their experience.

Q. And was that answer satisfactory to you?

A. I don't like the four percent induced utilization being included. Induced utilization is the additional utilization, because if something costs less, consumers typically buy more of it. So the induced utilization comes from the fact that the richer benefit plans, that the costs of health care services are less for the member. Because MVP was projecting the same population distributed from the same plans between '14 and '16, that extra utilization would already be in 2014, would already be in the 2014 experience.

So adding an additional four percent for more induced utilization seemed inappropriate.

Q. And what was the reason that the federal instructions allow you to have a difference between those two numbers?

A. Because of the claims distribution difference between the carrier and the federal government actual value calculator.

Q. And does induced -- does the induced utilization response that MVP provided, does that fall under the claims distribution --

A. No.
Q. -- reasoning?
A. No.
Q. So do you believe, as explained here by MVP, that their adjustment is permissible under the federal rules?
A. No. I've got to say no.
Q. Thank you. Do you review your recommendations to the Board on the paid to allowed issue?
A. Because I didn't really think the rates had been developed inappropriately, I didn't feel comfortable asking for an adjustment in the rates because of this. If you look at the documentation of the rate developments it's all based upon paid amounts. So because it was all based on something that came after that adjustment, I didn't feel that the rates were incorrect. But I felt the documentation, even if they were including these adjustments and I agreed with them, that original documentation should have said we calculated the AV differently than typical or as instructed by the actuarial value instructions -- sorry, the paid to allowed ratio instructions in the URR Instructions.
So it should at least be documented so we didn't have to go through this.
Q. Why did you feel it's important that it be

documented if you are unsure whether or not it will affect the rates?

A. Because then I could be sure. Right now I can't really tell for sure if they started with an index rate and worked through the instructions, if you would have come to the same rates. I think they would have. But I can't verify that.

Q. Okay. Thank you. So I would like to refer you to HCA Exhibit B. This shows a table starting with the first column titled Recommended Changes to Rate Filings.

Do you believe that this represents all of the recommended changes that we have heard today?

A. Yes.

Q. And under MVP Health Plan do you believe this accurately from your document review and testimony for today represents the points on which MVP has agreed?

A. Yes.

Q. And under Lewis & Ellis, do you believe this accurately represents the recommendations that Lewis & Ellis has submitted today --

A. Yes.

Q. -- in their report? And then finally under Donna Novak, does this accurately reflect your recommendations?

A. Yes.
Q. Thank you.
MS. KUIPER: I would like to ask that HCA-B be submitted for the record.
MS. HENKIN: Any objection?
MR. KARNEDY: No objection.
MS. HENKIN: Absent objection, HCA Exhibit B is admitted into evidence.
(Exhibit HCA-B was admitted into the record.)
MS. KUIPER: All right. Thank you. I have no further questions.
MS. HENKIN: Attorney Karnedy.

CROSS EXAMINATION

BY MR. KARNEDY:
Q. Ms. Novak, how are you?
A. Okay.
Q. If you please, go to Exhibit 10 please which is your report. And go to page six, tell me when you're there.
A. I'm there.
Q. Okay. I want to ask you about this URRT issue. Under findings, section roman numeral 5, the second to last sentence says: If the allowed amounts in the URRT are correct, then the rates are overstated by 3.8

percent.

Do you see that?

A. Yes.

Q. And that was your opinion that there was 3.8 percent in play at least when you wrote this document; correct?

A. Yes.

Q. You would agree with me now that in fact you've learned more that the rate developed was based on paid amounts rather than allowed amounts and therefore your 3.8 percent comes off the table?

A. Yes, I agree with you.

Q. When you were here and you heard Ms. Ellis (sic) testify when I asked her about the URRT issues and her review of your report, and her testifying that on all these URRT issues that you've raised -- testified to, she didn't believe they were material or need to be considered by the Board in terms of the rates here.

You heard that testimony, right?

A. I heard her say that. Yes.

Q. Would you go to page 11, please. So we just looked at a 3.8 percent in your original report. Now I want to look here, there is a sentence under number two. I'm going to read it to you. In the second paragraph. It says: The increase of .3 percent combined with the changes MVP has agreed to, listed above, result in a point two percent decrease in rates. So that was another ground, which we will talk about, but that was another ground .2 percent decrease in rates that you were opining on; correct?

A. Yes.

Q. Now just a moment ago you testified up to a .3 percent decrease, but you said .2, so which one is it?

A. The .3 is after the 2 points that had already been agreed to.

Q. Okay. So this report, if I understand it, you've got 3.8 percent potential reduction and then a .2 or three, so we are talking in total about four percent, or thereabouts, right?

A. I thought we had taken the one off the table.

Q. I'm just adding up what you put in your report. At this time you were thinking it could be up to four percent that should be reduced; correct?

A. Yes.

Q. And if you go to your exhibit which is Exhibit B, please. HCA-B. Exhibit B in the binder. You just talked about this a moment ago. There is the first -- that's a column, right, the first column, there is pluses and minuses. And you went through these in great detail. But the total of all of these is a four percent reduction, if the 3.8 percent is in play, right?

A. Yeah. There is a range in the final row in the first column. And if you took the lowest, I guess.

Q. If you added all the pluses and minuses and included the negative 3.8 percent, four percent rate reduction overall, right?

A. Yes.

Q. So in total, at the time you wrote the report you were asking the Board to reduce MVP's initial rate of three percent by a total of four percent if you go to the outside of your range. In other words, another way of saying that would be take the rate in 2015, and for 2016 it should be one point less, one percentage point less; correct?

A. If you look at my conclusions, the 3.8 percent was not included in my conclusions.

Q. But it was written in your report. I'm just trying to get a sense. It was in play until you got additional information, right?

A. No. My conclusion was that the rates were developed using paid, and so the 3.8 percent which would have been the maximum reduction was not applicable because the rates were developed on the paid.

Q. I'm sorry. I thought that at the time you wrote this report -- I don't want to spend too much and belabor this. You put in the range could be up to 3.8 percent. Now I understand you got information after that. But at the time you wrote the report in play was up to a four percent reduction, isn't that fair?

A. I don't know what information I got afterward that changed that.

Q. Okay. Let me ask it a different way. Three percent's off the table, when you wrote this report you put that percentage or wrote it down in the report, didn't you?

A. Yes.

Q. So on the issue of solvency, your report, I think if you go to page 11, Exhibit 10, page 11, it's the third paragraph under number two. And you see where you say since MVP's solvency level is strong. Do you see that?

A. Yes.

Q. And so your proposed reduction -- based on your proposed reduction you think MVP would have no solvency issues; correct?

A. Correct.

Q. And that was your opinion at the time you wrote this report, and that's your opinion now based on what you heard about MVP proposing a 2.4 percent rate increase, right?

A. That was based on my conclusions in this report along with a zero percent profit margin.

Q. Okay. So as you sit here today would you agree with what DFR said, or defer to DFR that the 2.4 percent rate increase does not create a solvency issue?

A. I would defer to the DFR. Yes.

Q. If you go to page 18 of your report. We are almost done. There is a section that says expert testimony, et cetera, for the last five years. That was part of what you had to let us know about, where you have been an expert testifying in the last five years, right?

A. Yes.

Q. Let's go through these. It looks like the first one you testified as an expert in insurance pricing for prosthetic devices in an arbitration in Nebraska, right?

A. Yes.

Q. And the second one you were an expert on post-purchase financial reconciliation in a Wisconsin arbitration; correct?

A. Yes.

Q. Two arbitrations. Then there is the next one is a California dental reimbursement issue. That was in triple A, triple A arbitration, right?

A. Yes.

Q. And then it lists -- you've also happened to testify in Vermont last year on the Blue Cross matter and on our matter, right?

A. Yes.

Q. So it's fair to say you are an expert in many things; correct?

A. I'm an expert in health care insurance.

Q. But you also are able to testify about prosthetic devices, financial reconciliation and dental reimbursements, everything that's listed here, right?

A. Those are all actuarial issues.

Q. And you were paid to testify in those other matters as well obviously, right?

A. Yes, I was.

Q. Thank you very much.

MS. KUIPER: I just have one more question, if that's okay.

MS. HENKIN: I'll allow you.

REDIRECT EXAMINATION

BY MS. KUIPER:

Q. So you heard testimony today from MVP that their rates are based on their paid amounts. Is it your opinion that they have demonstrated that this is true to the best of your knowledge, have they demonstrated that they are based on the paid amounts?

MR. KARNEDY: I'm just going to object. I didn't ask about that in cross.

MS. HENKIN: I'm going to allow the question.

THE WITNESS: I don't think they have demonstrated how they got from their incurred to the paid. So -- so I'm sorry -- from the allowed to the paid. But once they started the paid, they have a demonstration of the paid amount. The development of the paid.

BY MS. KUIPER:

Q. Have they demonstrated how they got their paid amount to begin with?

A. No.

Q. Okay. Thank you.

MR. KARNEDY: May I have follow up on that?

MS. HENKIN: I will allow it. Had I known this was going to be a volley, I would have started with the Board first, but I'll allow you to --

MR. KARNEDY: I'm happy to defer to the Board if you would prefer.

MS. HENKIN: It may get answered. I'll start with our Chair.

CHAIRMAN GOBEILLE: Thank you. Thank you for coming. I appreciate it. You're sort of coming last, so I'm going to ask you questions, but I think that they are general questions and not necessarily about anyone of the three dueling actuaries that have graced our presence today.

On page four of tab one, if you want to go there, I will say that there are no initials after my name, and I'm not very good at math, so I'm going to need your help, if that's fair.

So when I look at this issue that's before the Board today, I think we get caught up in things that no one in this room understands. And it's really cool. You could hide anything behind it. So I try to go to what is it we are fighting over. So I mean I think you're at a 2.8 is my take. And I think you're at a 2.7, and I think you're at a 2.4. And that doesn't mean anything to most of people in this room at all. It's just a percentage. Lower is probably better than higher because people in the room want affordability.

But next year if the rates have to go up because we blew it, then we didn't do very well either. And so when I look at this, I see there is a little over 6,000 people that are going to be customers of this, right?

THE WITNESS: At least.

CHAIRMAN GOBEILLE: I use different words because I don't really come from this world. I call them customers. And it's about a 32 million dollar thing, right?

THE WITNESS: Yes.

CHAIRMAN GOBEILLE: Pretty simple. Right. So when I think of 2.8 and 2.4, I go to what's a point? Well what's 10 percent. I don't do math. So how much is 10 percent of that, 3.2? Million?

THE WITNESS: Yeah.

CHAIRMAN GOBEILLE: So one point is 320,000 maybe.

THE WITNESS: Yes.

CHAIRMAN GOBEILLE: So tenth of a point is 32,000.

THE WITNESS: Yes.

CHAIRMAN GOBEILLE: So the difference between you and you is 32 thousand dollars. I bet you both got paid that to come here or close to it, and then between you and you, it's 120,000. Which divided by the reserves of the company is .0003 percent.

I mean it doesn't even seem worth fighting over, to the people with 6,419 lives, your price would be 18 dollars and 69 cents more than your price. And I didn't do yours. But that's really what we are fighting over here. You know, so there is manuals, and there is all sorts of gobbledygook words that have been created to make this really hard to understand, but that's the turf we are fighting over is it's 32 thousand dollars a point, and we are four points apart. It's about 120 grand.

THE WITNESS: Yes.

CHAIRMAN GOBEILLE: I want that to be plain to the room and anyone who will read this after you're done with your great work. Because I think that's what's important for people to understand. So how would you have us look at that? Do you have any thoughts on that? And if I'm wrong in any way, please correct me.

THE WITNESS: I think that's a second point.

CHAIRMAN GOBEILLE: Okay. Thank you. That's all I have.

MS. HENKIN: Betty, I'll start with you.

MS. RAMBUR: Okay. Thank you. Thank

you very much. I have just one question.

So our responsibility as I see it is to the public. Looking at both affordability or minimizing lack of unaffordability and solvency. DFR's responsibility is solvency, but we have certain both wings that we are responsible to the public, and as I hear this testimony and embellished by Chair Gobeille's illustration, I'm asking you is there any -- anything about the 2.4 increase that doesn't meet my concern about maximizing affordability and retaining solvency?

THE WITNESS: I think as the Chair pointed out, these numbers are close enough that it's not going to have that large of an impact on either of those issues.

MS. RAMBUR: Thank you. Just one follow up thing, unless I'm not seeing it, I'm not seeing the breakdown by the metal levels for the 2.4. Do we have that somewhere?

CHAIRMAN GOBEILLE: We do.

MS. RAMBUR: Yes. For the 2.4?

CHAIRMAN GOBEILLE: No, not for the 2.4. You're correct.

MS. RAMBUR: We have it for the 2.7. At least I haven't seen it for the 2.4. I would just be curious because there was quite a range between the catastrophic plan and the gold being the lowest, so I would like to be able to just understand what that is.

MR. KARNEDY: We could provide that.

CHAIRMAN GOBEILLE: Could that be included in the Monday?

MS. HENKIN: Yes. We can allow that to be part of the submission, absent any objection to that.

MS. KUIPER: I have no objection.

MS. RAMBUR: Thank you.

MS. HENKIN: Mr. Hogan.

MR. HOGAN: No.

MS. HENKIN: Dr. Ramsay.

DR. RAMSAY: You know the -- thank you for being here, Ms. Novak. The other responsibility we have is we approve the basic benefit package, standard benefit package for the-- all of the products that are allowed to be marketed by the quality health plans.

So I get back to this benefit kind of relativity thing, and just so I'm clear, the fact that according to the URRI AV calculator, MVP had paid to allowed of .7, 70 percent, but they submitted a paid to allowed of .81. And that's where the controversy is.

And just for me in thinking about the comments that I get from my neighbors and colleagues, does that generally mean that there was less cost sharing than would be anticipated for the MVP plans or the MVP enrollees over the past year? 10 percent less?

THE WITNESS: Yes.

DR. RAMSAY: All right. So that's good.

THE WITNESS: But they have to pay more in premium.

DR. RAMSAY: But they paid more in premium, right.

THE WITNESS: It depends on if you use a lot of health care or not, if it's good or bad.

DR. RAMSAY: Okay. Thank you.

MS. HENKIN: Counsel, do you have anything?

MR. DONOFRIO: No, thank you.

MS. HENKIN: Attorney Karnedy, did you still have a follow-up question?

MR. KARNEDY: Given the excellent tenor of the Board's questions, I don't think I have a follow-up question. But I will want to put Ms. Fish on just on that last exchange. I think we have a different answer, and it would be helpful for the Board to hear it.

I can wait until she is done testifying for that one question.

MS. HENKIN: We will finish up the testimony, then if you have a rebuttal witness, we can take that.

MR. KARNEDY: Thank you very much.

MS. HENKIN: Anything else?

MS. KUIPER: Nothing further.

MS. HENKIN: Thank you, Ms. Novak. And I will allow you to recall Ms. Fish.

KATHLEEN FISH

Having been previously duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KARNEDY:

Q. Ms. Fish, on the last exchange a question that Dr. Ramsay asked, what is your opinion as it relates to the impact on premium?

A. So I believe the question you asked was is the difference between the .8 and the .7, what does that mean as it relates to how much members have paid out of pocket?

DR. RAMSAY: Right.

THE WITNESS: And it really is irrelevant to how much members have paid out of pocket. The definition of paid to allowed is it describing the portion of the claim cost that a plan pays versus what the member pays. But comparing those two ratios is not telling us that the member paid more or less. Those are simply ratios, the 81 percent is MVP's actual paid to allowed ratio. The 70 percent is simply a number that's coming out of a federal calculator that has been documented to be flawed.

DR. RAMSAY: Well when we look at we are going to align the benefits and the out-of-pocket expense, which we did a few months ago, we have to use that federal AV calculator as part of our decision making.

THE WITNESS: The sole --

DR. RAMSAY: It may be flawed, but we are kind of in that -- forced to use that too.

THE WITNESS: The sole purpose of the calculator is to -- is to make a level playing field in how carriers represent benefits. So from that perspective, it's reasonable. But it is simply a spreadsheet model that is based on federal data and federal assumptions about how to quantify the impact of cost sharing.

It's a spreadsheet model that's putting a value to the benefit plan. Every insurance company has their own proprietary model that is putting value to benefit plans. And if you ask 10 actuaries, you'll get 10 different actuarial values because we are all using different models and different data.

So yes, it is reasonable to assume that they should be close, but it is not reasonable to assume they should be the same. And I don't believe in this case it is -- it is a larger difference than one would expect, but it is purely based on a federal spreadsheet model and has no bearing on our actual pricing or our actual claim expense.

MS. HENKIN: The Chair has a question.

CHAIRMAN GOBEILLE: So just to prove that I totally don't understand any of this, when we pick the plan designs, we had to figure out what I would call copays, deductibles, I think those are the words you use. Unless a silver comes out at 71.2 percent, there is a range it had to be within, are you saying that that 71 percent that we factored when we turned it over to you, it becomes 81, and it's actually -- silver is actually gold? Because if you can turn silver into gold --

DR. RAMSAY: Trying to make some money here. Come on, work with me.

CHAIRMAN GOBEILLE: Is that what's going on here? Obviously platinum can't become a hundred percent. Meaning what I'm saying --

THE WITNESS: Right.

CHAIRMAN GOBEILLE: -- if my premise fails in its extremes, but is that what this information means?

THE WITNESS: Yes and no.

CHAIRMAN GOBEILLE: This has nothing to do with this.

THE WITNESS: Yes and no. So actual

paid to allowed ratios for any given block of business are going to reflect the actual experience of that block. And the smaller the block of business, the more volatility there is in that paid to allowed ratio versus what you would expect. Because if you have a half million dollar claim that's sitting on a 4,000 member block of business, that paid to allowed ratio is going to be inflated. Because there is not a lot of cost sharing on a half a million dollar claim relative to the total claim expense.

So MVP's own pricing models the actuarial values are more closely aligned with the federal calculator versus our actual paid to allowed. And that gets to the point where Donna mentioned we had explained in our response that there was this calibration factor that she was not recognizing, which is simply taking your benefit pricing model and getting it calibrated to your actual experience. We didn't need to do that because we were pricing off of paids. And our pricing model was purely driving premium relativities between our plans. It was not being used to project the paid expense.

MS. HENKIN: And since we have opened it up to the Board, I think there is another question on this end before we go back.

MS. HOLMES: This is actually a follow up to earlier. We had talked about the 2.4 percent being a weighted average across the plans, and you were going to report back on, you know, the distribution across plans. Hoping that also in that may obviously give us is the projected enrollments that you're expecting on those plans. I was hoping that's also in the filing on Monday.

THE WITNESS: You're asking for the projected enrollment by plan?

MS. HOLMES: Yeah. You're going to give us, you know, the rates by plan.

THE WITNESS: We have that. That's in the filing documentation, but we can provide that to you again.

MS. HOLMES: Okay. Perfect.

THE WITNESS: And essentially it's the same enrollment we have in 2014 for our existing ACA-compliant membership, and then some assumptions about how our other existing membership that we used to help set the rates, what plans they will purchase when they go to the exchange.

MS. HOLMES: Okay.

MS. HENKIN: Thank you. Would you like

to continue?

MR. KARNEDY: No further questions. Thank you.

MS. KUIPER: No questions. Thank you.

MS. HENKIN: Does the Board --

MR. HOGAN: I have a question for the Chair. I really thought your earlier question about the timing of these events and the budgeting for the hospitals are really key. How can we fix that?

CHAIRMAN GOBEILLE: They have to be fixed through statute would be my quick answer. The second piece which is a third piece of this, Con, is, what I would call the benefit design phase that we are a part of. And so that happens -- that happened late and took too long, some of that is federal, but some of that is state.

MR. HOGAN: State.

CHAIRMAN GOBEILLE: That then drove the carriers a month back roughly, and I'm not speaking for the carriers, but that made it harder for the carriers. There is a time at which Vermont Health Connect needs to have the rates by just because they have to be put into the computer so that they are ready for January 1.

Something -- an analysis has to be done

of those three steps, the third one being hospital budgeting, to say how can they be done so they are better for the carrier, so they can be more precise in what they are saying, that they are better for the hospitals, so they understand what they are saying, and then it's better for the bureaucracy that does the benefits that we are a part of, so it's all done in a better way.

That's something that I think we have to talk about in terms of our legislative priorities for next year.

MR. HOGAN: Great.

MS. HENKIN: Anything else from the Board? Okay. Anything else from either party here that you would like to present? I would allow you to close, present a quick closing argument, a summation, but other than that, no more witnesses? Nothing.

MR. KARNEDY: My closing argument is it's 11:42. We appreciate the time. Thank you.

MS. HENKIN: Thank you.

MS. KUIPER: I didn't prepare closing argument. Thank you.

MS. HENKIN: And we do have memos coming next week from both parties. We had agreed to dates which I don't have in front of me. I believe you're submitting on Monday.

MR. KARNEDY: On Monday.

MS. HENKIN: Yes.

MR. KARNEDY: Yes. I do have a question on that, if I might. My memory is it's Monday at noon.

MS. KUIPER: That was my understanding.

MR. KARNEDY: What was the page limit? Was it 10 pages, five pages?

MS. KUIPER: I believe it's 10.

MR. KARNEDY: 10.

CHAIRMAN GOBEILLE: Do I hear five?

MS. HENKIN: I really had a hard time even answering that. I see hands going up in the back. But as you know, you can make us happier with five probably, but I believe it was a 10.

MR. KARNEDY: It would be poetry not prose, I promise you that. But there are some things that have been asked for that might be attached.

MS. HENKIN: Attachments are allowed, yes. We asked you for information that I would understand are coming in the form of attachment.

MR. KARNEDY: Thank you very much.

MS. HENKIN: Any questions on that from

either party?

Okay. We do have public comment at this time. There was a sign-up sheet. If you did not get to sign up, I don't know, Kelly, do you have that sheet?

MS. MACNEE: I do. We have Dale Hackett first.

MS. HENKIN: Would you like to stand up and speak up for public comment?

MS. RAMBUR: Does he have to be sworn in?

MR. HACKETT: I would do this --

MS. MACNEE: Do you want him to come up to the microphone?

MS. HENKIN: Yeah. That might help if you can come up and take two minutes or so for comment. And I believe that it is just comment.

MR. HACKETT: Definitely a comment. I have no expertise. Listened carefully to both sides, I have to admit I got lost several times. So I tried to focus on what I thought would be important to the consumer. And what I ended up focusing on was what is experience. We are talking about .4 difference, not arguing much, that's true. So what is experience?

Because all these point differences are around difference and experience. When I looked up in Latin I got for experience, callidus, if I said it right, which historically experience would be something like that. It can be clever, dexterous, skillful, in terms of what it's trying to tell you when you use it. But as a consumer, I'm more interested in the sentio which is experience. As a consumer I'm more interested once I have my plan and how I feel in using it, how I perceive it as I'm using it, and I'm definitely going to have an opinion or hold an opinion as I use what is my plan and have experiences from it. I don't want to buy a competitive edge. I want to buy a plan that delivers health care. If I go too far low in my cost, I'm not going to have a good experience. I may actually increase my costs in the future.

So what I got out of this is maybe I don't want to go too low on my rate. Maybe I just want to look at the experience in the health care delivery and the quality of the plan. Beyond that you can have your four points. I'm interested in what I get. I want the quality of that. That's my comment.

MS. HENKIN: Thank you, Dale.

MR. HACKETT: Thank you.

MS. HENKIN: Anyone else?

MS. MACNEE: Mary Alice Bisbee.

MS. BISBEE: B-I-S-B-E-E. Just like a city in Arizona. I'm Mary Alice Bisbee from Montpelier, and I haven't sat here the whole time, haven't heard the whole thing, and don't always understand it. But as a Medicare recipient I guess a lot of this doesn't really apply in my case for any co-insurances.

I also have UHC. I don't even have Blue Cross/Blue Shield or MVP as a co-insurance. But we are concerned about people coming up. We are concerned about state employees and retirees and some of the other groups that do have some of these plans. I'm fortunate to have Medicare. I wish we had Medicare for all in this whole country.

I wanted to ask a question, is -- tomorrow is the last day for testimony? Written testimony from consumers, right?

MS. HENKIN: Yes. I will announce at the end tomorrow is the last day you can send things either by snail mail or over the Internet to the Board, comments, a comment period. Yes.

MS. BISBEE: I know there are many

people. E-mails are going out. The Worker Center is trying to get a lot of people concerned about their rates going way up. I think for me from looking over some of the statements ahead of time, the catastrophic rates are the ones that really are outliers.

And I understand from what you were saying that it has to do with a million dollar claim or something, that -- and because MVP has so few people compared to Blue Cross Blue Shield, that may be one of the differences. I think as a consumer, some of us are more concerned about the CEO salaries and how it relates to the entire package. The golden parachutes that some CEOs have gotten recently in leaving, even though it's non profits, this may be more for tomorrow. But that's mainly what I have to say.

And I thank you all. I think this is a wonderful arrangement to hear from both sides.

MS. HENKIN: Thank you, Mary Alice. It is just a little bit before noon. I don't think anyone has anything else to say. We have gone through all the public comment. Again, the public comment period remains open through tomorrow. And you can submit through the Web site.

And I'm going to close the hearing and thank everyone for coming today.

MS. KUIPER: Thank you.

CHAIRMAN GOBEILLE: Thank you everyone. And so I will ask the Board to adjourn.

MS. RAMBUR: So moved.

CHAIRMAN GOBEILLE: Is there a second?

DR. RAMSAY: Second.

MS. HENKIN: All those in favor?

BOARD MEMBERS: Aye.

CHAIRMAN GOBEILLE: We are adjourned. Thank you everyone.

(Whereupon, the proceeding was adjourned at 11:50 a.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: Docket Number GMCB007-15rr, at the Second Floor Hearing Room, City Center, 89 Main Street, Montpelier, Vermont, on July 28, 2015, 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 131 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 29th day of July, 2015.