STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

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VERMONT HEALTH CONNECT RATE HEARINGS:
MVP HEALTH PLAN'S PROPOSED 15.4% INCREASE

August 13, 2014
9 a.m.

State House
Montpelier, Vermont

Hearing held before the Green Mountain Care Board, at Room 11 of the Vermont State House, State Street, Montpelier, Vermont, on August 13, 2014, beginning at 9 a.m.

GREEN MOUNTAIN CARE BOARD MEMBERS:

Alfred Gobeille, Chair
Karen Hein, MD
Con Hogan
Allan Ramsay, MD
Betty Rambur, Ph.D., RN

GMCB STAFF:
Judy Henkin, Hearing Officer
Michael Donofrio, Esq.
Susan Barrett, Executive Director

CAPITOL COURT REPORTERS, INC.
P.O. BOX 329
BURLINGTON, VERMONT 05402-0329
(802) 863-6067
(802) 879-4736 (Fax)
EMAIL: info@capitolcourtreporters.com

A P P E A R A N C E S

PRIMMER, PIPER, EGGLESTON & CRAMER
Appearing for MVP Health Plan
150 So. Champlain Street, P.O. Box 1489
Burlington, VT 05402-1489
BY: GARY F. KARNEDY, ESQUIRE
KEVIN M. HENRY, ESQUIRE

VERMONT LEGAL AID, OFFICE OF HEALTH CARE ADVOCATE
7 Court Street, P.O. Box 606
Montpelier, VT 05601-0606
BY: LILA RICHARDSON, ESQUIRE
KAILI KUIPER, ESQUIRE

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MR. GOBEILLE: Good morning everyone. Welcome to day two of the Green Mountain Care Board rate review hearings; festival. Festival.

Today is MVP. So welcome to MVP. Glad to have you here. Just so everyone is aware, I've now formally called our hearing to order. At this point I'm going to turn the hearing over to our Hearing Officer, Judy, and she will take it from here. Thank you, Judy.

MS. HENKIN: Okay. Good morning this nice rainy day. Welcome Schenectady people. This is Docket Number GMCB 17-14. And it's in re: MVP Health Care 2015 Vermont Health Connect rate filing.

This -- I have been appointed by the Chair to conduct this hearing as designee under rule and statute. This hearing is conducted under statutory authority Title 8 Vermont Statutes Annotated Section 4062.

Please everyone, if you have a cell phone, turn your cell phones off. Turn your ringer off.

And this hearing will be done according

to the Vermont Administrative Procedures Act. We have here MVP. Over here we have one witness from MVP this morning I believe; is that correct?

MR. KARNEDY: That's correct.

MS. HENKIN: We have the Health Care Advocate's office over here on the other side of the room. We have the Board's actuaries are here from Dallas. They will be testifying also. And we will have someone from the Department of Financial Regulation.

We also have an opportunity for public comment at the end of this hearing, if there are members of the public that would like to comment, we will reserve time at the very end. You can sign up. Is there still a sign-up sheet? By the door over here. It will be a limited amount of time. There is also the opportunity for public comment through the rate review Web site which you can find via the Board's Web site. You can call. The number is 828-2177, or you could send us snail mail. The comment period ends on the 18th of this month. All comments

must be comments on the specific filing. They are not questions for the Board or any witnesses.

We have a few matters to deal with first. There was a motion in this -- a motion in limine filed by MVP, Attorney Karnedy filed this. Would you like to address this motion now?

MR. KARNEDY: That's fine.

MS. HENKIN: Please.

MR. KARNEDY: So we filed a motion to exclude an August 11, which was Monday, a letter that the Health Care Advocates' expert Donna Novak prepared which we contend changes her testimony. And the basis of the motion which I'll discuss a bit is that it was untimely. It's a last-minute attempt to supplement her and change her opinion, and it's prejudicial to MVP.

I would like to sort of give the procedural background. On June 2 we filed our proposed rates. The Health Care Advocate had about two months to review those rates and analyze our filing, prepare for hearing. On July 1 Ms. Henkin issued a

scheduling order which required that the Health Care Advocate provide their opinions on August the 5th. They did not object to this schedule at the time. And Ms. Novak was presumably already working on her work during the months of June and July to prepare an opinion.

Also on July 1 the Health Care Advocate had the opportunity to pose questions from Ms. Novak to MVP to further prepare for the hearing. On July 30 the Board -- the Lewis & Ellis expert provided an opinion, and one of their opinions related to demographics and the 3.2 reduction in overall rates for MVP.

Fast forward to August 5, Ms. Novak provides a report, and in that report pursuant to the scheduling order she filed it, she indicated that she had reviewed those opinions about demographics, and indicated she did not -- she couldn't comment on it at that point in time.

So then let me tell you about the last week then. So those opinions come in, everything is in the can. We are preparing

for hearing over last week and in the weekend, and then on Monday, six days later after the opinion came in, two days before this hearing, she files a supplemental letter changing her opinions. She indicates that she has now had time to research things. But the letter doesn't discuss anything new, there is nothing as far as I can tell that was not included in the L&E opinion, and Ms. Novak had already had an opportunity to review and opine on our rate filing. So we think that respectfully what may be going on is it's an attempt to, you know, add some numbers and have a larger reduction from her perspective not based on her analysis but based on the analysis of L&E.

And as we agreed on the law it's not really appropriate in our view to allow the expert on the eve of a hearing to change their opinions and circumvent the scheduling order. The Hearing Officer set deadlines in the scheduling order. This case has been run really well this year and very efficient, and it's been very smooth. And

the notion that the order can just be ignored we don't think is appropriate. The Health Care Advocate argues in their opposition motion that those two months to prepare weren't enough time for Ms. Novak to come up with her own opinions. Well we contend that that's simply not true; that that was plenty of time for her to do her own homework, and we don't think it's appropriate at this point to prejudice my client and allow her to testify about any of these new opinions. And we would ask that the letter not be allowed into evidence.

MS. HENKIN: Would you like to respond please?

MS. KUIPER: I would. I apologize. I'm going to be reading quite a bit on this. Ms. Novak's original report was submitted August 5, and on time, and it covers her independent analysis of the filing. Her addendum which was sent out on August 11 at I believe 8:45, or it was a little before 9:00 A.M. so the beginning of the day, was an update to her opinion of Lewis & Ellis's analysis only. So it only addressed her

analysis of Lewis & Ellis's recommendations. The HCA had received Lewis & Ellis's opinion at 5:04 p.m., so after the end of the business day on Wednesday, July 30.

We appreciate that the Board made an effort to get it to us as soon as possible. But that's still inevitably provided three business days between the date we received the recommendation and Ms. Novak's report was due.

L&E's recommendation did not direct the reader to the source of L&E's assumptions pertinent to the calculations they used for their recommendation, so Ms. Novak was not comfortable opining on L&E's recommendations to the extent that she had not researched the bases for the recommendations, which she did not have time to complete before August 5 report was due.

After taking time to conduct diligence -- due diligence and research L&E's recommendations, Donna Novak found that her opinion had modified. Because Donna Novak's opinion had changed from the time of her August 5 report, the HCA sent an addendum to

update her report three business days after her original report was due. We felt that Ms. Novak's addendum was necessary. We felt that was the responsible reaction, that her opinion had changed due to Federal Rules of Civil Procedure Rule 26(E), which says that if an expert has an update to or has an update to their opinion, that you need to -- you need to report on that. And although this isn't a federal proceeding, we felt that was appropriate because we had used this Rule 26 as a basis for our expert witness disclosure in this case, and that was something that all parties agreed to.

We regret that it was not possible for us to provide this earlier. We certainly would have -- we certainly provided it as soon as we could. These proceedings provide a short time frame for all participants. We released the addendum as quickly as possible. This addendum is limited to Ms. Novak's assessment of L&E's calculations on the two of the three L&E recommendations. In her original report she said that she did not have enough information to opine on two

of the three points and that she spent more time researching, and this was an update after she had time to research them. It does not impact the substance of her recommendations.

There is no prejudice to MVP for these comments to be admitted. The report did not present new issues, so they already had the chance to research L&E's recommendations, and any argument that they might have against them, and MVP has the opportunity today to cross examine Ms. Novak on her report and the addendum at this hearing. Thank you.

MR. KARNEDY: Can I be heard briefly? I think this is important precedent for the Green Mountain Care Board. And I'm going to use an example. If we had decided to change our rate filing on Monday, two days before this hearing, that would have been a procedural morass for the Green Mountain Care Board.

I think it's important to allow your Hearing Officer the authority to tell the parties what they are going to do and when

they are going to do it. And that's what we did here. And the notion that -- knowing I was going to be at the Blue Cross Blue Shield hearing yesterday -- to get a change of an opinion the day before, I don't think that's fair. She had six days to do it. We were working weekends. She could have done it before.

But more importantly, I think the precedent of having a process that's fair and that works and can back up your Hearing Officer on scheduling orders, is important. So we would ask that you grant our motion.

MS. HENKIN: I did look at the cases that you cited, and I did look at the rule, and I've read both the motion and the response. At this time I'm going to allow testimony related to this issue. And really the concept behind allowing for the disclosure, and I understand your concerns from MVP's view, is to allow for time for effective preparation for cross exam and for rebuttal, and when the testimony's complex, as you said there is nothing new here. We knew this was going to be an issue in the

case as coming through the testimony of L&E. So I am going to allow testimony at this time. I'm not going to allow for that into evidence, but we will take it if there is a foundation, and I will take the objection under advisement. But I will allow some testimony on this. I will not bar the testimony or direct Ms. Novak not to discuss this.

Okay. With that said, I guess today I will swear in all witnesses again. Although Mr. Cassetty is not here, so I will remind myself that I will need to swear him in separately. Mr. Lopatka is going to testify; correct? And Ms. Novak will testify. Both L&E persons. We will swear them in at the same time.

PETER LOPATKA

DAVID DILLON

DONNA NOVAK

JACQUELINE LEE

Having been duly sworn, testified as follows:

MS. NOVAK: I do.

MS. LEE: Yes.

MR. LOPATKA: I do.

MS. HENKIN: Thanks everyone. Opening statement?

MR. KARNEDY: Yes, thank you.

MS. HENKIN: I do want to remind the parties again if there is anything of a confidential nature that's going to come up in testimony, flag that first for us so we can make sure the room doesn't have people that shouldn't be here in the room listening to it.

Okay. You may proceed.

MR. KARNEDY: My name is Gary Karnedy. I work at the Primmer law firm here in Vermont. And we represent MVP Health Plan, Inc. Kevin Henry is here with me from my law firm. We represent them in this 2015

rate filing.

I'm here today with MVP's Chief Actuary, Pete Lopatka who will be testifying. He testified here the last few years so you remember him. As we discussed when we were here last year for the 2014 filing, the Vermont health benefits exchange statute envisions a reasonable effort to maintain contracts with quote, at least two health insurers, end quote, in the Vermont health benefit exchange. MVP wants to continue to be one of those two insurers. Approving our rates will ensure that Vermonters have choice and will also foster competition.

MVP has a proven track record and a long history of providing affordable health insurance to Vermonters. We request that the Board adopt our 15.4 percent rate increase as filed. The evidence will show that this filing is a result of sound actuarial analysis in the face of rising costs in the marketplace. Those rates meet the statutory standards for approval. We look forward to the opportunity to present evidence regarding MVP's rate increase.

We will try to present the evidence in a simple manner. As you consider the evidence, my hope is that you will give due weight to the best testimony and evidence that you receive on any particular subject. No offense to my clients who are actuaries or the other witnesses that will be testifying, but I find these issues can be pretty dense, or as the Chair put it yesterday, quote, dry, end quote.

So what we are going to try to do is focus our presentation on the issues in dispute and in simple a format as possible. If the Board can't follow a witness, what they are talking about, please let me know. I can't speak for the other witnesses, but I have talked to Mr. Lopatka, and we will follow the KISS rule, keep it simple stupid. Not that he's stupid.

So we ask that you also give due deference to Commissioner Donegan and General Counsel Cassetty, who will be here on behalf of her and her opinions regarding MVP and how MVP's rate filing as proposed will not have a material impact on solvency

and surplus.

The evidence will show that there are differences of opinions between MVP and the Board's actuaries at the L&E. That's no surprise. The evidence will also show there is differences of opinions between MVP and the Health Care Advocates' actuary, Ms. Novak. That's no surprise. She is hired as a barber to give MVP a haircut. Did anyone ever go to the barber and have them tell you your hair looks great? You don't need to have a haircut. And then hold out their hand and say please pay me for that work. No. They always cut your hair in some way.

MR. GOBEILLE: Con, don't take anything from that.

MR. KARNEDY: I apologize to the General Counsel as well.

MR. DONOFRIO: What do you mean?

MR. GOBEILLE: I don't have any idea what he's talking about.

MR. KARNEDY: In this particular hearing though, we would ask you to carefully consider the difference of opinion between the Board's expert and the HCA's expert.

After their diligent work and effort the only reduction that they could initially now, initially now agree upon, amounts to a point one percent reduction. Let me say that again. A point one percent reduction.

Consequently we believe that once you consider the totality of the evidence, we think you will find that MVP's filing should be approved as filed. For MVP your approval of a 15.4 percent rate increase is not merely an aspiration of what MVP wants. The evidence will show that the 15.4 percent is, as the Rolling Stones put it, what MVP needs to survive and hopefully thrive in the Vermont marketplace and provide a choice to Vermonters. Thank you.

MS. KUIPER: My name is Kaili Kuiper. I'm here as a staff attorney for the Office of Health Care Advocate and Vermont Legal Aid. Can you hear me?

We are here today because the federal Affordable Care Act mandated that all citizens have health insurance, and that the states -- each state set up a health insurance exchange. When Vermont set up

their health insurance exchange they did so in a way that required individuals and small businesses to buy their policies on the insurance exchange. So the policyholders and MVP's exchange products have those products because they did what they were supposed to do. They purchased health insurance, and they did it on the exchange.

Now in their second year on the policy, they are facing an over 15 percent average rate increase. Now as we have seen in the public comments that have already been submitted, Vermonters feel that -- many Vermonters feel their exchange products are already unaffordable and that their budget won't allow for any rate increase. And now they are looking at over 15 percent rate increase. Some individuals will get subsidies to help with this. But others, middle income families, small business owners, and small business employees of any income bracket, they are going to have to figure out a way to afford this.

Now I know the Board is sensitive to these issues. But I think it's important

that we bring up Vermont policyholders today because they will not be testifying at this hearing. They will not be testifying because the legislature did not give them the burden to prove that this rate is unaffordable and unsubstantiated. It's MVP's burden to prove that these rates are justified. Therefore, any component of this filing that MVP has not justified those costs should not be passed on to Vermont consumers.

You're going to hear today from two actuaries who were paid to provide an unbiased analysis of this filing. Donna Novak for the Office of the Health Care Advocate is going to tell you that MVP's pharmacy rates are too high, that their administrative trend is too high, and that they made a mistake by double counting a miscellaneous charge in the filing that should not have been double counted.

I believe based on the report Lewis & Ellis is going to agree that the pharmacy rates are too high, and they are also going to explain to you that MVP used 2013 data to

project their 2015 age and family-size demographics when they could have gotten more accurate results by looking at 2014 data.

By adopting these recommendations we believe that that's the appropriate thing to do, because they represent components of the filing where MVP did not meet their burden of proof. In addition, taken as a whole, these recommendations, if adopted, will lower the rate increase today, and make these policies more affordable for Vermont consumers. Thank you.

MS. HENKIN: Your first witness.

MR. KARNEDY: We call Pete Lopatka.

MS. HENKIN: Your only witness.

MR. KARNEDY: Just so we are clear, we have a full set of exhibits, a binder for just all the witnesses to refer to. But some of them may also bring up their own binder. The original exhibits will be one binder.

MS. HENKIN: There is one on the table?

PETE LOPATKA

Having been previously duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KARNEDY:

Q. Pete, I know you just said it to Kim, but could you say it again louder. What is your name please?

A. Pete Lopatka.

Q. And who are you employed by?

A. MVP Health Care.

Q. Okay. And can you explain what MVP Health Care is versus MVP Health Plan, Inc. please?

A. Sure. MVP Health Care represents the entire enterprise. MVP Health Plan is one of the legal entities within the entire enterprise.

Q. So the filing in the Docket is MVP Health Plan Inc., right? On the filing?

A. Correct.

Q. What's your position at MVP please?

A. I'm the Chief Actuary.

Q. Okay. I want to go back a second. Those two entities you were just describing, the corporate entities, there is going to be testimony today about the issue of solvency. You're familiar with that, are you? So when -- can you explain to the Board what other entities they are

of MVP that might play into considering financial issues?

A. Sure. When discussing the general solvency or just financial strength of MVP, it's important to look at it's probably about six or seven different legal entities; some regulated, some unregulated. MVP Health Plan is one of the regulated statutory entities. We also have the health insurance company, in article 42, which is a big piece of our business that's regulated. We have an article 43, it's a different type of business. And then there is a few other regulated. And then there is unregulated for ASO business, and it's the totality of all six or seven of those entities if you want to get a viewpoint or perspective on MVP's financial strength.

Q. Thank you very much. So I forgot if I asked you this. What is your position at MVP?

A. Vice President and Chief Actuary.

Q. And what are your job duties as Chief Actuary?

A. Traditionally it's our primary -- it's pricing and reserving. So pricing for all commercial products in New York and Vermont. And we have Medicare Advantage. And it's -- I have responsibility for reserving and valuation work, so it's setting our IBNR which is our claim liabilities, any valuation reserves that we might have. And then reviewing cost drivers. We get involved with what's driving our health care experience. Also get

involved risk share arrangements with some of the negotiations with hospitals and the health systems.

Q. And you -- how long have you worked at MVP as the Chief Actuary?

A. Four years this November.

Q. And prior to that you worked in the industry?

A. Yes. I have been in the health care industry for 21 years.

Q. And so you have been an actuary for 21 years?

A. Part of that was studying to become an actuary.

Q. Okay. And so do you have any certifications?

A. Yeah. I'm a Fellow with the Society of Actuaries.

Q. How long have you been a Fellow?

A. 11 years.

Q. You've testified before before the Green Mountain Care Board?

A. Yes.

Q. More than once, right?

A. Yes.

Q. You remember the trip from Schenectady to Vermont, right?

A. I do.

Q. So Pete, I would ask you to turn to the binder

which has all the exhibits in it. I just want to do some identification before we get into testimony. So if you look at the first page, there is a stipulated MVP exhibit list. Do you see that?

A. Yes.

Q. So let's go through those, and then I'll move them all in. I believe they are in evidence. Exhibits 1 through 6, as I understand it 1 is MVP's rate filing. And 2 through 6 are the various objection letters, the questions that were propounded on MVP and MVP's responses; correct?

A. Correct.

Q. And you've reviewed all of those exhibits 1 through 6 and are familiar with them; right?

A. Yes.

Q. And then Exhibit 7 is the DFR's solvency analysis letter, and you reviewed that and are familiar with it; right?

A. Yes.

Q. And then Exhibit 8 is the L&E actuarial opinion they did for the Green Mountain Care Board. And you've reviewed that and you're familiar with it, right?

A. Yes.

Q. Exhibit 9 is the report of Donna Novak prepared for the HCA. And you've reviewed that and are

familiar with it; right?

A. Yes.

Q. And then Exhibit 10 Health Care Advocate asked that this go in as to the 2013 MVP Health Plan and annual statement; correct?

A. Yes.

Q. And you're familiar with that as it relates to rate filing contributions and reserve issues that are relevant here; right?

A. Yes.

MR. KARNEDY: So I think we have stipulated admission of Exhibits 1 through 10.

MS. HENKIN: Yes. That's correct.

(Exhibits marked 1 through 10 were admitted into the record.)

BY MR. KARNEDY:

Q. And then just for identification purposes, if you turn to the next page, please, Pete, there is an Exhibit 11 which is our exhibit which is a rate difference summary. You've reviewed that exhibit and are familiar with it; right?

A. Yes.

Q. And then there is an Exhibit 12 which is a summary of the issues that are in dispute in this case.

And you've reviewed that and helped prepare that document. Are you familiar with it, right?

A. Yes.

Q. And then Exhibit 13 is the L&E responses to the HCA's questions for the Board actuary. You've reviewed that and are familiar with it?

A. Yes.

MR. KARNEDY: I think it might make sense now I would move for the admission of 13.

MS. KUIPER: So I'm sorry, which one is 13?

MR. KARNEDY: 13 is L&E's responses to your questions.

MS. KUIPER: Okay. Yes. I also agree with that.

MS. HENKIN: So Exhibit 13 is also stipulated. It's the responses to the HCA questions.

(Exhibit 13 was admitted into the record.)

MR. KARNEDY: Thank you very much.

MS. HENKIN: And 11 and 12 are not.

BY MR. KARNEDY:

Q. Moving to Exhibit 11, if you turn to your

binder then, you've identified this for identification purposes. I've got a blowup of it. First just want to ask you questions about the very first line. And it shows -- what does that show?

A. It's an average of the submitted premium increases for all of our products.

Q. And that's 15.4 percent?

A. Yes.

Q. So could you explain when you say average, you said to me before weighted average, can you explain that please?

A. So it's the requested premium increases vary by product. So not all of our products will be going up at that weighted average, and that's one of the ways to weight it, is by contract or actually by single contract, so that's a weighting by single contract.

Q. So let's go to our Exhibit 1 which is our rate filing please.

MS. KUIPER: I'm sorry. Is this an exhibit? I don't believe this has been admitted yet.

MR. KARNEDY: No. I just marked it for identification purposes.

MS. KUIPER: Okay. Just want to make sure.

BY MR. KARNEDY:

Q. Exhibit 1 which is in evidence. If you would please go to page 59. And I just want to ask you a couple of questions, Pete. This is our rate filing, right?

A. Yes.

Q. So let me know when you're there at 59.

A. I'm there.

Q. And the scope and purpose, do you see that, the first paragraph, scope and purpose?

A. Yes.

Q. And the last sentence says; these rates reflect an average rate adjustment to prior rates of 15.4 ranging from 10.7 to 18.3. So you explain the 15.4.

Would you explain the ranging 18 -- the ranging clause; please?

A. The requested premium increases vary by product. So that's the range within the products, so a low of 10.7 percent, a high of 18.3.

Q. Okay. Can you describe, if you go down under market and benefits, the last sentence talks about our book of business, do you see that?

A. Yes.

Q. Would you tell the Board what we have for policyholders, subscribers and members at the time of this filing?

A. The time of the filing this we had 4,798 members. Roughly 5,000 members.

Q. Roughly 5,000 members. Okay. And so let me ask you the statutory question up front here. After reviewing the other filings in this case and the opinions that have been filed, do you stand by our filed rate of 15.4 percent as meeting the statutory standards such that it is adequate, fair, just, equitable, affordable, not excessive, and promotes quality of care and access?

A. Yes.

Q. About how many hours would you estimate went into this rate filing?

A. All in equivalent of 500 FTE hours.

Q. Okay. About how many people were working on it?

A. Five or six.

Q. Okay. So then I would like to go to this table. I want to walk through the table which I think will help illustrate some of the differences.

Pete, we are just going to focus on numbers now. We will talk about substance later. Okay. So let's start with the L&E overall reduction. Do you see that?

A. Yes.

Q. And it says 3.3 percent. And would you explain to the Board the break down on that, and then I

have a question about the 3.3. But can you explain the break down of the differences between L&E's opinions and ours?

A. Sure. There is two primary differences. One difference in assumed pharmacy trend. And one difference, in total best way to describe it, is in terms of health risk profile or demographics.

Q. And then there is also a line here difference from alleged error in manual rate. Do you see that?

A. Yes.

Q. And what did the L&E conclude on that?

A. That there was no impact. Zero percent for that.

Q. Okay. And was that an issue that they raised, or was that an issue the HCA raised?

A. That was raised by HCA.

Q. Okay. And then what's this line on administrative costs? What's that?

A. That's zero for the L&E opinion.

Q. Okay. So again that's an issue that the HCA --

MS. KUIPER: I'm going to object here. Mr. Lopatka is testifying as to the opinion of other witnesses. There is other exhibits that contain the actual expert's version of

these events, and they speak for themselves.

MR. KARNEDY: I think it's entirely appropriate to summarize what the issues here are so the Board can follow it. I'm 10 minutes into his examination. I don't intend to take a lot of time. This will create a lot of efficiencies, and experts are certainly allowed to opine and talk about what other folks are saying.

I'm just trying to keep it simple.

MS. HENKIN: I'm going to allow you to continue with this. This is just where these issues were raised and who raised these issues from the opinion of Mr. Lopatka. I'm going to allow it.

MR. KARNEDY: Thank you.

BY MR. KARNEDY:

Q. So can we go back for a second? I want to clarify. See that 3.3 percent for L&E?

A. Yes.

Q. So I want to make sure that we are clear that we are apples to apples. Would you please go to Exhibit 13. This is in evidence. And let me know when you're there.

A. I'm there.

Q. And here L&E was asked by HCA to break down their differences. And do you see in the bold that's their response, and do you see they say 3.2, 3.2, they don't say 3.3. They say 3.2. Can you explain the difference to the Board?

A. Yes. In that exhibit 13 page one their starting point is we are asking for a 15.3 percent increase not 15.4. So if you use the 15.4, that would become a 3.3 reduction. If you used a 15.3 it becomes 3.2. There is a bunch of different ways to get a weighted average depending on what you're weighting on.

Q. It's just because their number was different here. It's 15.3. Is this a result of a rounding error? Is this a material issue?

A. It's not material.

Q. Okay. So let's move to the Health Care Advocate overall reduction. And this is based on their filing, not on their recent change of opinion, but on their filing.

What's the total amount of the Health Care Advocate's proposed reduction?

A. In the filing a two percent reduction to rates.

Q. Okay. Would you break that down for us please?

A. Sure. The three components contributing to that are pharmacy trend, alleged error in manual rate, and the different administrative cost assumption.

Q. Okay. So let's do the pharmacy trend then. It says .5, and then it makes a reference to .4. Can you explain that slowly?

A. Yeah. The opinion has an impact of reducing rates .5 percent in total. So it's .4 percent incremental to the L&E reduction.

Q. So this is an issue that they both looked at; correct?

A. Correct.

Q. And then demographics. As it was originally filed, did the HCA make any adjustment relating to demographics?

A. As originally filed, there was no adjustment for demographics.

Q. Okay. And then this manual rate error, they're at .5 percent, right?

A. Yes.

Q. And then administrative costs 1.0, right?

A. Correct.

Q. So as originally filed, the overlap is point one percent; correct?

A. Correct.

Q. Okay. So Pete, now I want to get into the substance a bit to explain to the Board what the substance is of some of these distinctions. So what we have done is made an exhibit which lists the differences based on the filings. And we are going to walk through them and talk about them.

This is just marked for identification as Exhibit 12. And you helped in the preparation of this, right?

A. Right.

Q. So there is a total of five issues that are in dispute; right?

A. Yes.

Q. Okay. And what's the first issue that's summarized here for the Board? And this is in your binder at Exhibit 12.

MS. KUIPER: I'm going to object again. This contains MVP's analysis of what the experts are going to testify about today. And the witnesses can speak for themselves. Mr. Lopatka is welcome to testify on what he believes, but as an exhibit, this is very prejudicial, it's hearsay. It was created outside of this room. And I don't think it's appropriate.

MR. KARNEDY: It's a summary document. I have not offered it into evidence. I'm identifying it. He's going to talk through this. It makes references to exhibits. By the end of going through this document there will be evidence to support its submission. I think the objection is premature.

MS. HENKIN: And this is not offered into evidence at this point?

MR. KARNEDY: It is not.

MS. HENKIN: I will allow you to continue with this. And we do have these witnesses here if there are errors or other reasons to object to this when it's offered for admission. You can do so then.

MS. KUIPER: Thank you.

MR. KARNEDY: Thank you.

BY MR. KARNEDY:

Q. So I'm sorry, Pete. The first issue is the pharmacy trend?

A. Correct.

Q. So let's go by columns. Each column we have MVP, and we have the Green Mountain Care Board's actuary, and then we have the Vermont Health Care Advocate. Let's go through each column, okay?

So start with MVP. Can you explain again -- let's keep it simple. Just the reasoning behind the pharmacy trend?

A. Relied on the expertise of our pharmacy vendor which is CVS Care Mark, and their understanding of and their expertise of what the pharmacy market will look like in 2015 and 2014.

Q. And I should have asked you what's pharmacy trend mean? What does pharmacy trend mean?

A. It's an annual number of the increase -- projected increase in pharmacy costs.

Q. Okay. Good. So we relied on an industry expert for future market trends then; correct?

A. Correct.

Q. Now let's move to L&E. What did they do, going back to our original on the numbers, what was the overall rate reduction that L&E was looking at?

A. Point one percent to total premium.

Q. Okay. And let's walk through their reasoning. And if you go to Exhibit 8 at pages four to five, if you need to that's where it comes from. So would you please slowly walk through the Board their rationale please?

A. Sure. The -- first they indicated that they analyzed 36 months of MVP's historic pharmacy trend experience in Vermont. Then in that Exhibit 8 pages four

and five of L&E's opinion, commented on then they conceded due to other factors such as shifts in generic dispensing rate, drugs losing patents, changes in vendors, historical trends may not be indicative of future trends. And then they concluded in this line of reasoning that in absence of better information, that it would use Blue Cross Blue Shield Vermont specific pharmacy trend of 8.4 percent.

Q. And what are your concerns about that reasoning?

A. That the trend is all historical, and it's competitor's trend, not MVP's.

Q. And why as an actuary is that a problem from your perspective?

A. Well particularly in prescription drugs, one of the largest drivers of what the future is going to look like is what's going to happen with releases of -- well brand drugs either coming to the market or coming off patent. And that's like really what's shook up in the last 10 years. But in the new world now it's specialty. It's the biotech. It's when those -- where they are in their stage of development, and when they are going to be released into the market.

So the future look is very important to understand what's happening in the drug market as opposed to regression or analysis of last three years of what

happened in the past.

Q. But didn't the L&E actuaries concede that the historical trends may not be indicative of future trends?

A. Yes, they have. That is a comment from their filing. Their opinion. I'm sorry.

Q. And then what did they ultimately do then in terms of the data they relied on?

A. Used one from -- which was Blue Cross Blue Shield Vermont's pharmacy trend.

Q. And then moving to the third column, the HCA opinion. How did that affect the overall rate?

A. Reduced it an additional .4 percent of premium, so in total .5 percent.

Q. So you've reviewed their reasoning in Exhibit 9 which is their opinion, right?

A. Yes.

Q. And that's at pages 9 through 11 and 30 through 34?

A. Yes.

Q. And what was -- just generally again we are trying to keep this simple. What was the rationale for the reduction?

A. It's essentially weighting some of the historical experience with the future trend. So it's looking at the history, weighting it with the future, and

coming up with a .5 percent reduction in premium.

Q. Thank you very much. Okay. We have got five issues. This is issue two. What's the second issue; Pete?

A. It's a combination of actual factors that can be summarized as health risk profile. So based on demographics.

Q. Okay. And there is also something about a morbidity adjustment which you're going to explain in a moment?

A. Yes.

Q. Okay. So can you give MVP's reasoning on how you looked at demographics and morbidity in this filing?

A. Sure. We -- it's in general the basic building blocks of premium setting, you take your experience period and trend it forward. So in this case the experience period is 2013. So we took our 2013 experience, made adjustments for the future, and one of the adjustments that we made for that is a two percent reduction in that experience to account for morbidity improvement.

Q. And was that consistent -- on the morbidity issue, was that consistent with the 2014 Green Mountain Care Board order?

A. From last year. Yes.

Q. Yes. And what's your view on the data and the sufficiency of the data to modify that assumption?

A. For -- in our -- where we are now or at the time of the filing, there isn't -- there is some pieces of information but not sufficient data to replace that assumption. Because it includes diagnosis information and whether not just a sex, it's the actual health risk of the population. So we took the '13 experience and reduced it two percent, and that's the assumption of what '14 would look like is the minus two.

Q. Okay. So you reviewed actual claims experience; correct?

A. Yeah.

Q. Now let's look at the Green Mountain Care Board on this second issue. The actuaries L&E. What overall was the overall rate reduction they were looking for?

A. The summary of these changes of the sex and the average contract size have reduced overall premium 3.2 percent.

Q. And you've looked at their filing at pages five -- five through 10 where they explain that?

A. Yes.

Q. And you've also looked at the recent Exhibit 13 which was the answer to the questions that we looked at

a moment ago, right?

A. Yes.

Q. So what is your understanding of their reasoning on the demographic issue, please?

A. It's the combination of this is a way to get at what the -- call it morbidity, call it health risk profile, but what the 2015 population is going to look like. So they used demographic data, so age, sex, no diagnosis, but no claims experience, but the age, sex and contract size distribution which means your mix of basically single and family. Looked at that on April '14. And used that as a factor and added that to the rate development. What they failed to recognize was we already had an assumption in there that was doing that at the minus two percent. So that was left in there while they did this incremental 3.2 percent reduction.

Q. Okay. And you made reference to a particular date. I think it was April 14. Can you explain that? Why you have issues around sort of making a decision based on that point in time?

A. Well it's not -- I don't think it's the 14th day of April, but it's April of 2014. This past April. It's constantly changing. What that distribution looks like April of 2014 may be very different than 2015 which is what we care about here when we are setting premium

rates for 2015. Even if -- like at this point in time if we were to look at our most recent information it might be July or August, a snapshot of 2000 -- of July 2014 might look very different than April 2014.

Q. Okay. So your issue is the snapshot then?

A. Yes. As opposed to an annual -- a year's worth of claims experience.

Q. Okay. And then the last column pointing out the issues, Vermont Health Care Advocate, their August 5, the original filing, not the one that came in on Monday, but the original filing, what was their view on this issue?

A. There was no comment in the original August 5 filing.

Q. And then that's Exhibit 9. Is their filing at pages 13 to 14 that's where they indicate there is no comment?

A. I guess that's where it would have been if there was one in there. Yeah.

Q. Well actually let's go to it. That's Exhibit 9, page 13 and 14.

A. Thank you.

Q. And you see the last two paragraphs above reliance? Actually let's go back to 13. Do you see where there is a heading seven for L&E recommendations at page

13 of Exhibit 9? Do you see that?

A. Yes.

Q. And then that's where they point out what L&E said about the pharmacy trend, right?

A. Right.

Q. Okay. And then those last two paragraphs above reliance, what's the second -- what is the last sentence in each of those paragraphs? Starting therefore.

A. So there is the second to the last paragraph reads; "L&E did not provide quantitative supports for its calculation of the proposed rate change in the index rate. Therefore I cannot comment on this adjustment." And then the next line says the same thing about the single contract conversion factor. "L&E did not provide quantitative support for its calculation of the proposed change single contract conversion factor. I therefore cannot comment on this adjustment." So it is mentioned in here, but there is no opinion on it.

Q. Great. Okay. We are up to issue three of five. What's this issue, Pete?

A. An alleged error in the manual rate calculation.

Q. Okay. And so could you explain from MVP's perspective what this is about please?

A. This is about in a federal form that's

required there is -- that we need to fill out to supplement the rate development, there was an arithmetic error, but it was an arithmetic error in a section that had no bearing on the actual rate development. The section was assigned zero percent credibility in the formula, which means it didn't impact the rate development at all. So it's an error on a form or that needed to be filled out, that didn't have any bearing on rates. So --

Q. So was the manual rate calculated correctly in the development of the rates that we provided to the State of Vermont?

A. Yes.

Q. And then I next go to the column for L&E. Can you explain number three, it says; not referenced, but there is a line through it, there is new language. Can you explain that, please?

A. Yeah. That's in Exhibit 13. In answer number two. And I can go to that and just read right from the exhibit. It says; "L&E does not agree that MVP made an error in developing its manual rate."

Q. Okay. So this is a great thing where we have MVP and L&E agreeing on something, right?

A. Yeah.

Q. Okay. Well be more enthusiastic. That's a good thing.

A. That's outstanding.

Q. An actuarial heartbeat is just -- (indicating) the Vermont Health Advocate, Health Care Advocate. What do they allege please, and how does it impact the overall rate?

A. This error on the exhibit should reduce the overall premium increase by .5 percent.

Q. Okay. And on Exhibit 9 which is their filing at pages 8 and 25 to 29, that's where they talk about this; right?

A. Yes.

Q. And I've put -- or we put these words in. Just explain this, and I'm sure they can testify to it. "Calculation of costs/service should not have been trended for two years as evidenced by the URRT formulas." That's what they contend; right?

A. Yes.

Q. So going back to your earlier explanation just in short --

A. Agree with that, but the -- that calculation had nothing to do with the rate development. So it should not have been trended, but it's really -- it didn't have anything to do with the rate.

Q. So your opinion the .5 comes off the table, right?

A. In my opinion. Yes.

Q. Okay. We are up to issue four. What is issue four please, Pete?

A. Administrative costs.

Q. Okay. And would you please describe from our rate filing, which I believe it's at page 63, you're familiar with it, our view on administrative costs and what we did with this filing?

A. We -- MVP loaded 9.5 percent of premium, same as the 2014 filing. It was an additional network fee that amounts to .4 percent of premium. That additional network fee is because in 2015 we have added a national network and expanded our access.

Q. Okay. And going to the next column, L&E, what was their opinion regarding administrative costs?

A. Their opinion letter stated it found it reasonable and appropriate.

Q. And that's at page six of the opinion letter?

A. Yes.

Q. So are you happy about that that they agreed?

A. Yes.

Q. Okay. And then the Vermont Health Care Advocate, what do they say as it relates to administrative costs?

A. That essentially it's too high and suggested a

reduction that would reduce overall premium one percent.

Q. Okay. And that's reflected in their filing which is Exhibit 9; right?

A. Yes.

Q. That's at pages 11 through 13, 35 through 37 which is their attachment E, right?

A. Yes.

Q. And there is some additional language here, can you please explain what your concerns or disagreement might be on their view on administrative costs?

A. Converting what we load in there at 9.5 percent, our premium comes to a per member per month cost of $40.60. If you look at our 2013 supplemental health care exhibit, which is a statutory filing, it's our actual cost on a per member per month -- per member per month business or basis in Vermont to deliver small group and individual products was $45.58. So what we are loading in is actually 5 dollars pmpm, actually less than what it actually costs us to deliver these products in Vermont.

Q. So if I'm sitting on the Board, I would say well what the heck are you doing? Why less?

A. We recognize always has been a -- important to an insurance company to be able to be efficient. To efficiently pay claims, efficiently answer phone calls, efficiently product develop, efficient actuarial

department. But even in the new world, of -- it's even more important -- because of all the leveling mechanisms that are there for risk. And for leveling the playing field for risk selection, so really the name of the game is being operationally efficient.

And our company over the last year has taken action on that, with much more intensified under contract management, and that's all vendors; IT contracts, banking relationships, any kind of consulting relationship. We are taking a bigger focus on that.

We have reorganized. There are claims operations, our member services to be more efficient. Unfortunately, in after looking at all other areas to get more efficient, earlier this year had a reduction in force of about 100 full-time employees in an effort to actually get more efficient. And that's historical. And for 2014 going forward our singular goal set by the CEO for the remainder of this year is to focus on operational efficiencies. That's core to our service delivery.

And so the answer to the question why would we load in something that's less than what it actually costs us is we are working very hard to get that number down for what it's actually costing us.

Q. Is it fair to say MVP has taken a long view as it relates to Vermont?

A. Yes. I think that's fair.

Q. Okay. Issue five. If you turn to that. What's issue five please?

A. It's a contribution to reserves.

Q. Okay. And would you explain -- our filing at page 63 discusses our contribution to reserves. Can you explain that please?

A. Yes. In our premium rates we have included 1.5 percent contribution to reserves. It's the same as what we proposed for 2014.

Q. And then the next column, L&E, would you explain their view on the contribution to reserves?

A. Sure. Their -- on page Exhibit 8 pages 6 and 7, they have no change recommended on contribution to reserves. And then they also comment to consider the Department of Financial Regulation's analysis on this issue.

Q. Okay. So I got a little ahead of myself. No offense to Mr. Cassetty, but we should talk about the DFR first. The DFR that's Exhibit 7 in the binder, right? And what did Commissioner Donegan indicate as it relates to our rates impacting on solvency and surplus?

A. The rates as proposed will not have a material impact on solvency or surplus.

Q. Okay. So from a Green Mountain Care Board

actuary and from DFR no issue on our proposed contribution to reserves, right?

A. Right.

Q. And looking at the Vermont Health Care Advocate, Ms. Novak, what's their position on contribution to reserves?

A. That it should be decreased from 1.5 percent to 1.0 percent.

Q. Let's go to that Exhibit 9. And page 13 please. You see the section six that's conclusions?

A. Yes.

Q. And do you see the second paragraph where she talks about solvency, do you see that?

A. Yes.

Q. How many sentences of analysis were there on solvency from Ms. Novak?

A. Sentences?

Q. Yeah. Roughly?

A. Three or four.

Q. Thank you. So as -- we have just gone through all these issues. And as filed, the overlap between the two other actuaries was a point one percent reduction, right?

A. Yes.

Q. Okay. I want to go back for a second now,

because Ms. Novak changed her opinion on the second sheet. And I just want to add, you've read and understand how she has changed her opinion, right?

A. Yes.

Q. So does she identify any particular data or information that she reviewed?

A. It's my opinion there was no new data.

Q. Does she reference obtaining from L&E the research methodology that she felt she didn't have earlier on to opine, did she get something from them?

A. Not that I recall from reading the letter.

Q. And is it your understanding that all of the information that was at her disposal when she originally opined, there wasn't any additional information that she needed to concur with the 3.2, right?

A. That's my understanding, there was no additional information.

Q. So based on your work as an actuary, is it appropriate for an actuary just to say me too, or do they need to have their own independent opinion?

A. It's -- I guess I'm going -- you can change your mind. So I think that's what happened here. I think there is a -- it's my opinion it seems like a -- there is a changing their mind.

Q. Okay.

A. That's appropriate to change your mind.

Q. We can all change our mind. Okay. But if you change your mind it should be based on --

MS. KUIPER: I'm sorry. I believe the opposing counsel is testifying now.

MR. KARNEDY: Okay.

BY MR. KARNEDY:

Q. You referenced change your mind. I would like to ask you a question about that. When you change your mind as an actuary, do you do it simply because an actuary said something, or do you do it because you've reviewed additional information?

A. Sorry. It could be reviewing additional information. It could be giving it more thought.

Q. Fair enough. I would like to walk through the -- I was supposed to ask you about the weeds a little bit. Risk-based capital, what is that?

A. That's a mechanism to assess financial strength of an insurance entity.

Q. Okay. And you reviewed those sentences from the Health Care Advocate where -- expert where she talked about solvency; correct?

A. Yes.

Q. And what information did she indicate she reviewed, for what company?

A. The 2013 NAIC annual statement for MVP Health Plan.

Q. Okay. And do you remember at the beginning of your testimony I asked you about -- to describe MVP, the totality of MVP, do you recall that?

A. Yes.

Q. So what's your opinion as it relates to understanding the financial well-being of the company solvency issues as it relates to those different entities?

A. When you talk about MVP's solvency, it's very important to look at it holistically of all of our entities.

Q. Okay. And I would reference you -- it's in evidence -- to Exhibit 10. That's the MVP Health Plan, Inc. annual statement, Exhibit 10. Do you see that?

A. Yes.

Q. So to understand MVP's solvency, does this document answer all the questions?

A. Not as it relates to MVP's financial strength.

Q. Okay. So let's just run through the statutory elements. And we are almost done. Are MVP's rates excessive or unfairly discriminatory?

A. No.

Q. Are they reasonable in relation to the benefits provided?

A. Yes.
Q. Are the rates inadequate?
A. No.
Q. And why not?
A. Because they cover the expected costs of delivering health care for these products.
Q. Are the rates unjust, unfair, inequitable, misleading or contrary to Vermont law?
A. No.
Q. Why not?
A. I guess because they are not. I guess because --
Q. Are the rates actuarially sound?
A. Yeah. They are actuarially sound.
Q. And are we fairly charging a premium for the services covered?
A. Yes.
Q. Actuaries can only answer -- I hear you. Okay.
Do you believe MVP rates promote quality of care and access to health care?
A. Yes. For the quality of care, part of our administrative cost is credentialing. We have case management. We have health care advocates if you buy a certain product. We do have medical management that

promotes quality of care, and that's part of the administrative cost.

Q. You said health care advocates?

A. Yeah.

Q. Can you explain that?

A. Yeah. That's a type of -- they are generally nurses. It depends on what product you've bought, but you can call up, and they will help guide you through the health care system.

Q. What do we do around doctors outside the network?

A. Do around -- well it's inside the network there is credentialing. I guess I don't understand the question.

Q. Well does MVP provide -- you can see a medical care provider that's outside of the network, is that possible?

A. Yes. Well for certain products. Let me think about it for these products.

Q. Doesn't that promote access to health care?

A. Yeah. We have -- and in 2015 we have expanded our network. We added to our international network, so access for these particular products has expanded from '14 to '15.

Q. And how about our administrative costs, are

any of those relating to access to health care, promoting quality care?

A. Yes. That's what we have gone through the credentialing and --

Q. Good. The last thing I want to ask you about is administrative savings. What has MVP done to work toward administrative efficiencies?

A. And I think I hit that earlier. I can summarize it again, but that was -- that's the same question of why would we load in something less than our costs. And what efforts are underway. And it's really contract negotiations. It's reorganize claims operations, member services within the IT department, and unfortunately had to do another layoff.

And in terms of setting the company in forward, like when I set a corporate goal, that means all of the performance incentives, bonuses, performance pay, that risk-based pay is now based on your ability to be more efficient internally.

Q. And this is a sad question, but how many people were laid off?

A. Around a hundred.

Q. And when was that, in 2014?

A. Yeah. It was early 2014.

MR. KARNEDY: So I would move for the

admission of Exhibit 11 based on the testimony and the evidence already in in support.

MS. KUIPER: Again I think the witnesses can speak to these percentages themselves, but I won't object.

MS. HENKIN: Okay. I will admit exhibit MVP 11 into evidence.

(Exhibit MVP 11 was admitted into the record.)

MR. KARNEDY: And then I would move the admission of MVP 12, the summary of issues in dispute. I think it would be helpful to reference later for the Board.

MS. KUIPER: And this exhibit I do object to. It contains extensive explanation of MVP's opinion of the reasoning of the experts. I think the experts need to speak for themselves and use their reports to speak for themselves about their reasoning as opposed to their recommendation.

MR. KARNEDY: I would just say that I carefully went through every column, referenced every piece of evidence that is

now in evidence, so I think it's appropriate, and you can certainly put your witnesses on and they can say whatever they want. And my witness is available for cross exam.

MS. HENKIN: I'm going to allow it. I think this is helpful for the Board as a summary. If in fact there are disputes about what is in here and whether it depicts the HCA's opinion -- expert opinions -- that can come out. We have the witnesses here, so I'm going to allow for admission.

And just a reminder that these are the issues in dispute here, but the Board has authority over all issues regarding the rate. So keep that in mind. And exhibit MVP 12 is now admitted.

(Exhibit MVP 12 was admitted into the record.)

MR. KARNEDY: Thank you very much. So that's all the questions I have for this witness at this time. I may call him back in rebuttal if there is time.

MS. HENKIN: Ms. Kuiper.

CROSS EXAMINATION

BY MS. KUIPER:

Q. Good morning. I ask you to bear with me because this is a very complicated filing. I'm going to start talking about the administrative trend. So I was wondering if you could follow me, Exhibit 1 page 63.

A. I am there.

Q. And this contains -- this is part of your actuarial memorandum; correct?

A. Correct.

Q. And this contains some explanation or some descriptions of your administrative trends; correct?

A. Yes.

Q. Sorry, it's kind of halfway down the page.

A. Yeah. There is a breakdown of the 9.5 between QI and all others.

Q. Could you just read that first sentence that contains sort of your definition of administrative load, starting with the 9.5 percent?

A. "A 9.5 percent administrative load, parenthetical, it breaks down to 1.2 percent of that is for QI, that's quality initiatives, and 8.3 percent is for all other. It's included in the premium rate to cover MVP's expenses, to market, sell and administer health insurance products."

Q. Do you agree with this definition that

administrative expenses are expenses to market, sell and administer health insurance products?

A. Yeah. In general, yes.

Q. Thank you. Isn't it true that today's rate increase for 2015 as you just read it contains a 9.5 percent administrative load, not including your extra expenses for your expansion into other states; correct?

A. Yeah. The 9.5 does not include the network access fee including the rental network. Yes.

Q. And for your 2014 filing, you also had a 9.5 percent administrative load; is that correct?

A. Correct.

Q. So isn't it true that you're spending more money on administration this year, or in 2015 you're proposing to than you plan to spend in 2014?

A. I just want to make sure the assumption is there because we went over -- this doesn't equate to what we spent. This is less than what we spent. So but in general in terms -- I can answer in terms of the assumption. The assumption, there is an incremental, I think it was .4 percent, because it's a different product in '15 than it was in '14. So the cost to market and sell is different in '15 than it was in '14, so there is an incremental .4 percent for the cost of the national network that we have added on to our products.

Q. Could you review again how much the rate filing today is -- your proposed increase is for the entire filing?

A. For weighted average -- using weighting by single, the single contracts is 15.4 percent.

Q. All right. And so when you increase a filing by 15.4 percent, and then you take 9.5 percent of that for an admin cost, that means you're spending 15.4 percent more on admin in 2015 than you were spending in 2014; is that correct?

A. Not spending.

Q. Sorry?

A. Collecting.

Q. Proposing collecting. You're collecting 15.4 percent more for admin in 2015 than in 2014?

A. Yeah. Yes.

Q. And that doesn't include your market expansion costs?

A. Correct.

Q. Okay. Thank you.

A. And am I allowed to answer anything to comment more on that, provide context? When you go down in membership like we have, we have gone -- we are at -- your percentage of fixed cost increases. So meaning there is a certain critical mass of where you're actually covering

your fixed cost.

So yes, what's being built into the premium, the actual admin is going up at that 15.4 percent, but we are going to be well short of what we spend, and a lot of it is because we are below that critical mass level.

Q. Okay. Thank you. And you stated that your admin costs have gone down since 2013; correct? In pmpm numbers?

A. No. I didn't make that representation. I meant the actual what we are loading in for premium is less than what it cost us to do the business. So we are loading in 40 dollars pmpm, and it costs us 45 dollars pmpm. So it's not that the actual costs went down.

Q. I'm sorry. I misspoke on that question. I apologize. The amount charged for your admin in 2013; is that correct? That you testified that it went down between 2013 and 2015 by a per member per month basis?

A. I don't think we talked about 2013 rates. So I'm sorry. Can you restate?

Q. Okay. So you did not testify that your administrative load has decreased between 2013 and 2015?

A. '13?

Q. Yeah.

A. No. I testified on that, it's that our actual -- so comparing to what it's costing us, so I'm saying --

the cost of the 45 dollars pmpm was our cost in 2013. What we are loading in to the '15 rates is 40 dollars. So I'm comparing the pmpm load for the '15 rates to what our actual costs were in 2013.

Q. Okay. And your costs in 2013 those included commissions and brokers' fees; correct, in the administrative trend?

A. That's separate. That's not included in the 9.5. But I'll -- generally that's a separate line item. But I would like to be able to verify that.

Q. Okay. I'm sorry. Can I refer you to Exhibit 1 page 82?

MR. KARNEDY: Excuse me, if you would like a full response, Matt Lombardo is here and he could help supplement that, or I could do it on redirect. Whatever you would prefer.

MS. HENKIN: Why don't we continue with this witness.

MR. KARNEDY: That's fine. My fault.

MS. HENKIN: If we need to bring him in, we can swear in another witness on that single point.

MR. KARNEDY: Thank you very much.

BY MS. KUIPER:

Q. Sorry. You're at page 82 of the Exhibit 1?

A. Yes.

Q. And so this is sort of hard to point to, but sort of in the middle of the page right before the trending project assumptions it has -- is it correct that this has listed the elements that go into the administrative costs for your filing?

A. It would be one of those situations where it's part of a federal form that we need to fill out. And I don't know if you can tell from this exhibit whether it's included in the 9.5 or not. But I can tell you if it's going where -- we didn't load anything in for broker commissions, because we don't use brokers to distribute these products.

Q. You don't -- you didn't use brokers in 2014 and '15; correct?

A. Right.

Q. You did use brokers in 2013?

A. Yes.

Q. Okay. Thank you. So you testified that -- I'm going to move on with pharmacy, that MVP didn't use its own claims history to develop as a part of the calculation in its pharmacy trend; correct?

A. No. We relied on the projected look from CVS Care Mark, yeah.

Q. And CVS Care Mark used national data for that projection; is that correct?

A. National data adjusted for our specific contracts. So unit costs were adjusted, but the utilization was on a commercial population.

Q. Did MVP use national data for their 2014 filing to develop the pharmacy trend?

A. I don't -- I have -- I would have to verify.

Q. Okay. That's fair enough.

Now on to the manual rate error. So you testified that the -- the manual rate error that Donna Novak wrote about in her report was based on the URRT; is that correct?

A. Yes. That's where the error is, on the URRT.

Q. And you stated that because she said that as an example of the error, you can look at the URRT, does that sound correct?

A. Say that again.

Q. In Donna Novak's report she said an example of the error can be seen in the URRT, does that sound right?

A. Yes.

Q. That's where it is.

A. That's where it is.

Q. So let's go ahead and look at the URRT. So that's page 78 of Exhibit 1. Do you recognize this?

A. Yes.

Q. Is it the URRT you were referring to?

A. Yes. This is the page.

Q. Okay. Now if you could hold on to that and let me refer you to Exhibit 5. And on page 6 do you recognize this exhibit?

A. Yes. I'm familiar with this exhibit.

Q. Okay. Can you explain -- this exhibit is a letter that -- or response to a letter that you received questions from MVP; is that correct?

A. Yes.

Q. And so when you're looking at this exhibit, does it -- as far as the -- I'll direct you to the middle section, and the other category. Does it contain the same numbers that the URRT contains?

A. It looks like it does. Yeah.

Q. So is it your testimony --

A. Hold on. The prescription drug other, looks like there is a slight difference. Prescription drug other 1.021. On the URRT is 1.00.

Q. So there is a difference in the prescription drug. And so which one of these is correct?

A. I would have to verify with staff.

Q. But would you say that this information that you responded to -- to L&E with is correct?

A. Yeah. It's -- when I reviewed this back in the office, this correctly identifies the arithmetic error. But what's not highlighted on this page, which is highlighted on the URRT, is there is zero percent credibility, which means it's not used in the development that's on page 78. That's found like halfway down. It says how much credibility is assigned to this calculation. There is 0.00 percent there. So there is an arithmetic error. But it doesn't impact the rate development.

Q. So on this exhibit, these numbers in the others category, they do -- they are calculated into your final result of the 475.35, correct, on that page?

A. No, I'm going to have to bring that back to make sure that I can reconcile this exhibit with the URRT, do some further work on that.

Q. Okay. But you wouldn't send in response to L&E questions an exhibit showing data that isn't incorporated into your filing, would you?

A. Yeah. You know really in good faith if you ask a question whether it's relevant or not, we answer it. I don't know if that's a flaw of an actuary or not, but yeah, if you ask how come this doesn't add up, we are going to tell you why it doesn't add up.

We are also going to tell you that it's not credible. It's not used in the calculation. If you send

-- particularly depending on what analyst level it gets to, you ask them an objective question, they are going to answer it. It wasn't -- the question to the analyst wasn't can you explain why, you know, how this is impacting whatever it was .5 percent of premium rate. The question was on this particular arithmetic how come it's not our number. We answered that.

Q. Let's read the question then on page one. Could you read question two.

A. The entire thing?

Q. Unfortunately, yes.

A. "So we understand that the $475.35 in the URRT and file actuarial Memo Dataset, SERFF, was based on MVP's small group EPO, PPO, and HMO products, and MVP's individual indemnity products. We also understand that the adjustments described under the topic Projection Factors, Worksheet one Section two of Unified Rate Review Template, were applied to the base period incurred claims for those products of $323.62 from answer to L&E question 11 in first set of questions. Please provide qualitative and quantitative documentation starting with the utilization and cost/service by benefit category from the claims files and showing all adjustments to arrive at the projected 2015 allowed claims showing amount of $475.35."

Q. Could you -- again I apologize -- but on page

three it has your written response. Could you -- sorry -- question two. Page three.

A. So two, read the whole two thing? So read everything through two?

Q. Yes please.

A. Okay. "Please see the attached Excel file. Experience period allowed claim data is provided in the Excel file. Allowed claims include claims from our fee for service, FFS claim warehouse, along with additional medical expenses not captured in the claim warehouse such as payments associated with medical home, physician incentive payments, fee for service, write-offs and net reinsurance expenses. An allowance for incurred but not reported paid claims was added to the experience period allowed claims. The IBNR factors were supplied directly from MVP's reserving actuary. MVP uses a combination of pmpm and completion factor method to develop IBNR estimates. Vermont-specific data for the experience period was used to develop the factors, and they are consistent with the IBNR factors used in MVP's monthly financial statements." Keep going?

Q. I think that's -- well, could you -- yes, could you keep going?

A. "MVP determines benefit category based on the type of claim forms submitted in conjunction with the code

and type of code attached to the claim form, i.e., ICD-9, diagnosis code or HCPCS. Member encounter data is used to determine utilization for claims falling under the other category. The medical unit cost and utilization trends shown can be found in Exhibit 2A of the rate filing. Please note that the other trend shown reflects the impact of benefit modifications MVP had to make to meet the essential health benefit requirements. Benefit changes from the experience period to the projection period are shown in Exhibit 3 of the rate filing. The Rx unit cost and utilization trends shown can be found in the total column on Exhibit 2B of the rate filing."

Q. Okay. Thank you.

A. You're welcome.

Q. I'm just going to move on to a couple questions about your RBC. So you've explained what risk-based capital is. Is there a point in your risk-based capital where MVP has a policy that it considers the RBC inadequate?

A. I can give a little more -- elaborate more on risk-based capital. We are primarily regulated for solvency, as evidenced in Susan Donegan's memo, from the State of New York. State of New York does not use RBC. They use a percentage of premium, so it's 12.5 percent of premium. So RBC is not used from -- in our environment,

from a regulatory perspective to actually manage our minimum required reserve levels. So no, we don't manage using RBC because the regulators don't.

Q. That's fair enough. Could you -- in any way of calculating it does MVP have a policy of figuring out a point at which there are -- of which their levels of surplus are inadequate?

A. It's based on the we manage to the 12.5 percent, which for informational purposes is around 400 percent of RBC. It depends. RBC's a more complicated formula. But the primary driver of how much reserves you need to hold to be able to meet the financial obligations you've taken, is how much premium you have. So doing a percentage of premium is like a proxy for RBC. And generally 12 and-a-half percent is a 400 percent roughly.

Q. Okay. Thank you. And is there a point at which -- does MVP have a policy for a point at which their surplus levels are excessive?

A. I do not believe there is a written policy for that.

Q. Okay. Thank you.

MS. KUIPER: I have no further questions.

MR. KARNEDY: Brief redirect.

REDIRECT EXAMINATION

BY MR. KARNEDY:

Q. Pete, when you were testifying you made reference to page 78. This is on that URRT issue. Page 78 of Exhibit 1. I would ask you to go there. And this print is small, which I apologize for, but can you show the Board -- you made reference to something about zero percent credibility. Where that is. Would you point that language out please?

A. Sure. It's about halfway down on this form. It's section three, projected experience, and the line's projected allowed experienced claims ppm with applied credibility of applicable, and that shows zero percent, highlighted with a blue background.

Q. This federal form, this page 78, does this have any bearing on the rate filing for the State of Vermont Green Mountain Care Board?

A. Not in our rates. The arithmetic error that was pointed out did not have any bearing on the rates that we submitted.

Q. Okay. There was a question do we use national data to project 2014 pharmacy trend. He couldn't recall. Matt Lombardo knows the answer. I'd like to have that question answered, if that's appropriate.

MS. HENKIN: Do you have an objection?

MS. KUIPER: No.

MS. HENKIN: Are you through with Mr. Lopatka?

MR. KARNEDY: I am.

MS. HENKIN: You were also through?

MS. KUIPER: Yes.

MS. HENKIN: We are going to reserve you there. You're going to get questions from the Board.

Mr. Lombardo, there is a second seat up there if you would like.

MS. HENKIN: Have a seat. I'll swear you in.

MATT LOMBARDO

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KARNEDY:

Q. Matt, I just have one question for you. Did MVP use national data to project the 2014 pharmacy trend?

A. Yes. It's consistent.

Q. Thank you very much.

MS. HENKIN: Do you have any questions?

MS. KUIPER: I don't. Thank you.

MS. HENKIN: Mr. Lombardo, you may be seated again I believe. If we have questions from the Board, we will bring those up at the time. And now the Board, do you have questions?

MS. RAMBUR: Yes, I have a question about the pharmacy trend piece. I'm assuming that the pharmacy trend utilization varies markedly by the metal level. Could you just talk a little bit about that to me? Is that assumption of mine true? And if so, I'm also assuming that's factored in, so depending on the proportion of participants, there would be a very different kind of

pharmacy trends based on the proportion of the different metals. Is that a true assumption on my part? Could you talk a little bit about that?

MR. LOPATKA: Yeah. Absolutely. Great question. In terms of keeping our eye on, you know, pharmacy behavior, whether it's utilization trend caused by the different metal levels, particularly when you bring in the segments. You might have very different behavior on the different segments. The practical answer is we don't have any real kind of a nice, solid claims set to analyze that yet. We hope to next year and to be able to take that analysis, incorporate that into the trend assumption. We don't have that right now.

But it's absolutely not just the drug, but any of the -- so the usage patterns by not just metal level, but by the subsidy levels. So you might have different usage patterns, you know, with lower income than you do at the mid lower income, than you do with the fully subsidized.

Absolutely, we are going to have a

challenge in terms of just -- not an actuarial thing, but just the credibility. When you start bringing it up into those little segments, it's not stable enough to say we are going to be able to do a real good trend analysis on that. But we certainly keep our eye on what happens, any other studies are done. Call it like meta analysis, like somebody else does a study on it. And we say well that's -- they had a credible data set to work off of. If we think that's applicable to us, we will include that. So we don't have it. We just don't have the experience at this point.

MS. RAMBUR: And my assumption would be in general, catastrophic and bronze would use less pharmacy, is that not --

MR. LOPATKA: Yeah, just in general this is a really difficult time to be an actuary. Because we will see what happens with those assumptions, yeah. Kind of traditional thinking, yeah, you would think the higher the cost share, the less usage, but we will see.

MS. RAMBUR: Okay. Thank you. No

further questions from me.

MR. GOBEILLE: How are you?

MR. LOPATKA: Hi, Al. Good. Thank you.

MR. GOBEILLE: So if my memory serves me correct, there were some issues with MVP's network at the beginning of this year that we are in. Is that why the national network fee and the decision around that, is that to bolster your network?

MR. LOPATKA: I don't -- I'm not -- don't know what network issues we are referring to. But we actually have Andrew here, he might be able to answer that. But I can speak to the decision to have a national network, and it's really a two-player market. It's us and the Blues and they have the Blue Card which is very appealing to Vermonters.

And so to be able to access, you know, care across the country, we needed that in our products to be able to compete with them.

MR. GOBEILLE: Okay. Thank you. Good explanation.

MR. LOPATKA: You're welcome.

MR. GOBEILLE: Thank you, Judy.

MS. HENKIN: Mr. Hogan.

MR. HOGAN: I may not have it exactly right, but at some point in your testimony you indicated that there are other factors beyond the balance sheet that help determine the financial condition of the company. What did you mean?

MR. LOPATKA: I would say it's -- the factor is -- the balance sheet is the main one. It's just that we have seven different balance sheets and Health Plan is one.

MR. HOGAN: I see.

MR. LOPATKA: And specifically looking at the Health Plan this particular one is 2013. In early 2014 MVP transferred on a net statutory basis 65 million dollars out of Health Plan to help shore up other entities. It's not necessarily because Health Plan was doing so well. As membership moves around, the money has got to follow where the member is.

MR. HOGAN: It's timing.

MR. LOPATKA: It's really got to be look at it holistically. Similar to Blue Cross

Blue Shield where you have something similar if you're looking at one set of financials and not looking at the Vermont Health Plan, and then they also have some other things unregulated in their business. So it's very -- when you talk about the strength of a company to look at everything holistically. That was my -- my comment.

MR. HOGAN: Okay.

MS. HEIN: I would like to go back to the beginning of this hearing when Gary made an introductory metaphor about a haircut. And it focused our attention on two players, mainly MVP and Green Mountain Care Board. But our job in this hearing is to consider Vermonters in addition to MVP and the Green Mountain Care Board.

So I would like to ask your opinion about the affordability to Vermonter question. So there have been words like not unjust, not excessive, and so forth in your testimony. In order to put some meat on those bones I'm wondering if you could explain as you have around -- as Blue Cross Blue Shield did, around network adequacy,

around quality, those were all contributions to why the rate requests are what they are.

But we still haven't discussed in these hearings how to think about affordability to Vermonters and how to define excess cost or unjust. And this -- in thinking about that, I think we have a basic issue with MVP, because if we keep that narrow focus on MVP and the Green Mountain Care Board, we may miss the really overarching factor which sounds to me like it has to do with the critical mass of people. If it's under 5,000, we have got a problem here.

And your need to increase rates, but at some point this is really going to bump up against Vermonters' ability to afford those rates. So I'm wondering in widening the lens a bit, can you put some meat on the bones around affordability, around words like not excessive or unjust, and help us really think about this? I don't want to use an analogy to a spiral, but there is a problem with the critical mass, and in your opening testimony you said you want to do business in Vermont. How do we think about

this?

MR. LOPATKA: Start with wow. There is a lot there. What do we do? I mean there is -- I'm not sure where to begin. It's a national health care crisis, it's not just Vermont we worry about the cost of health care. Spending twice as much as the next country and not seeing the outcomes. It's a monster, monster problem. I feel comfortable speaking for our executive team and the leaders of MVP, we care a lot about affordability. We care a lot about affordability for a couple of different reasons. For -- that's part of the mission, is to improve health, improving health is affordable quality access.

MS. HEIN: My question is how do you define it? I think we all care about it. How do you define it?

MR. LOPATKA: It's probably not going to be a satisfying answer from an actuarial perspective. It's that language that says it's not excessive, or it's in relation to the benefits and in relation to the cost of doing business. And so the natural analysis

is, are these rates not overly loaded with profit, and are they going to be able to cover expected costs.

I would like to say on the admin piece though, the critical mass if we looked at the difference between what we are loading in and what it costs us, the 45 dollars versus the 40 dollars, just rough numbers, that's a 5 dollar pmpm. That's about a percent. That's not where the big -- the cost of health care is. It's our unique issue with critical mass. But it's not the primary major issue.

The primary major issue is the cost of hospital services, physician services and prescription drugs. I mean that's 85 percent. You know, for us more than that. Because we are not even running it. It's like 85 percent of the premium.

MS. HEIN: But would your situation not be improved if you had a higher critical mass?

MR. LOPATKA: It would be improved by one point. By 5 dollars pmpm.

MS. HEIN: So I'm just saying how should

we think about this critical mass number, and how can we help to define excess, unjust when it comes to affordability?

MR. LOPATKA: I guess I think there is a different -- I think for me actuarial definition of excessive, unjust is, if it's not -- if it's that far off from costs. That's a different question than the one you're asking which is a much bigger question about what do you do about the health care crisis.

I mean I hate to knock my profession, but it's not like all the answers come through the actuarial lens. What we do is price products that are -- and at this point we haven't been meeting our costs. We have lost -- four or five years. I look back the last four years we have lost money. We don't cover our costs. It's not all due to admin. There is a piece of it, but not the full thing.

And it's -- my lens is to ensure that that premium covers costs because we are not going to be there -- if we are too far below costs, we are not going to be able to

continue to do business.

MS. HEIN: Thank you.

MR. LOPATKA: You're welcome.

DR. RAMSAY: Mr. Lopatka, I'll remind you from last year, I'm a family doctor, so we all look at these issues through our own lens. I've got a couple of very specific questions, and then a couple of comments.

First, getting back to the network fee, I'm assuming -- and you hopefully can confirm that, when you purchase out of network services that .4 percent it is because those services are not available in -- throughout New York, Vermont and New Hampshire. Correct?

MR. LOPATKA: Yup.

DR. RAMSAY: Your entire market.

MR. LOPATKA: It will become an in network benefit. It's an expansion of our network, so it actually becomes an in-network benefit for the Vermonter.

DR. RAMSAY: Has there been a contraction of your New York network in any way in the last year? In other words, because that's -- I hear about that as a way

of people reducing their network size to control their costs.

MR. LOPATKA: We offer in New York limited network products. So you can buy the full network, or you can buy something that's a limited network for a reduced price. You have the option. If you want to make that tradeoff, then you can't go to every -- you know, the network is pretty expansive, and if you want to make the tradeoff I'll take a reduced price and only go to certain hospitals and physicians, we have those.

It's much more difficult to do that in Vermont because of your rural basis. It's hard to carve out.

DR. RAMSAY: Let me get back to the pharmacy trend a little. Just again a very specific question about your decision to change your pharmacy benefit managers. Was that part of your overall goal of efficiency throughout the company? You know, because I mean that pharmacy benefit management expense really is money that goes outside of Vermont.

So tell me about that. And can we expect better pharmacy trending information next year when we look at these rates based on what this decision you make?

MR. LOPATKA: That -- I can answer that question. Yes. We have that with the new vendor. We weren't getting the types -- the more detailed reporting that we needed from our past vendor. That's one of the reasons for moving to this vendor.

But I can answer just in general. The PBM industry is so complicated if you don't check them every two or three years, they are finding another way to make money off you. And it's usually not on the administrative. It's like cuts they are taking on the discounts and rebates and all sorts of things, so every couple of years you have to put it out to bid. It's not really operational efficiency, it's just how you manage your PBM. If you don't check them every two or three years, they're going to take advantage of you. I hope there is no PBM executives in the room.

DR. RAMSAY: Let me also reflect on a

comment you just made. That 85 percent of this -- of the premiums claims that you're going to pay are directly related to professional provider services and drugs. That's where all the trend is going up. Correct?

MR. LOPATKA: That's the bulk of it. We have our work to do on the administrative side, but the cost of health care lies within the delivery of health care services.

DR. RAMSAY: Right. So our attempts as a Board to focus on how we change that delivery system is really critical to every year what we see in terms of your rates.

MR. LOPATKA: I don't know how to say absolutely strong enough. Yes. Absolutely.

MR. GOBEILLE: That's animated for an actuary.

DR. RAMSAY: I know. I got some excitement. So lastly, a couple of comments. One around my knowledge of the pharmacy benefit management process really comes from the fact that our commercial payors, including MVP, have been willing to work with the Board on pilot projects to

reduce the burden of prior authorization for drugs and images, particularly in primary care. And MVP's Director of Government Relations has taken a lead on working with us. I think that's really important.

I think that has the benefit of getting us all -- us providers to understanding the importance of generic prescribing ratios. So I appreciate that effort. Around -- just one other comment around the reimbursement, and this is anecdotal, that's why a practicing physician sits on the Board, is that MVP has in its reimbursement practices -- hopefully has taken somewhat of a lead or taken some initiative in supporting primary care throughout the state, particularly on the independent side. And I hope that all of our commercial payors will continue to look at that on the reimbursement side. I think my neighbors feel like having a good solid relationship with a primary care physician is worth the money that they are spending on it. And that's one we hope to continue to support. So thank you.

MR. LOPATKA: Okay.

MS. HENKIN: Chair Gobeille, you have another question?

MR. GOBEILLE: I do. So yesterday we spent a fair amount of time talking about transitional reinsurance. Something I find to be the most interesting subject of my life. You have chosen as a company to go with the 45 thousand dollar attachment point.

Can you talk about your decision making? And you may not be the right person to ask this of. But can you talk about why you decided that? How you decided that, and what your thoughts are on that decision?

MR. LOPATKA: And yeah. I can decide from an actuarial perspective, is when we develop rates it's a collaborative effort in terms of talking to the network what your projected costs are going to be. In this case it's talking to Government Affairs about what is the most likely mechanism that's going to be in place in 2015. We consult with our internal Government Affairs Department and say what is the mechanism that's going to be in place. And they came

back with the 45,000. And they said that's what's going to be in place. So that's what we priced. So there is a lot of what actually happens is left to be seen. They change their minds and, you know, even like the reimbursement level and all that.

But it's a consultative process with Government Affairs, and that's the mechanism that's going to be in place, and that's what we priced it.

MR. GOBEILLE: Thank you.

MS. RAMBUR: Can I ask a quick -- one of the statistics we heard yesterday was an estimate that roughly 60 percent were going with the higher number. 40 percent with the lower. Do you have a sense of any kind of statistic?

MR. LOPATKA: Nationally? I don't know.

MS. RAMBUR: Okay. Thank you.

MS. HENKIN: Anything else of this witness? Okay. We are going to take a 10-minute break at this point. And then we will hear from Mr. Cassetty from DFR before L&E provides testimony. 10 minutes. Back in this room.

(Recess was taken.)

MS. HENKIN: Okay. Looks like we have most everyone here. Okay. We are back on the record. I would like to just mention that Dr. Ramsay is not going to be here for the end of this hearing. He will review the transcripts. He has to attend a memorial, I believe, and he will not be here for the rest of this. But he did speak to, I believe, both the HCA and Attorney Karnedy that he would not be here.

Next. Department of Financial Regulation has again sent Mr. Cassetty who is going to discuss their opinion. Can you raise your right-hand please?

DAVID CASSETTY

Having been duly sworn, testified as follows:

THE WITNESS: I do. Good morning. David Cassetty, the General Counsel for DFR, as designee of Commissioner Donegan for today's hearing. You've received our solvency impact report. And here to reiterate that the rate filings as submitted do not cause the Department any concern for the solvency of this carrier. And we are here to answer whatever questions you may have.

I would like to point out as the decision makers, your job is in large part to listen to all of the evidence and make up your mind on if there are competing interests that are competing versions of things on what to believe. I want to point out that in the State of Vermont the Department of Financial Regulation is the entity responsible and charged with -- statutorily for reviewing solvency. It is not an actuarial issue. To the extent that any actuaries may be opining on solvency, I

would like to give you our testimony that solvency is not an actuarial issue. It is an issue that is much larger in scope than the information available to the actuaries.

In this case for today's hearing the State of New York is in possession of a vast amount of information regarding approximately seven entities they review to determine solvency. We relied in large part on New York, and we coordinated with New York in reviewing the solvency of this entity.

There is a lot that goes into it, and it's not something that can be viewed or should be viewed in a one-time snapshot off an annual statement of one or all of the enterprises. New York puts a lot of time in on an ongoing continual basis monitoring the solvency of this entity.

Our opinion based on their work and our work, is that this filing as submitted will not impact the solvency of the entity.

MR. KARNEDY: Very briefly. Just so the Board can follow, Dave, there is a binder in front of you which has your letter in it

which is Exhibit 7. So the Board can follow.

THE WITNESS: Sure.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. So Exhibit 7, on the first page of the letter, I just want to point to the summary of your opinion. And I think you just said it indicates DFR is of the opinion the rate as proposed will not have a material impact on the solvency and surplus of MVPHP or MVP Holding Company; correct?

A. That is correct.

Q. And that continues to be the Department's opinion. Correct?

A. That's correct.

Q. And that was based on a review of MVP's filing and the other factors that you just described, right?

A. Correct.

Q. So if you go to MVP's filing which is Exhibit 1 in the binder, and go to page 63. Let me know when you're there.

A. I am there.

Q. Okay. And if you look down about six paragraphs or so, there is a reference to contribution to reserve/risk margin.

A. Yes.

Q. And in it MVP states a 1.5 percent charge is included in the premium rates and serve as either an expected contribution in reserves, maintain solvency requirements, and then it goes on from there, do you see that language?

A. I do.

Q. And so my general question is this was reviewed prior to the Department's letter and opinion which is Exhibit 7, right?

A. Yes. This entire filing was reviewed, and we were basing our opinion on this filing including the 1.5 percent contribution in surplus.

Q. Thank you very much. That's all the questions I have.

MS. HENKIN: Ms. Kuiper?

MS. KUIPER: I just have a question.

CROSS EXAMINATION

BY MS. KUIPER:

Q. You state in your report that you spoke to New York regulators before making your report; correct?

A. We speak with the New York regulators on an ongoing basis.

Q. Okay. And they do not have any concerns about MVP's solvency either?

A. They expressed to us that they were not concerned about the impact of this filing on the company's solvency either.

Q. Okay. Thank you. That's it.

MS. HENKIN: Ms. Hein?

MS. HEIN: I have a question which may -- which may or may not be answerable, that is also in Susan Donegan's letter on page two, it says that finally in 2013 all of MVP's Holding Company operations in Vermont accounted for approximately 5.3 percent of its total premiums earned.

We had prior to your testimony a bit of a discussion around critical mass numbers. And the number of close to 5,000 policyholders and so forth, is the book of business in Vermont for MVP. That's a rather small percent of MVP's overall premium earnings.

In thinking about solvency and then thinking about competitive relationships and having several insurers in Vermont, might you advise us on the number of 5.3 percent of their premiums being in Vermont? How should we think about the whole or just the

part that's in Vermont? Whether it's solvency or from the competitive point of view?

MR. HOGAN: Can I add to that, Karen?

MS. HEIN: Sure.

MR. HOGAN: Over time.

THE WITNESS: Well it's a percentage. So obviously outside of Vermont, and outside of your control, outside of our control is going to be the -- it's going to be the other aspect of that percentage. How much do they grow in New York. How much do they grow in New Hampshire. Since this is expressed as a ratio, so you know, to one extent there is not much you can do about how that percentage is going to, you know, -- if you're concerned about the number five being too low or something, as far as their percentage of the market in Vermont that's a separate question, that the size of their market share in Vermont turns out at current levels to be 5.3 percent of the Holding Company's premiums.

So if your question is really directed to their market share, I think that's a

different question.

MS. HEIN: Yeah. The question is we have to balance two considerations. Solvency, we are trying not to put companies out of business. And affordability, that's our basic job. When we now think about solvency, we are thinking about a large company with a lot of other considerations that's largely based down south in New York and doesn't even calculate the solvency the way Vermont attempts to. They use percent of premium. We tend to use RBCs along with other things.

So it's a much bigger entity when we talk about solvency, but when we talk about affordability and we come down to that 5,000 policyholders, small number, and we look very narrowly at the Vermont experience, so I'm just having difficulty in a sense balancing our job of solvency for a big company with a small presence in Vermont, but when it comes to affordability we have Vermonters who are facing a 15.3 or four percent increase in their premiums.

THE WITNESS: Well I think you have to

look at the components that go into the filing to determine if those are in fact reasonable. I mean the solvency opinion both from us and from New York, I think, depends on two things. One, we presume the rates aren't going to be inadequate, although they have historically been inadequate for this carrier over the last several years. And I, in fact, I think they have testified they have lost money in this market. It's not been such a phenomenal rate that it's caused them to withdraw from the market. But at some point affordability still has to address the cost of delivering the service, and what it's costing them for each carrier providing the services aren't the same, doesn't cost the same. That's why you have some variation.

And they don't provide the exact same services. So then you have some choice in the market. And then the market decides how much their share is going to be. So people decide, you know what, it may cost me more for this product, but I like its parts, so I'm going to buy that, whereas, you know,

maybe 90 percent say something else. It's -- the fact that the overall Holding Company's earnings are, you know, 95 percent to the 5 percent of the earnings here, suggest that a change in the requested rates is not going to have a material impact on the solvency of the enterprise.

What that does to the -- either the market share, the critical mass, whether it drives them out of the market altogether are separate questions, and those aren't really questions that we are here to address. So that's a different issue than just the solvency.

MS. HENKIN: Con has a question?

MR. GOBEILLE: I don't have a question. I just have a comment, I would like you to pass on to Commissioner Donegan and everyone that worked on this our appreciation for your thoughtfulness, and appreciate you coming here two days in a row.

THE WITNESS: Sure. Thank you. I will do that.

MS. RAMBUR: No further questions from me.

MS. HENKIN: You're excused.

THE WITNESS: Thanks.

MS. HENKIN: We are going to have L&E is the actuarial firm. I believe Jackie Lee will be testifying today. And Michael Donofrio will do -- lead you through some basic information.

MR. DONOFRIO: Thanks, Judy. So for the record, I'm Mike Donofrio. I'm the Board's General Counsel. Ms. Lee, as Judy mentioned, and as she will testify in a moment, is -- works at Lewis & Ellis, an actuarial consulting firm with which the Board has contracted to provide actuarial services in relation to the review of health insurance rate filings.

Because of the sort of the construct of the hearing we just thought it would be easier for me to do sort of a brief direct to allow the witness to warm to the chair and get some of the basic issues out there. And then Ms. Lee will be available to answer questions from the parties.

JACQUELINE LEE

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DONOFRIO:

Q. Could you state your name for the record?

A. Jacqueline Lee.

Q. And could you tell us where you work and what you do?

A. I work at Lewis & Ellis. I'm a Vice President and consulting actuary there.

Q. And could you describe briefly your experience and your credentials?

A. Sure. I have been with Lewis & Ellis for about six years. In my time before that I worked at a couple of health plans, insurance carriers. In regards to this, the last few years I've been working on -- with states reviewing -- after the Affordable Care Act -- reviewing their processes and reviewing rate filings. In my prior two jobs I did do filings on the behalf of all the carriers there. And I've been performing health work for the past 10 years.

Q. And what other states have you worked with besides the State of Vermont?

A. I have worked with the state of Maryland,

Arkansas, Louisiana, Kentucky. Hard to remember all of them, and I believe -- I believe that's it. Last year I did help with Ohio and Nebraska as well.

Q. And in your work with those states, can you just clarify are you working -- similar to here you're working with the state -- with a state regulatory agency?

A. Yes. We were working with the state regulatory agency there, reviewing mostly ACA-related filings, but we have done outside of the Affordable Care Act filings as well in some of the states.

Q. Great. Thanks. Could you describe for the Board and for the record what your review process consists of when a rate filing like this comes to you?

A. Yes. We have a staff that helps us review rate filing when it comes in the door. We have a primary reviewer who is an associate, in the Society of Actuaries, who kind of gets into the nuts and bolts, knows all the details of the filing, is the main correspondence between us and the carriers.

For this particular filing for MVP that was Rita Tansen, T-A-N-S-E-N. She has worked closely with MVP on all other filings here. I have been a very active role as a peer reviewer for this filing as well as the Blue Cross filing in the state.

And the next level is Dave Dillon. And he

kind of oversees all the big picture items and knows a lot of the details too. But mainly the hot topic issues for each of the filings. And that's the same for most of our states. We have the various levels of detail so that we can be consistent with our reviews across the state and across all of our clients.

Q. Could you open up the binder in front of you, please. And just for the record it's the binder of exhibits that the parties have stipulated to. The Exhibit Number 1 there is MVP's rate filing. Do you see that?

A. Yes, I do.

Q. And is that a document that you reviewed in the course of the work you just described?

A. Very extensively. Yes.

Q. And just take a look at the table of contents, if you would, Exhibit 2 through 6 --

A. Yes.

Q. -- are labeled different dates, but each one is labeled objection letter and MVP response. Can you describe what -- first of all, are those also materials that you reviewed and/or had a hand in preparing?

A. Yes. I helped prepare the questions that were presented to MVP which is what's included and the responses that they provided to us from those questions.

Q. And what is an objection letter?

A. An objection letter is after we review a filing we -- there is no way in the initial filing you can answer all questions. You try to be concise when you're preparing a filing so that people can understand it. And to the extent we have questions about some of the items within the filing or just further clarification, we address those to the carrier, and then they provide more detailed responses of those specific items.

Q. And then moving down the table of contents there. Exhibit 7 is the Department of Financial Regulation's solvency analysis. Did you review that?

A. Yes, I read that.

Q. And Exhibit 8 is the Lewis & Ellis actuarial opinion. I'm assuming you had a hand in that?

A. Yes. I helped write that.

Q. Exhibit 9 is the report of Donna Novak, the Health Care Advocate's expert. Have you had an opportunity to review that?

A. Yes, I have reviewed that.

Q. Exhibit 10 is MVP Health Plan, Incorporated's annual statement. Is that a document you've reviewed?

A. I have reviewed it. Not as extensively as the prior documents. But I have seen it.

Q. And then exhibits 11, 12 and 13 were just admitted into evidence today; is that right?

A. Yes.

Q. You haven't reviewed those prior to today, right?

A. I did write the responses to Exhibit 13. So I did see that.

Q. I apologize.

A. That's okay. Yes.

Q. I forgot what that was. Thank you. So if I can -- now I want to focus in on this rate filing a little bit --

A. Okay.

Q. -- if you could, and some of the other documents. If you could first flip to page six of Exhibit 1 which is MVP's rate filing. Just have a very brief question here.

A. Okay.

Q. You see like a little over halfway down the page there is a block of information with the heading Requested Rate Change Information.

A. Yes.

Q. And there is four lines there, the fourth line says percentage change requested.

A. Yes.

Q. And it gives a min, a maximum and an average?

A. Yes.

Q. What's the average that's recorded there?

A. This is a weighted average of all of their rate changes that they are presenting in this filing.

Q. And what is the value reflected on the page there?

A. 15.4 --

Q. And --

A. -- percent.

Q. Yes. And then could you now -- could you now flip to Exhibit 8 which is the Lewis & Ellis report. Do you see on page one in paragraph four there is a table?

A. Yes.

Q. And the second column of that table is labeled percent change, right?

A. Correct.

Q. And what's the overall value reflected there?

A. 15.3 percent.

Q. I realize that point one percent is not a tremendous difference, but could you explain the difference?

A. Yes. When we did our calculation of this percentage we did it as a percent of premium. And when MVP did their calculation they did it as a percent of overall contracts, I believe. And I was able to replicate their calculation, but based on our entire report for

consistency, we want to be on a percent of premium basis because that's how we also presented our results for Blue Cross, so we didn't want to have a mix. But given the immateriality we decided to go with this rather than being consistent with MVP's reporting.

Q. Thank you for explaining that. I'm not going to walk through these documents in any detail, but I do want to touch on a couple of issues that have been already the subject of today's testimony. And I think the easiest way to do it is if you could -- you might want to pull Exhibit 8 out of there for the moment. I'll give you a moment to do that. And then could you go to Exhibit 12.

So the first page of Exhibit 12 which is entitled Summary of Issues in Dispute, addresses the pharmacy trend, do you see that?

A. Yes, I do.

Q. And did you hear the earlier testimony given about this topic?

A. Yes, I did.

Q. Great. I would like to focus you on the middle column which is entitled GMCB actuarial consultant, Lewis & Ellis, Inc. July 30, 2014 opinion letter, do you see that?

A. Yes, I do.

Q. And at the same time because I know you're a

very good actuary and very good at multitasking could you also go to page four of the opinion letter.

A. Yes.

Q. Thank you. And you're going to have to bear with me because I'll ask questions in a sort of a simple-minded, non-actuarial way here as we go through this. So I want to talk a little bit about the information in that center column and in your report.

And let me start with your report. Towards the bottom of page four the report says, it's the second sentence of that last paragraph there, the annual trend factors for generic/brand drugs and specialty drugs as provided by MVP's new pharmacy vendor did not account for MVP's Vermont-specific scope of business given the partnership with this vendor is new. We consider this to be a limitation on the reasonableness of their trend assumption.

Could you explain that a little further?

A. Yes. When we reviewed the pharmacy trend, we were -- they let us know that they had a new vendor. And typically you can get a vendor to provide estimates for trend because they have a large amount of data. And a main concern for us is that the Vermont marketplace is different than the rest of the nation as with every other state, generally tends to want to use state-specific data.

And so when MVP stated that they did not consider or look at Vermont-specific data, we found that to be a limitation in the projection of the pharmacy trend.

Q. Is there anything about pharmacy trend -- I know that these rate filings involve a lot of components. Is there anything about pharmacy trend that in your opinion makes it particularly appropriate to look to state-specific considerations?

A. I wouldn't say that there is something specific about pharmacy trend over medical trend that really stands out that this is an assumption where you have to have state-specific data or else it's just a bad assumption. I would say across the board for all assumptions that you really want to consider, since that's where you're going to be delivering services, that's where you're going to be selling your products, you want to be as reflective as possible where you're going to be doing business. And using state-specific data is the best way to do that.

Q. Could you turn over to page five.

A. Yes.

Q. In the first paragraph there. The second sentence reads; for comparison purposes we analyzed 36 months of MVP's historic pharmacy trend experience. Could you explain what you did there?

A. Yes. With all trend assumptions across all of our filings, this year we have looked at three years of historical data to determine an overall reasonableness of the assumption used. We recognize that that's not always the best assumption there to be using historical data. But a lot of times the history does repeat itself in the future, and so we would like to look at that as kind of a first pass.

So we did this analysis on MVP's pharmacy trend and came up with an average of some negative trends when we performed that.

Q. And then at the bottom of that paragraph when it states historical trends may not be indicative of future trends. Could you explain what that means in this context?

A. Sure. There are a lot of reasons why historical trends don't -- are not reflective going forward. Specifically for pharmacy trend, you have drugs that are coming off patent, and that means that they are going to be -- the costs are going to start decreasing for them, and then in the foreseeable future because they are going to become generic. There is other reasons why they had a change of pharmacy vendors. That's another reason why historical trends might not be so indicative of the future. So there is definitely some reasons to take into

account other factors outside of the historical trend.

Q. And then moving to the next sentence in that section there, it states in the absence of better information we recommend using a Vermont-specific pharmacy trend of 8.4 percent. And there is a footnote there, and the footnote indicates that that's the trend used by Vermont's largest carrier based on state-specific experience. Could you explain your -- the process behind that sentence there?

A. Sure. We felt like it was a significant limitation to not be utilizing Vermont-specific data. And so we did a fair amount of research just outside and within working with the Board's staff to come up with some better ideas here. And due to the fact that Blue Cross Blue Shield has a very large presence in Vermont, we felt like that was the best source to go with. And their trend was based on their historical piece, plus they also accounted for changes in patent and everything going forward which is how, given all of the information, you know, that in the world which I recognize that MVP did not have, but if you had had all of that, I would have done the same thing. Looked at my history, then made adjustments to that as I saw appropriate for the future.

Q. And you may have -- this may be embedded in the answer you just gave, but I'm going to ask you to

tease it out a little bit. Does the Blue Cross information encompass both historical and prospective --

A. Yes, it does.

Q. -- information? Could you explain that a little bit?

A. Yes. In their analysis they performed a fairly extensive regression analysis on their historical pharmacy trends. And then went through and made adjustments for drugs coming off patent, the changes in generic dispensing rates, and any other contractual changes that they had.

Q. Thank you. Could you turn to the next page, Exhibit 12 please. Page two. And do you see in the -- at the top of the first column there, it says demographic/morbidity adjustment?

A. Yes.

Q. Just to make sure we are on the same page.

A. Yes.

Q. This at least to my actuarial pea brain gets pretty deep into the weeds, so I'm going to do my best here. You'll have to bear with me as I try to parse this a little bit. You heard the earlier testimony on this topic as well; correct?

A. Yes, I did.

Q. Great.

MR. KARNEDY: I would object to the reference to the size of the General Counsel's brain. It's larger than that.

MR. DONOFRIO: Making up for the haircut, right? Thanks.

MR. GOBEILLE: Does she deny that? Or what does she do? How do you --

MR. DONOFRIO: I think there will be an extensive written order from the Hearing Officer later on that one.

MS. HENKIN: I will ignore that. Go ahead.

BY MR. DONOFRIO:

Q. Did I also at the same time direct your attention to page five of your report section five?

A. Yes.

Q. I think that's where we begin here. So in section 5 of your report there and I think it's most -- encapsulated in the last paragraph of section five there. You recommend a 2.8 percent adjustment factor for demographics.

A. Yes.

Q. First of all, have I said that right?

A. Yes, you have.

Q. And could you explain what that means?

A. Yes. We recommended a 2.8 percent increase to the projected claims for 2015 due to demographics which means that what MVP did was they took their current block of business from 2014, April 2014, and they have projected in 2015 that they will have the exact same enrollment for 2015.

So in the projection it is my opinion that they need to be reflective of the general population that is going to be there and present in 2015. So to account for that, we have suggested that they make an adjustment for the average age distribution, so the fact that they had, you know, an average age of roughly 40, 45, I don't know the exact number, but if that's what they had, that they reflect that through the HHS age factors as a proxy. And MVP did provide this 2.8 percent figure as an increase from their projection period -- or from their experience period to their projection period. So that was provided, this 2.8 figure was provided to us.

Q. And I was just going to ask where is it derived or where was it derived from?

A. Right. So what MVP did to calculate this is they took their distribution by age of their -- I believe it was April 2014 population -- so they had so many who were 21, so many who were 40, and so many who were 60, and they are associated factors that were developed and

mandated by the Health and Human Services to kind of put a -- assign a value to how expensive each of that age range is. So it's just a weighted average of those factors. The 2.8 is the change.

Q. Thank you. And then could I direct you to the last sentence on page five where it says; please note, as a result of this recommendation, meaning the factor that you just described, the calculation of the single contract conversion factor will also be modified, see section 10 below.

A. That's correct.

Q. What is the single contract conversion factor?

A. In Vermont there are mandated tiers that have to be charged at the premium level. So for instance, a single rate you can take the rate times one. And then a couple is a rate times two. And then so on and so forth through families. This is not normally how claims costs are developed. It's not on the same basis. So what you have to do is reflect the fact that you cannot charge the appropriate amount that you would like to in the form of a premium to reflect your claims costs. So you make an adjustment so that at the end of the day you are collecting as many claims -- or as many premiums as you need to cover your claims.

Q. Okay. And could you explain why your

recommendation regarding the demographic adjustment results in a change in the contract conversion factor?

A. Yes. In the development of the originally filed contract conversion factor MVP utilized the 2013 experience, and their enrollment distribution by each of the tiers; family, couple, singles, to determine this overall adjustment, which we did not feel was appropriate since they are not utilizing -- they are not projecting that same type of enrollment as -- in 2015 as they had in 2013. Keeping in mind that their -- if they were similar, then this outcome may have been different.

Q. Okay. Could you flip to page seven now of your report.

A. Yes.

Q. And we will be looking at section 10 there. This is where you address the single contract conversion factor; correct?

A. Yes, it is.

Q. So do you see about a little more than halfway through the second paragraph under section 10, there is a sentence that reads; the average contract size has reduced from 1.79 in the experience period to 1.53 in the projected period resulting in a decrease to the single conversion factor.

A. Yes.

Q. Can you explain how that relates to the explanation you just gave of what the factor is?

A. Sure. The average contract size is once again an average of the number of people on a contract. So in the experience period there were 1.79 people per contract. However, in the projection period that went down to 1.53 people per contract, which means that you're having a different distribution, and kind of implying here that you would have more singles and less families because you have less people on a contract.

Q. And then continuing along in that paragraph you recommend that this factor be changed to 9.8 percent?

A. Yes.

Q. How did you calculate that?

A. That was a figure that we calculated at L&E. That was based on the distribution of the actual 2014 tiers and enrollment in those tiers. We used the same method that MVP used. We just replaced their distribution using 2013 data with the projected 2015 which is the same as actual 2014 in this case.

Q. Thank you. And now could I direct you back over to Exhibit 12?

A. Yes.

Q. In the middle column there which again is the L&E column, you see about halfway down it says reasoning.

A. Yes.

Q. That first segment there says considered MVP age/gender factor an average contract size for April 2014 membership snapshot instead of actual claims experience. What is -- could you explain -- sorry, do you agree with that characterization?

A. I would agree that we utilized member not claims experience.

Q. And could you explain your basis or rationale for doing so?

A. Right. Health claims experience takes a fair amount of time to be collected and then mature. And as of April 2014 it is pretty optimistic that they even had data available through March of 2015. And generally it takes three months to get a fairly solid amount of your claims in the door and paid, which means that it's fairly unreliable.

So we did not want to utilize data that was not credible and very immature for this particular adjustment. And so we looked just to membership, membership is a much more concrete, you have people here. They are there. You can look at who they are. How old they are, age, gender, but you don't know what they are going to do in the future as far as claims are concerned. And the timing of it was just not enough time.

Q. And now could you look at the last statement under that one where it says failed to recognize, need to remove two percent morbidity improvement factor, comma, amounts to double counting. Do you agree with that statement?

A. I do not.

Q. Could you explain why?

A. Yes. When we were reviewing the filing and looking at our question and answers, it became -- it appeared to us that there were two separate decisions made. One was they made no adjustment for age and gender, and two, they made a two percent morbidity improvement adjustment. And that was within one of their responses. I could probably find it. It's in here.

And so because of that, we have always interpreted them as two separate pieces. One is morbidity, we are talking about the health status of the group. And one is how old your individuals are. And so therefore, since we see them as two distinct adjustments, one does not -- should not be impacting the other. So we should not remove it here.

Q. Thank you. So I just want to wrap up briefly now. You understand that part of your role in supporting the Green Mountain Care Board that there is -- there are -- the Board has to meet certain statutory criteria in its

review of rates; correct?

A. Correct.

Q. And part of your role is to support the Board in doing so, right?

A. Correct.

Q. So -- and I know that in or is it -- it's correct that in your letter that we have been looking at Exhibit 8, you -- as we discussed, you suggested a number of modifications to MVP's rate; correct?

A. We did.

Q. And you concluded that with those modifications the resulting rate would -- would reasonably relate to the benefits being provided, right?

A. Yes.

Q. And would not be excessive, inadequate or unfairly discriminatory?

A. With our modifications. Yes.

Q. And is there anything about the testimony you've heard so far today that would alter any of those conclusions?

A. No.

MR. DONOFRIO: Thank you very much. I have no further questions.

THE WITNESS: Thank you.

MS. HENKIN: Mr. Karnedy.

MR. KARNEDY: Yes. Thank you.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. I have marked for identification purposes MVP 17, which is not in the binder. I would like to hand it out. These are questions that MVP posed to the actuaries, and I know we have all been busy and didn't have time to respond to them. I'm not going to trouble you, Ms. Ellis, with all the questions. Just one of them. It was -- I think we talked about question number one, so I'm going to move to question number two. You've seen this document before; correct?

A. I have seen this document.

Q. And we haven't gotten the answers, but I thought we could do it orally today.

A. Fine.

Q. So relating to the second question, first I want to ask you, you talked a bit about Blue Cross Blue Shield's drug trend; do you remember that testimony?

A. Yes, I do.

Q. So my question is, doesn't Blue Cross Blue Shield in formulating their drug trend isn't that based in part on their contracts that they have?

A. With their pharmacy benefit manager. Right.

Q. Yes. Okay. And those aren't the identical

contracts that MVP has; correct?

A. I don't know. I would assume not. But I don't -- I have not seen either of them.

Q. Okay. So in terms of apples to apples, it's fair to say it's not apples to apples as it relates to those contracts; correct?

A. That's fair.

Q. So let's go to that number two. Okay.

A. Okay.

Q. And I'm going to kind of read them. If you've already answered some of these, I apologize.

A. That's fine.

Q. Please explain why it's more appropriate to use historical Rx trends from a competitor than trending MVP's own claim data.

A. I would say that if MVP had their own claims data, I would have found that to be more appropriate to be utilized than a competitors'.

Q. Okay. I'm sorry. I didn't read the whole sentence. Forecasting trends from a national pharmacy benefit. So relying on -- you heard Pete testify earlier, relying on the expertise of the pharmacy benefit manager. You disagree with that; correct?

A. I disagree with using national numbers that were not accounted for the state-specific data in Vermont.

Q. So the second question under number two. In MVP's small group filing previously reviewed by L&E, you opine that using MVP's own claim data forecasted at its vendor supply trend rates was reasonable and appropriate; correct?

A. I did. When we reviewed that I believe it was on a Vermont-specific basis. At least that's the assumption we were under.

Q. So I am correct, right?

A. Yes.

Q. And do you agree -- the next question there, do you agree that pharmacy trend is very dynamic and has been influenced by many factors in relying on historical trend rates to judge the reasonableness of forecast trends may not be appropriate?

A. Yes.

Q. Do you agree that historical Blue Cross Blue Shield trend factor will be influenced by Blue Cross Blue Shield as circumstances that are not relevant to MVP?

A. Yes, I do. But I also believe that national data would produce similar results.

MR. KARNEDY: So I would move for the admission of MVP 17. It can just be that question two. It doesn't need to be the whole exhibit. We can fix it up afterwards.

MS. KUIPER: I have no objection.

MS. HENKIN: I will enter into evidence MVP 17. Exhibit 17.

MR. KARNEDY: Thank you.

(Exhibit MVP 17 was admitted into the record.)

BY MR. KARNEDY:

Q. Now so I had a straight question -- does higher age -- well I'm not going to ask that. I don't know what higher sex means. Does higher age and gender translate to higher morbidity?

A. It can influence it. Yes.

Q. If you would please turn to Exhibit 12. That was our summary of the issues exhibit which is now in evidence. I just want to go through some of these with you, if I could. Starting with issue one. Let me know when you're there. That's the pharmacy trend.

A. I'm there.

Q. Okay. And I understand your opinion, you talked about it. But the result of that opinion is a reduction in the overall rate by point 1; correct?

A. Agreed.

Q. And L&E is not of the opinion that there should be an additional reduction of .4 that's proposed by the HCA; correct?

A. That is correct.

Q. Okay, great. And then let's go to issue three. That was the manual rate error. Let me know when you're there.

A. I am there.

Q. So let's go -- and you'll see we say there was no problem with manual rate error. And as I understand it, Exhibit 13, which we will go to in a second, L&E has opined and agreed that MVP did not make an error in developing its manual rate; correct?

A. Agree.

Q. So let's go to Exhibit 13 and show where that came from. Exhibit 13, this is a question posed to you all by the Health Care Advocates' expert, that was question number two. Correct?

A. Yes. That's correct.

Q. And this is this whole URRT business about the form?

A. Correct.

Q. So you agree with MVP not with the Health Care Advocate on that issue; correct?

A. Yes. That's correct.

Q. Great. Issue four. On administrative costs. The Health Care Advocate is indicating that we should have our rates reduced overall by one percent relating to

administrative costs. And you all don't agree with that. Your opinion is that our estimate was found reasonable -- found to be reasonable and appropriate; correct?

A. Yes. We found your opinion -- your admin costs to be reasonable and appropriate.

Q. And then issue 5, which is on contribution to reserves. Do you see that?

A. Yes, I do.

Q. And as I understand it, you found that no change recommended to MVP -- excuse me, you found that we didn't need to change our recommendation of contribution to reserves, the 1.5 percent. You were comfortable with that; correct?

A. We were comfortable with that, but then as it says below, we did say to reference the DFR because that's more in their realm.

Q. And DFR testified today and you reviewed their letter which is Exhibit 7, from Commissioner Donegan which describes their level of comfort; correct?

A. Correct.

Q. And you still stand by L&E's opinion that our contribution to reserves, 1.5 percent is appropriate?

A. Yes, I do.

Q. And you would not agree then with the reduction of that proposed by the Health Care Advocate;

correct?

A. I would not agree. I think that we found that yours was reasonable and appropriate.

Q. So you agree with us, not with them, on that issue?

A. Correct.

Q. Thank you. You testified in direct examination about three levels of review. I'm sorry. I didn't remember who -- someone looked at it first.

A. That's correct.

Q. Then you peer review it?

A. Yes.

Q. And then your --

A. Dave looks it over. Yes.

Q. Dave looks it over after that, right?

A. Correct.

Q. And that's important because I think you said you want to be consistent when opining on rates; correct?

A. Correct.

Q. To make sure you don't miss anything, right?

A. Hopefully. That's the goal.

Q. And then the last point was on this, I think you explained it, and Pete had earlier, the 15.4 versus 15.3 that's not a material issue that we are fighting about here; right?

A. No.

Q. Thank you very much.

MS. HENKIN: Ms. Kuiper.

MS. KUIPER: I just have a couple quick questions.

CROSS EXAMINATION

BY MS. KUIPER:

Q. So on your pharmacy trend your report started with a nine percent pharmacy trend; is that correct?

A. I believe, yes. They had a nine percent trend for the pharmacy.

Q. And did you make that on incurred claims or allowed claims?

A. I believe there was -- it was on allowed claims, but I would have to look it up. Actually I think it was paid claims. I think it was paid. But I would have to actually look. I don't recall offhand.

Q. Okay. That's fair. Could you just explain the difference between incurred and allowed claims?

A. Sure. Allowed claims are before cost sharing. But taking into account any discounts that you possibly have. So cost sharing being if there is any copays, coinsurance, deductibles that are applied that hasn't been taken into account. Paid claims they have, and so there are differences due to the people who have paid it.

Q. Thank you. And you reviewed Blue Cross Blue Shield's 2015 filing for the exchange price?

A. Yes, I did.

Q. And comparing the two, which filing would you say was more difficult to review or can you say?

A. I would say the MVP filing was more difficult to review.

Q. All right. And when two experts review a filing that's this complicated, and they come to different recommendations, is one necessarily wrong and one necessarily right?

A. No. It could be a difference of opinion. You've also got their assumptions, so depending on how you have researched your assumption and made your calculation, you could come up with two different answers.

Q. And they both could be reasonable?

A. They both could be reasonable. Yes.

MS. KUIPER: Okay. Thank you. That's all.

MR. KARNEDY: I have one follow up if I might.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Just on your last point.

A. Yes.

Q. Differences of opinion.
A. Yes.
Q. As I understand it, L&E hasn't changed their opinions on the rate reduction that you're proposing here in the last four or five days; correct?
A. No, we have not.
Q. You stand by your opinions; don't you?
A. Yes. That's correct.
MS. HENKIN: That's it?
MR. KARNEDY: Yes. Thank you.
MR. DONOFRIO: Sorry.
MS. HENKIN: That's okay.
MR. DONOFRIO: May I ask two very brief questions?
MS. HENKIN: Yes, you may.
MR. DONOFRIO: A couple of background things I skipped over on my notes.

REDIRECT EXAMINATION

BY MR. DONOFRIO:
Q. How long have you been assisting the Green Mountain Care Board in reviewing health insurance rates?
A. Since January 2014.
Q. And about how many filings have you reviewed in that time?
A. In total? For MVP specifically?

Q. In total?

A. In total we have done 20 filings.

Q. And do you recommend changes in every filing you review?

A. No, I do not.

MR. DONOFRIO: Thank you.

MS. RAMBUR: So I have a question about the pharmacy trends. I would like to better understand the recommendation of using Blue Cross Blue Shield's experience, and what I would like to understand is was that using the entire book of business or just their exchange book of business?

THE WITNESS: I believe that was using just their exchange book of business. But I would have to go look. I can get back with you on that.

MS. RAMBUR: Are those similar enough that it's the basis -- reasonable basis of comparison?

THE WITNESS: You mean between --

MS. RAMBUR: I was thinking of the metal levels and the potential for different --

THE WITNESS: Right. As I think MVP testified to earlier, you could have

differences, since there are differences in cost sharing most of the time, you have a lesser copay, you're more likely to fill a script. But given the fact that it is early on, we can't really make that determination. But given if you look at the past, I mean we have -- we haven't had metal tiers, but we have always had high deductibles versus copay plans.

And you do see a different pattern when the cost sharing structure is different.

MS. RAMBUR: So I'm curious if it was limited to Blue Cross Blue Shield's exchange, how it would be that the proportions would be the same at the different levels.

THE WITNESS: It did have very distinct distribution among plans, so it could be that that needs to be considered. But I also feel like there is a lot more than just the fact that there is a cost sharing involved to consider when looking at the pharmacy trends.

MS. RAMBUR: Okay. No further questions. Thank you.

MS. HENKIN: Dr. Hein.

MS. HEIN: Just to go back when you look at what the differences are across your recommendations.

THE WITNESS: Yes.

MS. HEIN: HCA and MVP, the big one is the difference regarding demographics.

THE WITNESS: Correct.

MS. HEIN: You were great to go over some of the details. But I just want one more time --

THE WITNESS: Sure.

MS. HEIN: -- to go to the reasoning portion of the age and gender factors, got that, having to do with the balance of single and family. This one, fail to recognize need to remove two percent that you don't agree with.

THE WITNESS: Yes.

MS. HEIN: Just one more time explain it.

THE WITNESS: Sure. It's our understanding that they are two distinct adjustments. One, you're taking into account how old your population is. And one

you're taking into account how sick your population is and what the health status is. There can be, you know, a little bit of a correlation across the board, but generally, especially on these Affordable Care Act filings, they have been very distinct to have two separate adjustments here.

The morbidity would account for things such as new insureds entering the market, and how they will be utilizing, who's transferring into these types of plans from small groups that maybe drop coverage or who is leaving to do self-insured-type plans. So this is their -- how we viewed the minus two percent, is that that's their adjustment of that piece is how sick their population is going to be.

And in fact, for them it's that they are not sick, they are healthier. And so they have taken a two percent improvement. Does that help or --

MS. HEIN: Yes, and it's just in contrast with yesterday Blue Cross Blue Shield, different situation, different company.

THE WITNESS: Right, right.

MS. HEIN: But the assumptions and actual outcome was quite different from this.

THE WITNESS: Right. In Blue Cross's filing they had the luxury of having a larger block, so they took the people who were in their 2013 block and moved it and said who would -- who actually enrolled in a plan, and then who wasn't enrolled in a plan.

MVP probably could have done a similar study, and they probably looked at it in preparation for this filing, but since it is smaller, I'm not sure I would have agreed with using it or not using it in the case that they did. It would be really small and not credible, because I don't know how many people from 2013 actually enrolled in a plan with them. So they could have had all new members. I don't know that.

MS. HEIN: And again I'm only drilling into this one because it is the largest reduction that you've recommended.

THE WITNESS: That's correct.

MS. HEIN: Thank you.

MS. HENKIN: Anyone else from the Board? Thank you very much.

THE WITNESS: Thank you. Do I keep this exhibit here? The 17?

MS. HENKIN: Yes. Okay. We now have the HCA's witness.

MS. KUIPER: Okay. Call Donna Novak.

MR. KARNEDY: Can I just ask a timing question? I may need to put Pete on very briefly for two questions to follow up here. Just in terms of our time I didn't know if you wanted to take a brief bathroom break now before we start the witness or whether you want to press through.

MS. HENKIN: I would like to keep going at this point.

MR. KARNEDY: Fair enough.

MS. HENKIN: We just had a break recently. We are good.

DONNA NOVAK

Having been previously duly sworn, testified as follows:

MS. KUIPER: I'm happy to go through our expert's credentials again, but just for expediency sake, I would like to offer would the Board like to take judicial notice of her testimony from yesterday on her expertise?

MS. HENKIN: I think that would be fair. Do you have an objection, Mr. Karnedy?

MR. KARNEDY: No. To the extent that I was here yesterday. I may ask some questions about what she said yesterday on that.

MS. HENKIN: That's fine.

MR. KARNEDY: And her resume.

MS. HENKIN: We do have the CV in her report.

MR. KARNEDY: In terms of the actual record then, I would ask that that portion of her testimony yesterday be incorporated into the record.

MS. HENKIN: Do you have any objection to that?

MS. KUIPER: That's exactly what I was thinking.

MR. KARNEDY: Thank you.

DIRECT EXAMINATION

BY MS. KUIPER:

Q. Just for clarity sake, could you state your name?

A. Donna Novak.

Q. And your occupation?

A. I'm an actuary.

Q. And could I refer you to Exhibit 9. And I just want to start specifically with page 18. Do you recognize this?

A. Yes. That's my CV.

Q. Okay. Thank you. And do you recognize the entire report?

A. Yes, I do. That's the report we prepared.

Q. Okay. Thank you. And what did you prepare this report for?

A. The 2015 rate filing in Vermont for MVP.

Q. Okay. Thank you. And what did you do to -- in order to prepare for your testimony today and prepare this report?

A. Pretty much went through our normal process. We summarized the filing in our format just because we are

used to going through a certain format. As part of that we have a series of questions that we ask that are consistent with having effective rate review process in a state, as well as some additional questions that I've added that go beyond what HHS, Health and Human Services, has listed out as necessary for an effective rate review process.

And then we develop a series of questions or what they call objections in SERFF. In the case of the MVP filing we also were, as we were doing our analysis, provided with Lewis & Ellis's questions and MVP's answers to Lewis & Ellis's questions. So some of the questions we would have asked we took off our list. And then we had some remaining questions.

Our set of questions were peer reviewed to make sure we didn't miss anything. And then we get our answers back, see if we have any additional questions. I did in this case, but it was minor, so we didn't have an opportunity to ask it. And then we create our final report, and I have that peer reviewed.

Q. Okay. Thank you. So we have gone through Exhibits 1 through 10 several times today. Are those all documents that you reviewed for today's filing?

A. One through 10. Yes.

Q. Okay. Thank you. When you look at a filing

do you concentrate on any particular areas?

A. As I said, we have got our set of questions. I have particular areas that I'm sensitive to that I always make sure that are clear, or I have certain criteria for the assumptions and methodology being appropriate in rate filings, and I go through those maybe a little bit more closely than others.

Q. Okay. Thank you. When you refer to we, who is we?

A. For this particular team, it was myself, as the lead actuary. I have an actuarial student who does the filing summaries for me, and some editing of any communications. And in this case one of my employees Rick Diamond was the peer reviewer.

Q. Okay. Thank you. Let me refer you to -- on Exhibit 9 to page 13. Did you have any findings on today's filing?

A. Yes. We had three conclusions in our original report.

Q. All right. Could you tell me what they are?

A. Yes. We found -- we had asked for the development of a manual rate, and MVP provided us with a development of the manual rate. And I felt there was an error in it. The manual rate is what they used in the filing. The prescription drug trend I did not feel that

using the national trend was appropriate. And the administrative cost trend or level I did not feel was appropriate because it was going up at the same rate as claims trend.

Q. All right. Could you go into a little more depth on the pharmacy trend and explain why you felt the pharmacy trend was too high?

A. A pharmacy trend I think is one of the most difficult trends right now, maybe forever, to determine. And I think that there is a range of methodologies that produces the most accurate trend. The most accurate is to look at the drugs being used by your population, get input from pharmacists as to what's going off brand, what new specialty drugs might be coming on, what new brand drugs might be coming on. Look at your population and see if your population would be using any of the new drugs based upon their diagnosis or their drugs they are currently using.

The least accurate is using national data, national reports put out by consulting firms or PBMs. So since that was the approach that had been taken by MVP, I felt that there would be information that would inform that trend a little bit more and create a better answer. Better projection.

Q. Okay. Thank you. And what did you use as

your starting point for your pharmacy trend analysis?

A. The starting -- well there are two points that I weighted. I weighted mostly on MVP's pharmacies recommendation, but I wanted to take into consideration at least for the first year, it's two years of trend, at least for the first year some of the historic trend from MVP.

I'll be the first one to admit that historic drug trends only can be an information point or a point to blend. You can't just take historic drug trends and use them. That's why it's difficult. There are too many moving parts in there. But I think they can inform the decision and my methodology for doing that was using them as a blend.

Q. And did you use allowed or incurred trends as your starting point?

A. I was using allowed numbers, allowed trends.

Q. All right. Thank you. If implemented, what impact would your pharmacy trend rate reduction have on the overall filing?

A. Yeah. That is reported in my findings on page 38, actually probably 39. And that's where I've presented the estimate of the change in the rate. And for the prescription drug that was a half percent.

Q. Okay. Thank you. Do you believe that there

is anything in particular about prescription trends that benefit from state-specific data versus national data?

A. Again, the very best is to use your population. And the state would be a better predictor of the way drugs are used by the providers and the population in general, so I think it would be better than national. I would think that drug usage in Vermont would be different than California and New York.

Q. Okay. Thank you. All right. I'm going to move on to administrative trends.

Could you explain your finding that MVP's administrative trend is too high?

A. Yes. MVP is using -- because we are using the same percentage of premium, the same trend in their administrative costs as they are in their claims cost, plus a little bit because of the new network fee, which comes out to somewhere therefore above the 15.4 percent that the whole premium is going up on average.

Q. All right.

A. And I think that's too high.

Q. And just to clarify, is it your understanding that MVP -- the amount MVP is proposing to spend on administration is going up in 2015 compared to 2014?

A. Yes. I tried to do an estimate of '14 to '15. Because the filing in '14 has already been approved.

Yeah. So I tried to do an estimate of '14 to '15. So my revised increase would be against the 2014 filing.

Q. And by how much is it going up according to your calculations?

A. Between '14 and '15?

Q. Yes.

A. $6. It's in -- $6 and some -- something, 8 cents.

Q. And is that per member per month?

A. That's per member per month. And that's based on because I didn't have the 2014 filing, I had to do an estimate of the increase per member per month by going to the second worksheet in the URRT where MVP reported the dollar increase for each one of their plans, and then do a weighted average of that increase. So it's an estimate.

Q. All right. And what's your estimated percentage increase between 2014 and 2015?

A. A little over 19 percent.

Q. Okay.

A. And --

Q. I'm sorry. Was there anything else you wanted to add on the explanation?

A. No. Not for 2014, '15. On '13.

Q. Do you think it's fair to compare 2013 administrative costs to 2015 administrative costs?

A. If you do it on an apples-to-apples basis. In 2013 there was over 13 dollars worth of commissions and broker fees that aren't there any more. So if you were going to compare '13 to '15 you would have to remove those costs that MVP doesn't have any more. And look at without the brokers and commissions compared to the 2015.

Q. And which year would have the lower admin rate if you take out the brokers' fees and commissions?

A. The lower, 2013. It reduces it -- well, if it's -- the math I can do in my head when I'm in the hot seat. If you did 45 dollars rounded minus the 13 dollars just truncated, you would end up with 32 dollars of admin pmpm in '13 versus the 40 dollars and 60 cents in '15. So it's an increase of about 27 percent.

Q. Okay. Thank you. And if implemented, what impacts would your recommendations on administrative trend have on this filing?

A. The -- in the reduction administrative costs which is called retention in my report, it's one percent.

Q. All right. Thank you. What is the basis for your belief that MVP made a mistake in its manual rate error?

A. Okay. Let's start with the URRT. And somebody has it tabbed.

Q. Page 78 of Exhibit 1.

A. Yes. Page 78. Okay. On page 78 in the URRT there is this zero percent. It's highlighted in blue. It's maybe two thirds of the way across the page right below the pmpm, projected pmpm. And that's a zero percent, means that half of the year, 2/3 of the year isn't used.

Okay. Then there is a hundred percent there. And that's where the manual rate is used, to develop the rate. Now MVP also provided an exhibit showing that it developed its rates on instead of allowed starting with incurred. But starting with allowed or incurred matches that part of the URRT. It matches when you get down to this $352 and 16 cents. So they parallel each other. So when Lewis & Ellis asked for the development of the manual rate, MVP provided an exhibit that we looked at earlier, that --

Q. I'm sorry. Was that Exhibit 5?

A. Yes. And we can go to that now. But what we are trying to see is their development of that $475 and 35 cents. And it's page six of Exhibit 5. And this is what we had looked at earlier. And this was the development of that $475 and 35 cents.

What it doesn't show is the formulas. But what is important is -- and this was discussed in earlier testimony -- this other change. This other change is for

essential health benefits that were not in the base period as well as a number of other things, also benefits that were in the base period that aren't part of the essential health benefits. So that is a factor that goes from 2013 experience to 2015 projection. So it's a one-time going from '13 to '15, unlike cost trends which are annual, the cost trends are basically doubled. They are squared, because it's an annual, so you go from '13 to '14 and then '14 to '15.

Same with utilization trend. It's squared. It goes from '13 to '14 and '14 to '15, but in the calculation of the average cost per service, and they allowed pmpm, MVP squared that amount. And as a matter of fact, in their recast of the URRT, their correction was squaring that amount. And my contention is that the other is -- should not be squared.

And unfortunately, I referred to the URRT not because I was looking at it for proof, except for the formula in the URRT does not square that amount. Just as proof that it should not be squared, because the Excel spreadsheet provided by the Health and Human Services does not square it. And I'm sorry, this is way in the weeds, but -- hopefully I connected a few dots.

Q. So what exactly does it mean when you're looking at a trend from 2013 to 2015 you square it?

A. You double it. You double it.

Q. And why might someone want to square a number?

A. Well as I said, the cost is because it's an annual trend. And utilization is because it's an annual trend. It was put in here as an annual trend, but the morbidity is the one-time adjustment from '13 to '15. And the other is a one-time adjustment from '13 to '15.

Q. Am I understanding you correctly someone might square the number if the number would count twice?

A. It was supplied in both years. Right. And the two-year projection.

Q. All right. And I just want to refer you to Exhibit 9 page 26. Do you recognize this exhibit?

A. Yes.

Q. Okay. Can you explain what you did here?

A. What I did here was average cost per service that we saw in the earlier exhibit I changed the formula. Now this is an Excel spreadsheet that was provided by MVP. So I checked it for reasonableness. I think all the formulas are right in it. The only change I made was to not square that amount.

So when that happens, just because of pagination on the next page, on page 27, the projected allowed amount is $472 and 95 cents. So it reduces the projected allowed amount, and then as it runs through the

calculations reduces the premium.

Q. And when L&E -- I'm sorry -- when MVP responded to L&E's question on this issue, did they give any indication that their answer was not something that was -- that affected the rate filing?

A. They did not indicate one way or another.

Q. So if implemented what impact would this manual rate error correction have on MVP's rate filing?

A. About a half a percent. It's rounded up to half a percent.

Q. Thank you. Okay. And can I now refer you to Exhibit 10. Do you recognize this document?

A. Yes. It's the statutory health filing for MVP Health Plan.

Q. And have you reviewed it?

A. Yes, I've reviewed sections of it.

Q. Can I refer you to -- I'm sorry, we didn't have this until this morning. So what's now marked as page 43. And do you recognize this page?

A. It's a five-year historical exhibit from the filing.

Q. Is this something that you looked at in connection with this rate filing?

A. Yes, it is.

Q. And what did you use it for?

A. I used it to look at their risk-based capital level.

Q. All right. And how do you do that?

A. In order to get risk-based capital percentage there is two rows under risk-based capital analysis in this exhibit. And the total adjusted capital, and it's on 14 and on row 15, is the authorized control level risk-based capital. And you divide 14 by 15 in order to get the risk-based capital percentage.

Q. All right. I'm going to keep my questions general to avoid any specific confidential information. But did you form an opinion of MVP's contribution to reserves?

A. In their filing of the 1.5 percent? Contribution to reserve in their filing?

Q. Yeah. And how that relates to their risk-based capital level.

A. I felt they had a very strong solvency and risk-based capital level, and that amount could be reduced.

Q. Is there -- when you look at risk-based capital, is there a point at which you think the company should be scrutinized for having too high of a risk-based capital level?

A. Yes.

Q. And is MVP above that point?

A. MVP is getting into the area where I feel that that should be a consideration. Yes.

Q. And what generally -- what effect does that have on your analysis of the filing if you feel that RBC is getting too high?

A. In order to have an effective rate review process you have to take into consideration the solvency of the company. It's one of the criteria that you have to look at. And so I look at if you've got a very high risk-based capital, is what I use, level, then I feel that -- more comfortable in questioning the level of not only contribution to surplus but other criteria. If risk-based capital is very low, then I think consideration of risk to solvency is more of a consideration.

Q. Thank you. Based on your analysis of MVP's five-year historical data, do you have any concerns that if MVP implements your recommendations for this filing that MVP's solvency will be threatened?

A. My recommendations, no.

Q. All right. Let me refer you now to Exhibit 8. Do you recognize this document?

A. Yes, I do.

Q. And did you review this as part of today's filing?

A. Yes, I did.

Q. And I'll refer you to page seven. Could you read the three recommendations listed here?

A. Yes. The first one is to reduce the pharmacy trend from 9 percent to 8.4 percent. Increase the projected index rate by 2.8 percent to account for changes in demographics. And the third one is to reduce the single contract conversion factor from 1.165 to 1.098.

Q. Okay. Thank you. Do you agree with L&E recommendations to reduce the pharmacy trend?

A. Yes, I do.

Q. And what is your basis for that? I mean I guess do you have anything to add other than --

A. I believe that a reduction in the pharmacy trend is needed. What the exact number is is it should be reduced to at least 8.4 percent. On -- this is on an incurred basis.

Q. Okay.

A. These numbers are so different that we had to be careful about incurred versus allowed.

Q. And I would like to present you with a document. Do you recognize this document?

A. Yes. It is the letter that was distributed on August 11, 2014 from --

MR. KARNEDY: Could I get a copy?

MS. KUIPER: Sorry. We are passing it around.

THE WITNESS: From myself to your organization.

BY MS. KUIPER:

Q. So you wrote this document?

A. Yes.

Q. And could you explain what this document -- what the purpose of the document was?

A. The purpose, after I had an opportunity to track the source of Lewis & Ellis's recommendations and rethink my original analysis, which took a little while to find out where my error in thinking had been, and I wanted to acknowledge that I had changed my opinion.

Q. All right.

MR. KARNEDY: Can I just note an ongoing objection to this line?

MS. HENKIN: Yes, you may.

MR. KARNEDY: Thank you.

MS. KUIPER: Could I mark this now as HCA Exhibit A for identification?

MS. HENKIN: Okay. Is that -- do you have the marked copy?

MS. KUIPER: I'm sorry. I don't. I apologize.

MS. HENKIN: I'll mark my copy here. Exhibit A?

MS. KUIPER: Yes. Now I would like to now move that this document be entered into the record.

MR. KARNEDY: Just note my objection. This is the letter that amounts to the change of opinion, so it's my ongoing objection.

MS. HENKIN: Did you intend to refer to this and take more testimony concerning this letter?

MS. KUIPER: I'm simply going to ask Ms. Novak about her opinion of the two final points of L&E's recommendation.

MS. HENKIN: Before this is admitted, I would like to hear some more foundation for that. If you could proceed with questions before this is admitted that would -- before I consider that.

BY MS. KUIPER:

Q. All right. So in your original report you also -- you described your analysis of L&E's increase in the projected index rate by 2.8 percent to account for changes in demographics; correct?

A. In my original report. Yes.

Q. And then did you give an update to that recommendation in your addendum?

A. Right. I wrote a letter acknowledging that I had changed my opinion on that.

Q. So what's your opinion as it is right now and as it's stated in this addendum?

A. That I agree with those two findings.

Q. And what did you do to analyze whether or not you agreed with that?

A. Went back and figured out why I had accepted the original documentation and not noticed that it should be changed. And I can explain this a little bit. It's a little confusing.

Most of the rate filings that I review use the federal age curve. And when you use the federal age curve you make an adjustment for average age of your data, of in this case the 2013 data, because one company it could be age 40, another company it could be age 42. So in order to get everything on a common basis you normalize it to age 21. And typically that's done using the base year data. Because then when all the projections are said and done to '15, you have an age factor that goes ahead and takes into consideration what the age distribution is in 2015. Actually what the actual age distribution is in

2015.

So when I originally looked at the filing and saw that there was no age adjustment, and that there was -- that the single contract conversion factor used the 2013, I think now I erroneously equate it to that same process. Whereas in fact when you don't age adjust your rates, you have to take into consideration if there is a change from your projection period going from your base period to your projection period, which would normally be done using MVP's projection of age and family size. And they would project age and family size to 2015 and would use that.

MVP didn't do that projection themselves. They didn't have a projected population and demographics for 2015. So then I think Lewis & Ellis appropriately said which is going to be the better predictor then of 2015 when you have large changes in your population as MVP did going from 2013 to 2014? And I think they appropriately chose the demographics of 2014 rather than 2013. Whereas if you were trying to match up allowed costs with demographics you would have used '13, but you're not, you're predicting the changes that will take place in '15.

Q. All right. Thank you. And what is your opinion of Lewis & Ellis's third recommendation to reduce

the single contract -- reduce the single contract conversion factor from 1.165 to 1.098?

A. Yeah. They are both a result of using the 2014 demographics. And I do agree in using the 2014 demographics for the 2015 projected.

Q. Was that an opinion that changed from your original report to the addendum?

A. When my thinking -- when I did my original report, would have been that it was appropriate to use 2013 because of my prejudice coming from an environment where you adjust by age. And using that logic instead of more appropriately looking at what is being done with average family size and the fact that because you do an age rate you have to age adjust.

Q. Okay. Thank you. And so your updated opinion is on points two and three are included in your addendum letter?

A. Yes.

MS. KUIPER: I would like to now move that the HCA-A be admitted.

MR. KARNEDY: Same objection.

MS. HENKIN: Noting the ongoing objection, I'm going to allow for admission of this, would be entered into evidence HCA Exhibit A.

MS. KUIPER: Thank you.

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

BY MS. KUIPER:

Q. When you review filings, do you ever recommend that the rates need to go up?

A. Of the -- looking just at ACA filings at the one hundred plus that I've done in the last couple years, I've recommended twice that they go up. Once I recommended a change in assumption that resulted in restructuring the filing, but the rate not changing. Another time I recommended that the carrier again rethink an assumption, and they came down, and in all the other filings we have not made a change.

Oh, I'm sorry. There is one other where we made multiple recommendations. Some went up, some went down. The net amount was the rate went down.

Q. So about how many filings?

A. ACA filings over 50 both years. Over 50 this year, and over 50 last year.

Q. Okay. And is there a point in when -- in your opinion, where a higher rate increase for a filing would actually result in reduced profit for the company?

A. That's a problem. Yes. And when I worked at Blue Cross Blue Shield Association we had one situation

where the actuary and I were adamant that the rate increase should not take place because it was going to actually reduce profitability. And I can explain the phenomenon, but --

Q. I would like you to explain it please.

A. Okay. So when you get a large rate increase, typically if there is another option to purchase insurance, and certainly in an environment where you have very comparable products and there is an option for an individual to go out and purchase a competing product, the logical thing would be for them to do it. Except if a person is ill and is under a certain -- in the middle of being cared for and is committed to certain doctors, and they feel that is going to be threatened by them leaving. There are a lot of other reasons people don't leave, but the biggest one for staying with the current organization is that they have health problems and that they are afraid making a change will cause a problem with their payor.

Q. So can you be more specific, how would that have an effect?

A. Healthier people leave, leaving the less healthy behind, and now the rate is not adequate for the people that are left behind. And you lose membership and now you have a lot more of the critical mass.

Q. Is that in part because less healthy people

are more expensive than healthy people?

A. Yes.

Q. I have no other questions.

MS. HENKIN: Attorney Karnedy.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Good afternoon, Ms. Novak.

A. Good afternoon.

Q. Call you Ms. Novak, is that okay?

A. I'll answer to that, yes.

Q. I'll take that as an okay. There is something that you just said that I didn't quite understand. In 100 cases you reviewed in only two of the hundred cases have you recommended a rate increase; is that right? Two percent?

A. Yeah. Actually I recommended a change -- in one case I recommended a change in an assumption that the carrier accepted and raised the rates. And another one a number of changes of assumption, the net amount was an increase.

Q. So should we say four percent then instead of two?

A. No, those two.

Q. Two out of one hundred?

A. Yes.

Q. Now you have been retained to review MVP's rate filing and look for savings, where the HCA would say the rates should be cut; correct?

A. I'm sorry. Could you say that again?

Q. Sure. You have been retained by the HCA to opine and look for savings -- places where our rates can be cut; fair?

A. No. I was retained to review a rate filing and see if I had any issues with the methodology or assumptions.

Q. Fair enough. Have you ever done work for the Health Care Advocate in Vermont before this assignment?

A. No -- oh, I have actually. I have reviewed other rates. This is the first time I've actually come to hearing.

Q. Welcome to Vermont.

A. Thank you.

Q. You understand that the purpose and role of the Health Care Advocate in these proceedings is to look out for the public interest; correct?

A. Yes.

Q. And their purpose and role is to ensure that Vermonters get the lowest rates possible; correct?

A. The most appropriate rates possible.

Q. Fair enough. And their purpose is not to

advocate for increasing MVP's proposed rates, right? That's not their purpose?

A. I doubt if that's their mission statement.

Q. And to your knowledge have they ever advocated to increase MVP's proposed rates?

A. Not to my knowledge.

Q. And you're here testifying on behalf of the HCA; correct?

A. Yes.

Q. If you would opine that MVP's filing, proposed rate increase, was reasonable and well supported and agreed with our 15.4 percent, that would not have met the needs of the HCA in this proceeding; correct?

A. It would not have met their goals. No.

Q. When a company hires and pays an outside consultant to come in and look at ways to cut costs, and that consultant does not identify any costs to cut, well they really haven't justified their existence, have they?

A. Well not in that particular case, but they have given an honest answer.

Q. Fair enough. Exhibit 9 is your actuarial opinion, right?

A. Yes.

Q. And I note there is a supplement, but I want to focus first on just Exhibit 9. That is your complete

opinions. In addition there is a supplement we will talk about, but that contains your complete opinions as of August the 5th, right?

A. Yes.

Q. And how many hours did you personally spend working on Exhibit 9?

A. Personally 36 and-a-half as of last Friday. And that's not just in preparation. That's also in additional correspondence after that.

Q. Just want to ask you detail. Let me show you what's been marked for identification as MVP 14. And I'll represent to you that this is an E-mail that I received from the HCA as part of an expert disclosure that sets forth your hourly rate and other information.

Do you see that?

A. Yes, I do.

Q. And the date of this E-mail is July the 18th. Do you see that?

A. Correct.

Q. Okay. So this shows that you're paid 350 dollars an hour?

A. Correct.

Q. That's correct; right?

A. Yes. It is.

Q. And this shows some work by other consultants.

I think you identified they're at 170 an hour, 350 an hour; right?

A. Correct. Yes.

Q. And this also says that you will be prepared to testify as total billed to date at the time of hearing, do you see that?

A. Yes.

Q. Could you give me that figure please?

A. The total dollars billed?

Q. The total dollars that your company is being paid for opining here.

A. Okay. I don't have that number in front of me as far as what we have been paid. I do have a number of what we have earned through last Friday. But only -- it only has been -- well hasn't been paid. What's been billed, I don't know if we have been paid or not. We've billed July.

Q. I hope you get paid.

A. Eventually. But --

Q. How much have you billed, and then can you estimate the balance for me? I just want to get at the total number.

A. What I can give you is the total number of the -- I don't have the billings. But I do have the total number that I have earned through last Friday.

Q. Go ahead. What have you earned through last Friday?

A. 23 thousand dollars and -- 23,058 dollars.

Q. Okay. So that's through last Friday. And then you've got -- I won't count the Blue Cross Blue Shield, but you've got your work here today. We are talking in the magnitude of $25,000?

A. Might be a little more than that. By the way, can I correct a number I gave you earlier? I'm pretty sure on replay I gave you a bad number of my total number of hours. It's 46 and-a-half. I believe I said incorrectly 36 and-a-half.

Q. Okay. And the amount that your company is being paid for your opinions here is somewhere north of 25,000 but less than 30, is that fair?

A. That sounds right. That sounds right.

Q. And as of August the 5th when you prepared your actuarial opinion, how much of that 30 was spent -- how much time? I'm not holding you to the exact dollar. Give me a sense.

A. The majority of it. You know, the majority of it. I think there has been a few hours spent on, you know, E-mails and questions and things in between. I don't have the number in front of me.

Q. And now just to get a sense of magnitude. Do

you generally spend more or less time providing actuarial opinions on rates in other states when you opine?

A. I spend significantly less when I don't have to testify and don't have to prepare to testify.

Q. So can you help me apples to apples, generally did you spend the same amount of time on your work here -- forget about the testifying -- as you did in other states, or did you work more on this filing?

A. On this particular filing this was a more difficult filing than average, and I spent more time on it than average.

Q. Did you have any kind of budget in this case?

A. I did not.

Q. I saw from your resume and your testimony yesterday that other than three or four years when you worked for the Blue Cross Blue Shield Association that was back in the '90s, right?

A. Yes.

Q. So since that time you worked primarily for government agencies and employers; correct?

A. I worked as a principal at Mercer since that time. After I left the Blue Cross Blue Shield Association, I can't -- I never remember the chronologic -- chronology of this. But I know I worked for -- I was a principal at William M. Mercer now Oliver Wyman in

between.

Q. But your CV -- if you please go to Exhibit 9. I know it's hard to remember. You've had a very long and good career. But this sets out your professional experience, right? And at page 19 to page 20 it lists your professional experience. This is Exhibit 9 page 19 to 20. Do you see that?

A. Yes.

Q. And best as I can tell there were 18 references, two of them were about Blue Cross Blue Shield work, and the balance were for government agencies or employers, am I correct? Roughly?

A. I'm sorry. What page are you looking at here?

Q. I'm sorry. Page 19. Exhibit 9.

A. Specifically.

Q. This is your CV. It says professional experience, and then you list your professional experience. And I saw last thing listed was reference to Blue Cross Blue Shield, and about four or five up it says monitoring the solvency of Blue Cross Blue Shield. This is a general question. I don't want to go in the weeds. General question is other than working for Blue Cross Blue Shield and this other employment which isn't listed here, other than that generally in the last 15 years or more and working for government agencies or for employers; correct,

in providing opinions?

A. 15 years. 15 years would go back to 2000. And I don't remember if Deloitte & Touche was in there or not. But William M. Mercer now Oliver Wyman was, and then I started my own firm in 2002, and since I worked for my own firm primarily government agencies. Yeah. There are a handful of exceptions to that.

Q. And the best evidence of all of that is your CV that you provided as an exhibit, right?

A. Yes.

Q. Thank you. Now some philosophical questions if I could. Based on your experience you don't believe that health insurance carriers like MVP are to blame for the increases in health care costs for Vermonters over the years, do you?

A. For the cost?

Q. I'm sorry. I'm not quite done. My bad.

Would you agree with me that very large percentage of the increase in premium is attributed to an increase in contract costs, the service providers, and hospitals?

A. I agree that what drives health care premiums is health care costs from providers and utilization, yes.

Q. And would you agree with me that further complicating insurer pricing decisions is that health care

providers will be in short supply and less likely to reduce their fees or negotiate with insurers? Would you agree with that statement?

A. Yes, I do. I agree as you reduce the uninsured there is more demand and provider cost will go up.

Q. Would you also agree with me that the actuaries have a daunting task of predicting the impact the ACA will have on the cost of health care claims?

A. Yes.

Q. Okay. So let's go, if we could, to Exhibit 12 and focus on the issues that are in dispute. So we have got five issues, and I want to kind of take them out of order, starting with issue four please. So Exhibit 12. Issue four. Let me know when you're there.

A. I'm there.

Q. Thank you. So you challenge the administrative costs workup of MVP, but do you agree with me that the L&E opinion was that they were reasonable and appropriate; correct?

A. Yes.

Q. Okay. So on that point it's kind of two versus one, MVP and L&E think one thing, and you think something different; correct?

A. Good thing I'm part Irish, yes.

Q. Well I am too. Okay. And then on issue three please. This is the manual rate error. You talked about that a fair bit in testimony. But you would agree with me that on that issue which is a .5 percent issue here, this is another case where L&E agrees with MVP, and it's kind of two versus one, would you agree with me?

A. I do.

Q. Issue five. This is on contributions to reserves. Now if you testified yesterday, and I was here and I tried to write it down, so it might not be quite correct, I think you said, and you would agree with me, quote; it's important to protect the solvency of an insurance company.

A. I agree with that.

Q. Here you want to reduce our reserves, 1.5 to 1.0. And you would agree with me that the Department has indicated that they are of the opinion that the rates as proposed will not have a material impact on solvency and surplus of MVHP or the MVP Holding Company, that's the Department's position; correct?

A. Can I disagree with two points with what you just said?

Q. I'm just asking whether that's the Department's position. I'm quoting and I can get it out.

MS. KUIPER: The Department is here to

testify. You have the chance to ask the Department their opinion, and now you're asking our expert to --

THE WITNESS: You also stated something about me, what I was saying. And that was incorrect.

MS. HENKIN: Can you repeat your question at this point?

BY MR. KARNEDY:

Q. I'm going to read you a quote. And then I'm going to ask you a question. Okay. So quote -- this is from the Department's letter.

DFR is of the opinion that the rates as proposed will not have a material impact on the solvency and surplus of MVPHP or the MVP Holding Company. Do you recall reading that?

A. Yes.

Q. And is it also true that the Green Mountain Care Board found that quote; we do not recommend any changes to the contribution in reserves, but the results of Department of Financial Regulation solvency analysis should be considered. Did I read that correctly?

A. That's correct.

MS. KUIPER: I'm sorry. I object to -- could you repeat that second part of that

question?

MS. HENKIN: Can you make it clear where that comes from please, so we can follow that in fact that's the quote?

MR. KARNEDY: Sure. I was quoting from the -- we can go to the exhibit if you would like.

MS. HENKIN: That would make sense.

MR. KARNEDY: I'm trying to move it along. I apologize.

MR. DONOFRIO: I think the confusion, Gary, may have been that you prefaced that second question the Green Mountain Care Board found, I'm assuming you're quoting.

MR. KARNEDY: Actuary found.

MS. HENKIN: You said Green Mountain Care Board. Please refer to the document, and we will get that straightened out.

MR. KARNEDY: Thank you. I apologize.

BY MR. KARNEDY:

Q. And I had it written down right. I read it wrong.

If you go to please Exhibit 8 in your binder. And it's page 7 and up above paragraph 9. Number 9. There is a sentence that starts "We do not." Do you see

that? And the "we" in that sentence is not the Green Mountain Care Board. It's their actuary.

Do you see that? So the sentence reads; we do not recommend any changes to the contribution to reserves, but the results of the Department of Financial Regulation solvency analysis should also be considered. Do you see that sentence?

A. Yes.

Q. And you've heard the testimony of L&E and the Department on this point. Correct?

A. Yes.

Q. So would you agree with me this is another case where there is a difference of agreement, that's fine. But that L&E, MVP and the Department don't agree.

A. No. Not totally. Because I never recommended a reduction. I just said that one could be made without any concern about solvency, and that's different than what the others are saying.

Q. Excuse me. I apologize. So this is a non issue from your perspective?

A. All I'm saying is it could be reduced. I'm not recommending it be reduced.

Q. I apologize. Thank you. So now we are down to two issues. Go back to Exhibit 11. Excuse me, Exhibit 12. Issue two. Which is demographics and morbidity. Let

me know when you're there.

A. I'm there.

Q. Now first I want to ask you about your August 5 opinion. In that opinion you did not recommend making any adjustment for demographics; correct?

A. I said I did not have an opinion on it because I hadn't sufficient time to research it. And I wasn't going to just say "me too" without researching it, understanding it, and having it peer reviewed.

So all I said was I didn't have enough information to make an opinion.

Q. So you did not provide an opinion on that in your August 5 --

A. Right.

Q. Okay. And MVP certainly didn't recommend a 3.2 percent demographic adjustment, did they? MVP.

A. They did not.

Q. So at that point in time, as of August the 5th, there you've got Ms. Lee kind of falling in the minority. She had an opinion, we disagreed, and I guess you were neutral on that. You had no opinion one way or the other?

A. I had not done the research to have an opinion on that.

Q. But you had plenty of time to come up with

your August 5 opinion, and as of August the 5th it was not an issue you had spotted; correct?

A. Correct. I had not spotted that issue.

Q. And you worked hard and were very thorough, the majority of the money you had spent to date in this case was working on that August 5th letter, right?

A. Correct.

Q. So now you provided a different opinion as of August the 11th, right? In your letter which you testified to today?

A. I'm providing an opinion. I had no opinion at that time. A different opinion than everything in August. Yes.

Q. Right. So this past Monday your opinion changed.

A. Actually it was last Friday. But yes.

Q. We didn't get the letter until Monday.

A. It was communicated on Monday.

Q. And that change in your opinion basically doubled or more than doubled the percentage. You were at two percent reduction, now you're adding 3.2 to it effectively, right?

A. That would be the result. Yes.

Q. So you would agree with me, I think you said when you look back to figure out what the error was, tried

to work it out, you would agree with me that your August 5 opinion was deficient then, wasn't it?

A. Was deficient?

Q. Yes.

A. Yes.

Q. You weren't thorough, and you found that you missed something, right?

A. I made a bad assumption. Yes.

Q. Okay. Our rates were filed on June the 2d. So the HCA had several months to retain you and have you look over all this to opine on August the 5th, right?

A. Yes.

Q. And you also talked a little bit today or yesterday about your process, and I think you talked about it today as well where you said that the peer review -- you have a peer reviewer to make sure you don't miss something, right?

A. Yes.

Q. So both you and the peer reviewer as of August the 5th didn't believe in this 3.2 percent reduction, did you?

A. We did not identify that as a possibility. No.

Q. And would you agree with me that all of your opinions should be based on your own independent review?

A. I ask for input from a lot of my staff and actuaries when I'm getting --

Q. In-house I mean, your company's opinions, you work as a team, I understand that.

A. Unless I request it outside. Yes. I have often called CCIOO and asked for input, so I do get outside input.

Q. And between August 5 and August 11 did you receive any additional information from the Green Mountain Care Board actuary regarding quantitative support for its calculation?

A. No.

Q. But you indicated you couldn't comment without it, right?

A. I couldn't comment without finding where it was and rethinking it. It was -- actually had been provided in answers to their question.

Q. So you said "me too." But I think you also said that it's not appropriate just to say me too. You need to have your own independent support for that conclusion of a 3.2 percent reduction, right?

A. Yes.

Q. And the only support that you provided are three sentences in your -- strike that.

The only support you provided is your

testimony today and this Exhibit A; correct?

A. The only support I provided was my testimony today.

Q. Okay. Last issue is on the pharmacy trends. Issue one on Exhibit 12. Now this was the only issue until this past Monday where -- when you and Ms. Lee had some agreement, as best I can tell, on the pharmacy trend she said reduce the rate I should say -- L&E said reduce the rate by .1, and you've indicated to reduce it by an additional .4, is that a fair summary?

A. Yes. We used different assumptions and those are the results of the different assumptions we used.

Q. So on this issue again, MVP -- well actually no. It's you two against MVP. You win two to one on the point one. But on the point four they don't agree with you, we don't agree with you, but you're entitled to your opinion, right?

A. Yes.

Q. And you said for your analysis on the pharmacy trend that you didn't have the 2014 filing. I think you said that in your --

A. I did not have the URRT from the 2014 filing.

Q. Was that something you wanted to be able to provide a fair and clear opinion?

A. It would have allowed me to do a better

calculation instead of an estimate.

Q. Thank you very much.

MS. KUIPER: I'd like to ask more questions.

MS. HENKIN: You're finished?

REDIRECT EXAMINATION

BY MS. KUIPER:

Q. After you received L&E's recommendations did you submit additional questions to L&E for clarification?

A. No.

Q. Why did you feel unprepared to opine on L&E's recommendations on August the 5th?

A. I was in the middle of finalizing my own report. It wasn't immediately obvious to me where the 2.8 percent came from and some of these other numbers. I started to research it through all the materials that had been provided. Couldn't find it. And felt that it was more important to get my report peer reviewed and published than at the last minute trying to research somebody else's opinion and research the methodology and assumptions that went into it.

Q. And you didn't want to just say "me too" without knowing?

A. Right. Because saying "me too" means it's my opinion too, and without my understanding it, I couldn't

do that.

Q. Thank you. Could I refer you to Exhibit 13. Do you recognize these?

A. Is that Exhibit 13?

Q. I'm sorry. It's not in here.

A. It's not in the book. Unless -- 14.

Q. I'll give you mine.

MS. HENKIN: Can you just provide a copy?

THE WITNESS: Yes, I have it.

BY MS. KUIPER:

Q. Do you recognize these questions?

A. Yes, I do.

Q. Okay. And so would you agree these are additional questions that we submitted to Lewis & Ellis after their recommendation?

A. That's what you had submitted.

MS. HENKIN: Could you please speak up?

THE WITNESS: I'm sorry. Usually my voice carries so well. Yes, this is what had been submitted to Lewis & Ellis asking for additional information.

MR. KARNEDY: I apologize. I was looking down. What exhibit are we looking at?

MS. KUIPER: I'm sorry. I think we were done.

MS. HENKIN: It was Exhibit 13.

MR. KARNEDY: Thank you very much.

BY MS. KUIPER:

Q. You testified as to the number of hours that you worked on this filing. Why did you work so many hours on this filing?

A. It wasn't well structured. It wasn't complete. There were a lot of follow-up questions from Lewis & Ellis that I had to analyze the questions and the answers. The questions and the answers were in two different documents and Excel in another one.

I spent a lot of time trying to get all the pieces together so I could put them side-by-side with the questions and answers. A lot of numbers didn't match. And so I spent a lot of time trying to figure out why numbers I thought should match weren't. It was some of this incurred versus allowed.

Q. Would you say it was more difficult than all of the other ACA filings, or the majority of the other average ACA filings that you review?

A. It's more difficult than the average. Yes.

Q. Okay. And you testified that you reviewed other filings for the ACA -- HCA office of Health Care

Advocate?

A. Yes.

Q. And to the best of your recollection how often did you recommend increases in those filings that you reviewed for our office?

A. I honestly don't remember the result of my recommendations. My recommendations are normally just issues to ask questions about and look into. But not how to impact the final rate filing. You know, just ask about this and that, it's more what to follow up on and understand than it is change the rates.

Q. So you didn't make a point to increase rates for every recommendation?

MR. KARNEDY: Object to the form.

MS. KUIPER: Sorry?

MR. KARNEDY: I don't think there is a basis for that.

MS. KUIPER: So I think he asked her about --

MS. HENKIN: Can you just repeat your question again?

BY MS. KUIPER:

Q. Did you make a point to increase rates when you reviewed filings for the HCA?

MS. HENKIN: I'll allow that question.

THE WITNESS: No. My point is looking at methodologies and assumptions and then when I recalculate the impact of those assumptions, sometimes it goes up, sometimes it goes down.

MS. KUIPER: Okay. Thank you. That's all.

MR. KARNEDY: Two brief follow ups, if I could.

RECROSS EXAMINATION

BY MR. KARNEDY:

Q. Forgot to ask you on solvency, you're providing -- and I think we got to the end. Just briefly did you talk to the New York Department of Financial Services at all about issues relating to MVP?

A. No.

Q. And then I meant to ask you, ask about other things you've worked on. I think you're currently -- I remember from yesterday I think you're currently working in three other states for the equivalent of the Health Care Advocate here --

A. Yes.

Q. -- on the filing.

A. Yes. Two other states. Three states in total.

Q. Two plus one. Thank you very much.

MS. HENKIN: Is that it?

MR. KARNEDY: Yes.

MS. HENKIN: Let me ask if the Board has questions.

MS. RAMBUR: I just have one brief question. Really more for my own understanding. Exhibit 10. Page 43. You talk a little bit about risk to solvency in the five-year historical data. Without going into specifics I'm just curious in terms of best standards in the industry, how you look or how you advise a group like us when there is a small -- a small book of business within a much larger book of business.

Is it typical that that smaller group of -- book of business sort of can hold its own, how much it's carried by a larger entity, sort of what's the standard.

THE WITNESS: The standard. Usually, and Blue Cross Blue Shield Association rules are consistent with this, if you have a smaller entity that is supported by a larger parent company, you allow their particular

capital level, there is no reporting in this case of the other entity. But often there is say a small HMO that's part of the bigger Blues plan. And so their capital is allowed to get a little bit lower because of that support of the parent organization.

But if -- it's usually watched very carefully. And if that other organization is out of state, many states, so you have a small HMO in a state, and the parent organization was out of state, the regulator would be very careful about that extra profits or solvency being moved out of state from in state. Just in general those are the issues.

MS. RAMBUR: Thank you.

MS. HENKIN: Con? Karen? I think that's going to be it for this witness. Thank you very much.

Mr. Karnedy, did you have anything else? You made a comment earlier.

MR. KARNEDY: I did. If I could put Mr. Lopatka back on, I've got three questions.

MS. HENKIN: If it's three questions I can allow it.

Is there anyone here from the public who is going to be commenting? There's no one on the list. Okay. Mr. Lopatka, remember you are sworn in.

PETE LOPATKA

Having been previously duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. KARNEDY:

Q. First question; why do actuaries calculate age and gender factors?

A. They are -- it's tried and true for the last 50, 60 years about -- to help with the predictability of health care costs. So when you're adjusting your experience period to the future period, and if your age/gender mix changes, then your projection period will be different.

And to get an order of magnitude, the difference between roughly say a 63 year old and a 20 year old is like eight to one. So a 63 year old consumes eight times more health care service than say a 20 year old, in orders of magnitude, but it varies by gender, but the biggest one is age.

Q. And are age/gender factors and morbidity mutually exclusive?

A. Absolutely not.

Q. Explain that.

A. That's the -- age is a big indicator of usage of health care services which is the -- what you're

getting at by making all these adjustments is the future usage. And so the older you are, call it sicker, the morbidity level, the more usage of health care. So it's entirely appropriate to adjust your health risk profile, terminology I like to use, of your experience period for what you think the projection period is going to be. But the concept of morbidity and age factors being mutually exclusive, that's not the case. They are highly correlated.

Q. And the last question. Ms. Novak talked a bit in a prior year broker commissions used to be in and now they are out. I got lost.

Can you explain what the facts are on that please?

A. Yes. I can refer to the exhibit.

Q. Exhibit 12?

A. Exhibit 12. Page four. Where --

Q. Just wait a sec until everybody is there. Okay. Go ahead.

A. We're quoting a -- what we are building into pmpm or in the premium on a pmpm basis of $40.60 for administrative costs and comparing that to actual costs in 2013 of $45.58. Neither of those include broker commissions. Broker commissions is a separate entry. It's not included in this definition here of admin just

like taxes aren't included in here. There is other costs that aren't health care that are called retention load, so you would have your admin, brokers and taxes.

Q. So is this brokers' issue a red herring then?

A. It's not on this exhibit. When we talk about that, what we have loaded in, less than it cost us on an administrative basis in '13, the broker issue is not part of that.

Q. Thank you very much.

MS. HENKIN: Do you have anything of this witness?

MS. KUIPER: No.

MS. HENKIN: Would you like to make a short closing argument?

MR. KARNEDY: No. I think the Board would rather that I not talk any more.

MS. HENKIN: Let me remind the parties that we have memos due in this on August 21. A decision will be issued in this matter no later than September 2. The public comment period is open until the 18th, and I described how to do that for anyone here who wishes to still comment.

And if there is nothing else, I will turn this hearing back over to Chairman

Gobeille.

MR. GOBEILLE: Thank you, Judy. I want to thank all the parties here today. And pretty much all we have left to do is a motion to adjourn.

MS. HEIN: Move that we adjourn.

MR. GOBEILLE: Thank you, Karen. Is there a second?

MS. RAMBUR: Second.

MR. GOBEILLE: Thank you. Any discussion? All those in favor?

ALL BOARD MEMBERS: Aye.

MR. GOBEILLE: Any opposed?

(No response.)

MR. GOBEILLE: We are adjourned. Thank you very much everyone.

(Whereupon, the proceeding was adjourned at 1:12 p.m.)

C E R T I F I C A T E

I, Kim U. Sears, do hereby certify that I recorded by stenographic means the hearing re: Docket Number 017-14, at Room 11 of the Vermont State House, State Street, Montpelier, Vermont, on August 13, 2014, 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 193 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 14th day of August, 2014.

_____

Kim U. Sears, RPR