STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-006-20rr

VERMONT HEALTH CONNECT RATE REVIEW HEARING
(MVP Health Plan, Inc.)

July 21, 2020
8 a.m.

Hearing held remotely before the Green Mountain Care Board via Microsoft Teams on July 21, 2020, beginning at 8 a.m.

P R E S E N T

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

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VT Department of Financial Regulation
GAVIN BOYLES, ESQUIRE

INDEX OF EXAMINATION

EXHIBITS

CHAIRMAN MULLIN: So good morning everyone. I believe it is the 8 o'clock hour and we'll get started. First things first. I want to announce that at 4:30 today there will be a public hearing, and if we have any time at the end of today's hearing, which it will probably be unlikely, we could take some comment at the end of this hearing, but it might be more appropriate for people to join into the time period specifically allotted for public comment.

Today's focus is the MVP QHP filing and for the purposes of today's hearing I am hereby appointing Michael Barber the Hearing Officer, and at this time I will turn over the meeting to Mike.

MR. BARBER: Thank you, Mr. Chair. Good morning. As you heard I've been designated by the Board Chair to serve as the Hearing Officer for today's hearing. The purpose of this hearing is to take evidence and argument on MVP Health Plans 2021 individual and small group rate filing. The Docket Number for this case is GMCB-006-20-rr. The GMCB has jurisdiction over this matter pursuant to Title 18 of the Vermont Statutes Annotated Section 9375 as well as Title 8 of the Vermont Statutes Annotated Section 4062.

Representing MVP today are Gary Karnedy, Ryan Long, and Michelle Bennett of the law firm Primmer Piper Eggleston & Cramer. Representing the Office of the Health Care Advocate are Jay Angoff, Kaili Kuiper, and Eric Schultheis, and also want to recognize the Board's Associate General Counsel Amerin Aborjaily. She will be conducting the Board's direct examination of the Board's experts. Gavin Boyles is also on the line I saw, General Counsel for Department of Financial Regulation.

Because we are holding the hearing remotely today before I go any further I want to make sure all of the Board Members, all the attorneys for the parties, can hear okay and can be heard by everyone. So just going to do a quick roll call. If I call your name if you could just let me know if your system is working okay. Mr. Chair, we already heard from you. Board Member Holmes.

MS. HOLMES: Yes.

MR. BARBER: Board member Lunge.

MS. LUNGE: Yes.

MR. BARBER: Board member Ucifer.

MS. USIFER: Yes.

MR. BARBER: Board member Pelham.

MR. PELHAM: Yes.

MR. BARBER: Amerin.

MS. ABORJAILY: Yes.

MR. BARBER: Mr. Karnedy.

MR. KARNEDY: Yes and I have, watching on the screen next to me, Attorney Long and Attorney Bennett.

MR. BARBER: Great. Mr. Angoff.

MR. ANGOFF: Yes, sir.

MR. BARBER: Mr. Schultheis.

MR. SCHULTHEIS: Yes.

MR. BARBER: And Ms. Kuiper.

MS. KUIPER: Yes.

MR. BARBER: Great. So I would like --

CHAIRMAN MULLIN: Before we get started I didn't announce it today, but I did announce it yesterday, I know it's a little bit cooler, but I'm setting the example by not wearing a jacket recognizing the summer heat. So Gary and Matt, if you wish to take yours off, feel free. Sorry, Mr. Hearing Officer.

MR. BARBER: Appreciate that. I was sweating all day yesterday even without the jacket.

MR. KARNEDY: If the Chair could take judicial notice it will accelerate my examination in return for this favor.

MR. BARBER: So as we've discussed if at any point you get dropped from the call, you have my cell phone number, please text me. I'll pause the hearing, allow you to get back on. Yesterday we were on for a long time. We didn't really have any technical issues. I'm hoping things will go smoothly today.

We are recording today's proceedings via the Teams app. We also have a court reporter here, Ms. Carson, to transcribe the proceedings. I should have checked earlier, but, Ms. Carson, are you on?

(Off-the-record discussion.)

MR. BARBER: It looks like we have 37 attendees in the meeting, most of whom I can see are here. We have a couple phone numbers. The Board has been basically doing a roll call for its board meetings. Since people may be coming and going throughout today's proceedings I don't think we need to do that. Does anyone think we need to take a roll call attendance of people who are here on the phone? (No response.) No. Okay.

So for any members of the public who are present, like the Chair said, we will be taking public comment at the close of the proceedings today, however, it's unclear when that will be. So I can't

say when we'll get to the public comment portion of the meeting, and if you don't want to sit through what's going to be hours of testimony, we have a meeting this afternoon from 4:30 to 6:30 that is dedicated exclusively from hearing from the public on this filing and the other individual and small group rate filing for Blue Cross/Blue Shield of Vermont. Information for how to participate in that meeting can be found by going to the GMCB's web site and clicking on the rate review tab. Additionally, you can submit written comments to the Board via our web site or by regular mail. We'll be taking public comments on this filing through July 23rd. Please do not use the chat function of Teams if you're on the computer. That's going to be very distracting for all of us.

We already did the microphone check, muting check. So the last thing before we begin I just want to remind the Board and the parties to exercise caution regarding any information in the binders that has been marked confidential. These matters can't be discussed in the public setting. The parties have marked documents that contain confidential materials as confidential in the hearing binders and, Mr. Karnedy, I wonder if you could just

explain to the Board how the material is designated because there's a bit of a difference between the way MVP did it this year and the way Blue Cross Blue Shield did it, just to remind the Board how it's set out in the binders.

MR. KARNEDY: I'm happy to do that. I can go through the exhibit list and explain that when Mr. Lombardo is on the stand. I can do it at that time if you like.

MR. BARBER: Okay. So let's get into the exhibits. We received the binders on July 16th with 33 Bates stamped exhibits. I understand the parties have stipulated to the admissibility of these documents. The binder also contains three exhibits marked HCA A through C that I understand the parties have not stipulated to, and on Friday afternoon we received four additional exhibits from MVP labeled D through G that I understand the parties have stipulated to as well. Am I understanding all that correctly?

MR. KARNEDY: Yes.

MR. BARBER: I just want to check to make sure the Board Members have all those documents. Do you have the documents readily available that came in on Friday exhibits D through G? (No response.)

Does anyone not I guess? (No response.) Looks like everyone does. Okay.

Mr. Karnedy, I do have a question about exhibit G which is the solvency opinion for Blue Cross Blue Shield of Vermont. Can you tell me why the majority of that document has been redacted?

MR. KARNEDY: I think it goes -- we basically have left two paragraphs where the Commissioner discusses some uncertainty about returning premium. That's all we wanted to ask about and I thought it would be inappropriate to have the balance of information about Blue Cross Blue Shield's solvency in this hearing. That has nothing to do with this hearing.

MR. BARBER: Okay. Do you have unredacted copies available should the testimony or the questioning require that?

MR. KARNEDY: We can certainly get those. My expectation is that anything beyond those two paragraphs wouldn't be relevant to these proceedings and I would probably object to that, but we can certainly -- our team can get copies of those certainly.

MR. BARBER: Okay. So I'm assuming neither party has any objection to me admitting

exhibits 1 through 33 and exhibits D through G at this time; is that correct?

MR. KARNEDY: Correct.

MR. ANGOFF: No objection.

MR. BARBER: Okay. I will do that at this time.

(Exhibits marked MVP 1-33 and D-G were admitted into the record.)

MR. BARBER: So that leaves exhibits A through C. Mr. Angoff, how do you plan to introduce documents A through C?

MR. ANGOFF: Mr. Hearing Officer, I'm sorry, I'm unfamiliar with those exhibits. Maybe Mr. Schultheis or Ms. Kuiper can address that.

MR. SCHULTHEIS: Sure. We would like to move the Board to take administrative notice of exhibits A through C. Both -- all these documents are statistics provided by the U.S. Bureau of Labor Statistics. They are relevant because they speak to the price shocks that Vermonters are currently experiencing. Unlike in the past we felt that because the coronavirus economic fallout is evolving so rapidly that we wanted to provide monthly data so we could get a sense of what things are looking like in May and June, and that yearly estimates were not

going to be helpful to the Board.

MR. BARBER: Mr. Karnedy, do you have any objection to me taking administrative notice?

MR. KARNEDY: I do. All three exhibits reference percent changes in the CPIU for all urban consumers, urban consumers, and exhibit A in fact, documentation goes along with it, indicates a technical note that not including the CPI or the spend patterns of people living in rural non-metropolitan areas, farming families, et cetera.

So the general objection is this data relates to people who live in the city. There are -- I love Vermont, but there aren't really any urban areas and this just isn't relevant to Vermonters, and I would add that we've stipulated to a number of other exhibits some of which come from the Vermont Department of Labor. So I don't think there's any relevance.

MR. SCHULTHEIS: Just for clarity our position is that CPI is a widely accepted statistic. Unfortunately these numbers are not released for at a state level nor are they released by the State of Vermont. You know this is a known drawback of inflation numbers, and I think rather than exclude the evidence for that, we have relatively

knowledgeable triers of fact here and they can give the evidence the weight it deserves.

MR. KARNEDY: Last point on that. I think using your common sense these shouldn't go in. If you buy a cup of coffee or a beer in Vermont, that's a totally different experience than buying a beer down in New York City. So using your common sense I just don't think that this data is relevant.

MR. BARBER: Beyond relevance is there any objection to the admissibility of the documents in terms of authentication, things like that?

MR. KARNEDY: No. Absolutely not.

MR. BARBER: Okay. So I'm going to admit them. I do think they are relevant to the issue of affordability and the weight they should be afforded is a question the Board can figure out. So I'm going to admit exhibits A through C at this time.

(Exhibits marked HCA A-C were admitted into the record.)

MR. BARBER: So is there anything we need to address before we get into opening statements?

MR. KARNEDY: I don't believe so.

MR. BARBER: Mr. Angoff.

MR. ANGOFF: No sir.

MR. BARBER: Okay. Then Mr. Karnedy, would you like to make an opening statement?

MR. KARNEDY: Yes. Thank you very much. My name is Gary Karnedy. My law firm Primmer Piper Eggleston & Cramer represents MVP again this year in the 2021 rate filing. 2020 has been an extraordinary year with this pandemic. MVP, Department of Financial Regulation, and this Board have risen to the challenge of addressing the complexities of COVID and the world health. For this 2020 rate filing the evidence will show that the actuaries for L&E and MVP are in agreement on 15 out of 16 factors L&E identified in its memorandum. The evidence will show that MVP is now seeking an increase of 6.06 percent. The evidence will show that L&E has recommended a rate increase of 5.38 percent. This difference is around .6 percent depending on rounding.

The one issue of disagreement this year is the extent to which COVID will impact rates in 2021. The evidence will show that both L&E and MVP recognize that due to COVID disruptions even higher premium increases may be required than what they propose. As to the .6 difference they disagree by about .3 on whether pent-up demand for surgeries will impact the rate. They disagree by about .3, so the

other half, on how COVID vaccinations will impact the rate, they disagree on the extent of the impact and how to account for a rate increase.

We believe L&E is correct on 15 out of 16 of its rate factor opinions which amounts to 94 percent, which is an A but it's not A plus. This disputed issue is very important. MVP's conclusions on COVID-19 are actuarially sound and reasonable. We believe MVP is making tough calls this year measuring risk uncertainty based on sufficient data and expertise which is what actuaries get paid to do.

We believe the weight of the evidence and the common sense of the Board in considering these issues will result in adoption of MVP's 6.06 percent rate increase request and rejection of L&E's rationales on this one rate factor difference.

MR. KARNEDY: Thank you very much.

MR. BARBER: Thank you, Mr. Karnedy. Mr. Angoff, do you have an opening statement?

MR. ANGOFF: Yes I do. Good morning, Mr. Hearing Officer. Good morning, Mr. Chair and Members of the Board. This year for the first time we're asking the Board to give the benefit of the doubt to the policyholder. This is not what MVP does and it's not MVP's job to give the benefit of the

doubt to the policyholder. Clearly that's not what L&E has done either. You remember last year L&E said MVP wasn't asking for enough money, that they should be charging Vermonters more. So we're asking to ignore what MVP asked for.

So what we're asking the Board to do is for the first time to give the benefit of the doubt to the policyholder and we're asking that for three reasons. First, this year people obviously are suffering more than they ever have before because of the Coronavirus pandemic.

Second, unlike Blue Cross, MVP's surplus is not an issue in this case. No matter what the increase or decrease the Board orders for MVP this year it will have a minimal, nominal effect on MVP's surplus. That doesn't mean that the Board -- that doesn't mean that the Board should disregard the facts. Of course not, but if there's a range, and there always is a range, the Board should err on the side of giving the benefit to the policyholder not to MVP.

Third, there's so much uncertainty this year. Blue Cross has said it, MVP has said it, we'll continue to say with so much uncertainty, again, that's another reason that the Board should give the

benefit of the doubt to the policyholder.

Second point I would like to make. The amount that MVP has paid out in 2020, it's already got six months of paid claims data, it is very, very important both in determining what the rate increase or decrease should be for 2021, also in determining, assuming the Board believes it has this power and I don't know whether it does or not, but if the Board believes that it has this power, it should consider whether to order a rebate for 2020 rates in connection with 2021 rates. So I just ask the Board to look carefully at the data that MVP has disclosed about their paid claims in 2020 and look equally carefully at the analysis that L&E has done regarding those paid claims and regarding what it thinks those paid claims will ultimately result in, in 2020 and to make its own decision as to the level of increase and decrease for 2021 and whether or not to order a rebate for 2020.

Third point. MVP gives us all a terrific opportunity to see how much difference there is between Vermont, which has done the best job, which has the fewest coronavirus cases in the country and New York which has the most. So I think it's very important to look at the assumptions that MVP

has made regarding how the coronavirus will affect claims in Vermont and compare those to the assumptions it's made as to how the coronavirus will affect claims in New York.

So finally I would just like to conclude by saying -- by emphasizing again please give the benefit of the doubt. There's always a range. There's no one perfect one correct assumption for any of it. Please give the benefit of the doubt to the policyholder. If MVP has disclosed sufficient data that you believe it has made a clear and convincing case that its assumptions should be adopted by the Board, then adopt that assumption, but if MVP has not disclosed sufficient data to allow the Board to conclude that it has made that clear and convincing case, please give the benefit of the doubt to the policyholder. Thank you very much.

MR. BARBER: Thank you, Mr. Angoff. I'm going to check on Tom Pelham. Maybe he had a bird fly in the stove again, but I don't see him on video. Are you still there? You are. Okay. Okay. Mr. Karnedy, would you like to call your witness?

MR. KARNEDY: MVP calls Matt Lombardo please.

MR. BARBER: Let's all just take a

minute to pin Mr. Lombardo if that's what you're doing -- I'm doing. Okay. Mr. Lombardo, ready to take the oath?

MR. LOMBARDO: Yes.

MR. BARBER: Will you please raise your right-hand?

MATTHEW LOMBARDO,

Having been duly sworn, testified as follows:

MR. BARBER: Okay. Mr. Karnedy.

MR. KARNEDY: Thank you.

DIRECT EXAMINATION

BY MR. KARNEDY:

Q. Good morning, Matt.

A. Good morning.

Q. Bright and early. Would you please state your full name?

A. Matthew Lombardo.

Q. And, Matt, who is your employer?

A. MVP Health Care.

Q. And as I understand it this rate filing is MVP Health Plan, Inc., correct?

A. Correct.

Q. What is the relationship between those two entities?

A. MVP Health Plan, Inc. is the non-profit HMO legal entity under the MVP Health Care umbrella.

Q. And what's your position at MVP?

A. Senior Leader of Actuarial Services.

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

A. I'm a Fellow in the Society of Actuaries and I'm a member of the American Academy of Actuaries.

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

A. About 15 years.

Q. How many years at MVP?

A. 12 and a half years approximately.

Q. And can you tell the Board your involvement in Vermont rate filings for MVP and the GMCB?

A. Yes. So since the ACO rolled out in 2014 I've overseen these small individual Vermont emerging market rate filings. So this is the seventh rate filing -- eighth rate filing I'm working on.

Q. And what are your job duties at MVP?

A. In addition to pricing, setting premium rates, I'm responsible for forecasting our state programs in New York and commercial lines of business, reserving our IBMR, financial competitive intelligence. I oversee value based arrangements and strategic issues.

Q. Matt, would you turn to the exhibit binder please and go to the exhibit list?

A. Okay.

Q. What I want to do is just walk through these exhibits. They are all in evidence now, but to acclimate everyone to what we have and what you have knowledge of. Okay?

A. Okay.

Q. So if you look at exhibits 1 through 7 on the list that includes MVP's rate filing responses to objections, and you'll also note that, for example, exhibit 2 has a 2A which represents confidential. So the lettered exhibits are the confidential versions, the complete versions of the exhibits, correct?

A. Correct.

Q. And you're familiar with 1 through 7, correct?

A. Correct.

Q. And exhibit 8 is your CV that you prepared, correct?

A. Correct.

Q. Exhibit 9 is your July 7 prefiled testimony, correct?

A. Correct.

Q. You're familiar with it, right?

A. Yes.

Q. And exhibit 10 is the L&E actuarial opinion July 7th, memorandum, correct?
A. Correct.
Q. You have reviewed that and are familiar with it?
A. Yes.
Q. Exhibit 11 is the DFR solvency analysis letter that relates to MVP, correct?
A. Correct.
Q. And you've reviewed that and you're familiar with it?
A. Yes.
Q. And exhibit 12 is an actuarial standard of practice number 26, correct?
A. Correct.
Q. You have read that and are familiar with it?
A. Yes.
Q. And exhibit 13 is MVP's calculation of L&E's July 7th actuarial memorandum rate impact, correct?
A. Correct.
Q. And you prepared that and are familiar with it, right?
A. Yes.
Q. And then exhibit 14 is MVP's supplemental prefiled testimony. You authored that and are familiar

with it, correct?

A. Correct.

Q. And then exhibit 15 is prefiled testimony of Jackie Lee, Ms. Lee, of L&E, correct?

A. Correct.

Q. And you have read that and are familiar with it?

A. Yes.

Q. And then if you would please go to the third page, third page of the exhibit list, you'll see -- well let me know when you're there, Matt.

A. I'm there.

Q. You see a heading MVP Health Plan, Inc. Do you see that? There's lettered exhibits D, E, F, G.

A. Yes.

Q. So exhibit D that's the DFR emergency rule on COVID, correct?

A. Correct.

Q. And you're familiar with that?

A. Yes.

Q. And exhibit E is a draft -- it says draft, but a draft of terms from DFR, correct?

A. Correct.

Q. And then skip over F. Exhibit G is the DFR letter regarding Blue Cross Blue Shield this year which

has been redacted and has those two paragraphs Hearing Officer Barber and I discussed, correct?

A. Correct.

Q. And you're familiar with those two paragraphs, right?

A. Yes.

Q. So these exhibits that we just went over that we reviewed it includes statements from MVP, as to those you reviewed them or are familiar with them and adopt them as your testimony, correct?

A. Correct.

Q. And as we've done in prior years the bottom right-hand corner of the exhibits should be colored numbered pages and as we go through this I'll do my best to reference those page numbers. If you could do the same.

A. Okay.

Q. Okay, Matt, so first I want to start with an explanation of the rate increase at a high level. What was the original request for a rate increase -- MVP's original filing?

A. For the filing we submitted on May 8th MVP requested 7.34 percent increase to our 2020 rates.

Q. Okay, Matt, would you please go to exhibit 10 in the binder? Exhibit 10 is L&E's memorandum, and if you

go to page 17 please?

A. Okay. I'm there.

Q. You see there's two tables on this page. I want to focus on the one at the bottom that's entitled Components of 2021 Recommended Rate Increase. Do you see that?

A. Yes.

Q. And the bottom right-hand corner it shows L&E's recommendation of a total rate change of what amount?

A. L&E's recommended rate change is approximately 5.5 percent.

Q. And thank you. So if you would go to exhibit 13 please -- exhibit 13.

A. Okay.

Q. On page 2 there's a MVP calculation of L&E's Actuarial Memorandum Rate Impact. Do you see that, the title of the document?

A. Yes.

Q. So as I understand it this year the Board asked MVP to check the math, check the calculation of L&E's assumptions, and run it through the rate filing to confirm that their 5.5 number as a matter of math is accurate. Is that a fair summary?

A. Yes.

Q. And what does this memorandum exhibit 13 show?
A. So L&E's opinion had approximate rate changes and there were three changes that were made. So everything was an approximation. MVP took those recommendations from L&E's opinion and put them into our actual rate filing to see what the actual calculated amount was removing the approximation. The result was that the rate increase based on L&E's recommendations would actually be 5.38 percent not 5.5 as they had estimated.
Q. So that's not changing any of their assumptions or questioning anything they have done, it's just double-checking their math; is that right?
A. That's right.
Q. Would you please go to exhibit 15 and this is the prefiled testimony of Jacqueline Lee.
A. Okay.
Q. And go to page number 7 please.
A. Okay.
Q. And are you familiar with -- on page 7 there's two Q&A's. Are you familiar with those?
A. Yes.
Q. What is Ms. Lee saying here about the change to the 5.38?
A. In row 10 of this exhibit on this page she

says we believe that 5.3 percent is a reasonable computation of the impact of our recommended modifications because our calculation was based on estimates of numbers provided by MVP. We rely on the calculation of 5.3 percent as they have all the specific figures and formulas to determine the rate change more accurately.

Q. Matt, I couldn't hear you clearly because of age, but it sounded like you said 5.3. Doesn't it say 5.38?

A. It does say 5.38.

Q. So we have agreement with L&E on the math to 5.38, correct?

A. Correct.

Q. Would you go back to exhibit 10 please?

A. Okay. I'm there.

Q. And that on page 10 that table we were looking at, the recommended rate increase table, at the bottom --

A. I'm there.

Q. -- how many rating components did L&E identify?

A. 16.

Q. Okay, and again this is high level at this point. Of those 16 how many did they identify changes on where MVP's rate should be reduced in their opinion?

A. Well they identified three changes; two of

them are reductions, one of them is actually an immaterial increase.

Q. Okay. Is the first change item 4?

A. Yes.

Q. And does that relate to the COVID disagreement we had -- respectful disagreement we had?

A. Yes it does.

Q. And item 10 looks like another change -- excuse me. What's the amount approximately of the COVID-19 dispute on item 4?

A. Approximately 0.6 percent.

Q. And then item number 10 says change to risk adjustment, correct?

A. Correct.

Q. And that's a change of approximately what?

A. 1.1 percent.

Q. And do we agree with that adjustment?

A. Yes.

Q. Okay. We'll talk about that in more detail later, and then there's an item 12. This may have been what you were making reference to. Can you explain item 12 and the footnote and whether this is material?

A. Sure. I would start by saying it's an immaterial amount. It's 0 -- it's .02 percent and what this represents is all the plan designs submitted have to

be medal level compliant per regulations. One of the plan designs submitted by MVP, which is under review by DFR, was out of compliance with the bronze medal level. As a result through the former view we had to make a modification to the plan design which resulted in an increase in benefits. That increase in benefits has an overall rate impact of .02 percent.

Q. So let's go to the bottom line. Go to exhibit 14 please.

A. Okay.

Q. And this is your supplemental prefiled testimony that was filed after you got L&E's report, correct?

A. Correct.

Q. If you would go -- you see how there's Q&A's. You go to Q&A 4 which is on page 3.

A. Okay.

Q. If you could refer to that, my question is what -- can you describe to the Board as a result of the agreement with L&E what the reduction is from our original filing?

A. Sure. As you referenced earlier we agree with the risk adjustment change and the change in the actuarial value. We disagree with the recommendation for changes to our COVID assumption. So if we take L&E's recommended

changes for risk adjustment and the actuarial value we arrive at 1.28 percent reduction from the 7.34 percent proposed increase for an ultimate rate request of 6.06 percent.

Q. Difference between L&E and MVP is .6, correct?

A. Approximately .6 percent.

Q. If you would go back please to exhibit 10, L&E's memorandum, exhibit 10.

A. Okay.

Q. Go to page 16 please.

A. Okay.

Q. And do you see there's a section recommendations and there's five bulleted items below. Do you see that?

A. Yes.

Q. So again this is high level just to identify issues for the Board we'll talk about in more detail. The first item references considering updated hospital budget information. Do you see that?

A. Yes.

Q. And we have general agreement on that?

A. Yes.

Q. And the second item we talk about, that's the COVID adjustment, that's where we have disagreement, correct?

A. Correct.

Q. And what is the third item and do we have agreement on that?

A. The third item relates to the Unified Rate which is the federal platform called the URRT. Essentially L&E in the instructions for the URRT it directs carriers to place the net reinsurance factor into a different location than where MVP put it. We agree with L&E that we should move it. It has no impact on the actual rates.

Q. And the next item is the updated risk adjustment you have already referenced and we'll talk about, correct?

A. Correct.

Q. And then the final item is updated actuarial value. Is that what you just discussed the non-material .02?

A. Yes.

Q. As you sit here today on the 16 factors we agree on 15 of them, correct?

A. That's correct.

Q. All right. So let's talk about where what we don't agree on and that would be the COVID issue. Matt, first I want to talk about MVP's position on it. Then I want to talk about L&E's position on it and the

difference. Okay?

A. Okay.

Q. So let's go to -- I think you had some prefiled testimony on this. Go to exhibit 9A. I would note that's a confidential exhibit, but I don't believe you will be talking about anything confidential. I just want the Board to have the whole item in front of them.

A. Okay.

Q. And there's a section on COVID that starts at page 20, Matt. Go to page 20.

A. Okay.

Q. Matt, I'll do -- I'm going to watch the Board and see if they have caught up to us where we're at. Okay?

A. That works for me.

Q. I see nods. How does the Board like our big thick binder this year? It's really easy to go through, isn't it?

CHAIRMAN MULLIN: We're concerned you might be charging by the page, Gary.

BY MR. KARNEDY:

Q. Okay. So, Matt, we're going to talk about COVID, and as I indicate starting at page 20 you discuss this in your prefiled testimony, correct?

A. Correct.

Q. So it's an important issue. I want to expand on it a little bit and we want to talk about how the COVID pandemic has impacted and affected MVP's proposed 2021 rates. Let me ask you this question first. There's been decreased utilization in the early part of 2020, correct?

A. Yes. January and February were prepandemic levels so they were normal, but we did see decreases to paid claim volume in March, April, and May. In June, though, across our enterprise we did see pay level return to much more normalized expectations. More like prepandemic levels.

Q. Okay. So could you explain to the Board, take your time, how this, the decrease in utilization in 2020, will result in your opinion an increase in utilization in 2021?

A. Sure. So for approximately two months elective procedures were cancelled due to all the stay at home orders that were in place, and essentially MVP analyzed the cost of elective procedures across our commercial block. They were approximately the same in New York and Vermont. It was around $45 per member per month, and we recognized that COVID, the number of cases is different in New York versus Vermont, but the fact that there were stay at home orders and cancellations impacted both states in a similar fashion.

Once -- we're now assuming that providers are going to be able to increase capacity for two reasons. One is that patients need care. So if somebody had a bad shoulder or bad knee and they deferred an elective procedure, we're assuming that the provider community wants to actually treat patients, that's what they do, and they are going to find a way to help bring less pain or, you know, to solve this issue for their patients.

The second item is that we're assuming that 20 percent of elective procedures are just going to be outright cancelled. That was based on a 2010 Society of Actuaries paper where they have a range of 5 to 20 percent of procedures were cancelled. So we actually went with the higher end which has the least amount of impact going forward, and basically went from a moderate scenario of 5 percent to a severe pandemic scenario was at 20 percent.

So what we're assuming is that if you cancel 20 percent of procedures but providers increase their capacity, which is based on conversations with our medical management team they did confirm that elective procedures are generally done at full capacity, but based on conversations we have had with providers we know that they are willing to work extra hours, work weekends, et cetera, to do exactly what we talked about which is to provide care to patients as well as make up for lost revenue in

those two months.

So the way we modeled it out is that it would take a little bit of time for providers to implement this increase in capacity. It's not something that we can turn the switch on immediately. So we assume beginning in August of 2020 providers would operate at a 10 percent additional capacity, so 110 percent, and that's assuming two months of COVID stay at home orders and cancellations of elective procedures and no further outbreaks of COVID. With that assumption there would be four months of elective procedures that should have happened in 2020 that will actually occur in 2021. At that point, as of the end of April, we estimate that providers will all be caught up. The system will be caught up.

The approximate impact of that is $4.51 for the four months of January through April. Since we charge calendar year rates, we don't charge monthly rates, we took $4.51 and divided it out by three. It's a third of a year to get to $1.50 PMPM.

Q. Can you just clarify? So there's a window of time that MVP, for the reasons you described, that MVP is considering providers will perform at 110 percent. When does that window start and when does it end?

A. It starts in August of 2020 and it would end in April of 2021.

Q. Thank you. Matt, as an actuary to get a statutorily adequate rate for 2021 do you consider whether individual treatments or surgeries take place in 2021 that were scheduled in '20? Said a different way does it matter when they are scheduled or when the treatment and cost is actually incurred? Explain.

A. It matters when the treatment actually occurs. We set our rates to be actuarially sound, and we included an exhibit, which is actuarial standard of practice number 26, which speaks to what defining actuarial soundness is. Actuarial soundness is when you set your premiums in such a way that will cover claims, overhead, reinsurance recoveries, et cetera, for the time period where you're collecting premiums. In this case we're setting premiums for calendar year 2021. So if we expect an increase in claims in a portion of 2021, our premiums should reflect that to be an actuarially sound rate.

Q. Matt, would you go to page 22 of exhibit 9A please?

A. Okay.

Q. And you see this is on the issues we're talking about. Do you see A32 at line 3?

A. Yes.

Q. The second sentence -- would you read the second sentence please starting with according to?

A. According to actuarial standard of practice number 26, Section 2.1, actuarial soundness is defined as for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.

Q. Next sentence, therefore.

A. Therefore, MVP must consider health claims expected to occur in and only in 2021 when setting premium rates that are effective for 2021. If MVP were to reduce rates in 2021 for claims that were expected to occur but did not in 2020, those rates would be considered inadequate based on actuarial principles.

Q. Okay. Matt, so what actuarial concerns do you have if the Board reduces rates for 2021 based on reduced 2020 claims in the recent months during the COVID crisis?

A. The actuarial soundness of the rate that would be approved would be in question. There would be a concern.

Q. So why aren't you assuming that 2021 is going

to be the same as 2020?

A. Well we did model out various scenarios, but what we're really looking at is when the stay at home orders went in place in March and April and May we were just learning. We didn't really know much about the COVID pandemic and we've learned a lot in the last four months, and as time has gone on we figured out ways to move throughout our lives cautiously and intelligently to minimize the spread of the virus.

As a result of that, and we expect to continue to learn more and more about that over the course of the year and until this pandemic is squashed, and, you know, as a result we expect 2021 utilization levels to look more like 2019 utilization levels. So we're using 2019 data, our base data, to set our rates projected into 2021 for any expected changes in unit cost, utilization, or in this case pent-up demand or vaccinations. So because we expect -- because we somewhat figured out how to move intelligently through our lives, which is supported by the fact in health care that we are seeing our paid claim volumes start to go back to pre-COVID levels, we expect 2021 to look a lot more like 2019.

Q. In 2020 are there -- do you have any concerns about, as you sit here today in the middle of July, what 2020 is actually going to look like for the whole year?

A. There's a lot of uncertainty about what 20 -- how 2020 will ultimately play out. As I mentioned, we did see some depressed claims in a few months. In June we did see claims renormalize back to prepandemic levels, and what also isn't known was it deferred care or the lack of utilization for those few months where there was not only stay at home orders and cancellation of elective procedures, but also just general societal fear of going to the doctor like that. Until we learn more about the virus we are -- we do expect to see 2021 come to more normalized levels, but the rest of '20 as those services that were cancelled or deferred it's unclear if that's actually going to lead to a higher morbidity rate that will result in higher costs over time. That's going to take time to play out. That may not be by the end of 2020. It may be into 2021 or even 2022.

Q. Do you have the 2020 risk adjustment yet?

A. We do not have the 2020 risk adjustment. We received the 2019 risk adjustment this past Friday.

Q. And how would that help you in terms of determining what's going to happen in 2020?

A. Rates are set to be actuarially sound or -- and to be to the market-wide average rate level or the market-wide risk level. So we receive risk adjustment from CMS on an annual basis. We don't receive the first

five months of the year or six months of the year risk adjustment level, and what we have to do is take our claims, and if we're paying into the system, which means we have less morbid population than our competitor and they have a higher morbidity population, risk adjustment levels the playing field so we're on the same level. So you're removing morbidity from the equation in how we're setting our premium rates. We don't have that information from '20. We only have it for 2019. It's unclear right now how 2020 is going to play out as a result of this, but time will tell and we'll see as time goes on.

Q. Thanks, Matt. I want to ask you about the impact of a potential vaccine. Would you please go to page 21? You will see at the top of 21 there's a paragraph that starts additionally, first full paragraph, that's where we start talking a bit about vaccines, but I just want to ask you to please describe your thoughts about vaccine and how that might impact rates?

A. Sure. MVP hopes that there's a vaccine as soon as possible and we're watching the news very, very closely to see how that's progressing so (1) so we can return to our lives, and (2) people don't continue to get sick from this virus and potentially passing away as a result of it. So we're monitoring progress of vaccines.

When we set our rates in May we were aware

that the government was sending out expectations through Operation Warp Speed to accelerate the approval process of a vaccine. We also were aware that there feels like almost every biopharmaceutical company or pharmaceutical manufacturer is researching and developing some sort of vaccine. So our hope is that in early 2021, we don't have an exact time just in early 2021, a vaccine will be approved and widely available to the public.

Q. Matt, would you please go to exhibit 2 which is one of the interrogatories and page 6 of that exhibit?

A. Okay I'm there.

Q. Exhibit 2 page 6. Okay. Matt, there were some interrogatory questions and responses around COVID and the vaccine issue so I just want to refer you to those. First, there's a question about immunization cost. Would you tell the Board about that please?

A. Sure. MVP --

Q. Interrogatory 13.

A. Yes. The Wakely Consulting Group provided a study where they are estimating how COVID -- a COVID vaccination cost, and they used Tamiflu as a baseline for their estimate of an inoculation cost. MVP used that assumption, but based on our own data and our own cost of Tamiflu which was $75 per dose. So we're assuming that each vaccine will cost $75.

Q. And question 14 goes to immunization rate. Would you please discuss that?

A. So also included in the Wakely paper was an assumption that 80 percent of the population would have -- would accept a COVID vaccine, and we thought that seemed like a reasonable balance between where the flu vaccine rate is 55 percent and something that's a vaccination you provide to children like MMR which is north of 90 percent.

Q. What's MMR?

A. Measles mumps rubella.

Q. You said that's north of 90 percent?

A. Yes.

Q. And that's the immunization rate, and then the next question 15 asks about the date when it might become available -- the vaccine. Talk about that.

A. As I referenced a few minutes ago, we recognize that the government, as well as pharmaceutical manufacturers, are working as fast as possible day and night to try to -- to try to stop this pandemic so that people can return to normalcy, no one else has to get sick from this, and our hope is that a vaccine will be approved in early 2021. There's recent news from a few pharmaceutical manufacturers that are going to enter phase two/phase three trials and we're hoping those go according to plan and there is actually a vaccine available at some

point early 2021.

Q. Can you say entering phase two and phase three what does that mean about phase one?

A. It means phase one proved that they were safe and I don't know a whole lot, but my understanding is that phase one is a trial. Phase two, phase three more of an efficacy trial.

Q. There's been some success with phase one basically?

A. That's correct.

Q. Staying on this exhibit, if you go to the next page and you'll see on page 7 there's an interrogatory 17, let me know when you're there.

A. Okay.

Q. And this is a discussion -- a question around the second wave of the COVID virus. Would you talk about that please?

A. Sure. We recognize that this pandemic is ongoing and it's not something that's solved for. So we did model out numerous scenarios with either more months of outbreak in '20 or more months of outbreak in 2020 as well as 2021.

In our modeling what's reflected in our rates is two months of deferred services being suppressed and cancelled and then no future outbreaks in 2020 or 2021.

If we were to assume increase in the months of outbreak or stay at home orders, cancellation of procedures for 2020, we would actually experience a $4.51 increase to our rates for the full year. So that's three times the amount. That's basically the 10 percent capacity increase that we're going to see for January through April in our assumptions. All that's essentially saying is that if there are more months of outbreak, the providers will still not be able to catch up by the end of 2021, and they could actually -- that deferral could actually lead into 2022. If there is another outbreak in 2021, that will actually lead to a suppression of claims similar to what we've experienced in the early spring.

Q. Would you go to exhibit 5? Exhibit 5. It's the third page of that exhibit. Exhibit 5 page 3.

A. Okay.

Q. So there's an interrogatory that starts on the very bottom number 8 and it asks about COVID effect on non-benefit costs such as travel, overhead, profit. Would you please speak to those issues?

A. Sure. MVP's administrative costs are -- some areas they are higher because of working from home in the pandemic and other areas they are decreased. It's still too early to tell exactly how 2020 is going to play out in full, but our expectation is that 2021, similar to our

claims cost, will look much more like 2019 prepandemic. So as a result we're using 2019 data with an adjustment for any changes to our administrative costs until 2021 and no adjustments being made for what's happening in 2020. Still too early to tell.

Q. On that page 4, the next page, there's an interrogatory 9 which asks about consumer savings in light of COVID. There's a bullet. Do you see that?

A. Yes.

Q. I would ask you to walk through those bullets and explain those savings to the Board.

A. Sure. Before the bullets I will add that MVP rolled out a brand agnostic web site called tricalmedicinefirst.com. It's a directory of all the available telemedicine or telehealth doctors that you have in New York and Vermont just because we recognize that patients and members need care, and when there was stay at home orders it was hard to go to the doctor and maybe feel safe. So we rolled this out as the way to help guide members into the right way to receive care when they are at home.

Starting with the bullets we've been providing telemedicine visits for a few years now, and in addition to providing telemedicine we've also rolled out a new service called myERnow. That's like a triage service

where you can call up the myERnow app and they will direct your care to either -- maybe you do have to go to the ER, maybe the right answer is you have a telemedicine visit, maybe the correct answer is that you go to urgent care, or you just go to your local pharmacy and pick up some sort of Advil or Tylenol. We're also cost sharing for our telemedicine or myERnow app and we're also promoting prescription refills to go from 30-day supplies to 90-day supplies so you don't have to go into the pharmacy as quickly as you normally would.

In addition, there's also been changes to our medical management policies which are making it easier for us to go through medical review or there is no medical review for a few months or was no medical review for a few months so you could have the care you needed as quickly as possible. We've also notified our Vermont members of the available state programs in case they do have financial needs and they can't afford their premiums in the commercial space. So that's another way that we're helping promote and helping our members navigate through the COVID virus.

Q. Great. Thank you. Next I want to ask you about coverage for COVID testing.

A. Okay.

Q. Give me a second. So does MVP in this 2021

rate filing include COVID testing costs in our analysis?

A. We are not.

Q. So would you go to exhibit D please? Exhibit D as in dog.

A. Okay.

Q. And do you see that's an emergency rule? If you look at the top, Emergency Rule H-2020-03-E from DFR regarding coverage of COVID-19 diagnosis treatment and prevention. Do you see that?

A. Yes.

Q. You're familiar with this document?

A. Yes.

Q. I want to focus on COVID testing. If you would go down to Section 3A, Section 3 says coverage of COVID-19 diagnosis. Would you read that first sentence of 3A please?

A. When medically necessary or directed by the state or federal government, health insurers shall cover any COVID-19 testing performed by the Center for Disease Control, the Vermont Department of Health, or a laboratory approved by CDC or VDH with no co-payment, co-insurance, or deductible requirement for members.

Q. And this is a two-page document, correct? Almost two pages, correct?

A. Correct.

Q. And that term medically necessary, is that defined in this rule?

A. It is not.

Q. Okay. Would you go to Section 3B and read the sentence please?

A. Health insurers shall cover provider office or urgent care visits and emergency services visits to determine whether COVID-19 testing is medically necessary with no co-payment, co-insurance, or deductible requirements for members.

Q. So in a nutshell what does 3B say?

A. It's saying that when COVID-19 testing is medically necessary there will be no charge to members whether it's co-pay, deductible, or co-insurance.

Q. Thank you very much. Now, Matt, would you turn to exhibit E please. Exhibit E. So this is a draft. I want to be clear it says draft across the front of it, but it's insurance bulletin 214. It is entitled medically necessary COVID-19 testing. Do you see that?

A. Yes.

Q. What's the date on it on the front?

A. July 6, 2020.

Q. And again this is just a draft, but would you read the first sentence?

A. The purpose of this bulletin is to clarify

when COVID-19 testing shall be covered without cost sharing under emergency rule H-2020-03-E.

Q. And that goes to this issue of what is medically necessary, correct? That's what the document is entitled?

A. Correct.

Q. So if you go to the third paragraph, it says in the Department's view medically necessary testing includes all testing and then it goes on from there, correct?

A. Correct.

Q. And then would you please read the first bullet under that?

A. Recommended testing for asymptomatic individuals without known or suspected SARS, COVID exposure for early identification and special settings.

Q. Do you have a concern about this first bullet?

A. Well it's -- from a societal standpoint I understand it because if you're asymptomatic and you're not showing symptoms and you're entering public, it's a good way to help spread the disease. There's a good way to help prevent the disease from spreading. That said, though, from an actuarial soundness perspective there is concern because this kind of opens up the door to testing across the board under almost any scenario.

Q. Okay. So you were talking about the term asymptomatic individual, correct?

A. Correct.

Q. And looking at the draft, I know it's just a draft, but that's not defined anywhere, is it?

A. No it's not.

Q. Okay, and the bullet ends with early identification and it says special settings. Do you see that?

A. Yes.

Q. Do you have a concern about the term special settings?

A. Yes. It's broad and I can use an example. We do have an employer group that is a school that's in New York and has faculty and students in Vermont, and they recently informed us that they are going to do very rigorous regular testing to help manage the spread of the virus throughout the school year, and they are estimating they are going to do some 20,000 tests over the course of the school year. The cost, it's not finalized yet, but regardless even at 20,000 -- 20,000 tests the cost would be substantial very quickly.

Q. That would be like an occupational setting. Do you know how that would fall under this definition of special settings?

A. It's not defined what a special setting is so I would assume that it would fall under a special setting.

Q. You don't know because it's not defined, is it?

A. No.

Q. And are you concerned about these costs and actually figuring out the amount that would rise to actuarial level of reasonableness so you could include it in a rate filing?

A. Yeah there's definitely a concern on our part. It's a big unknown. What we're hoping, as we talked about earlier, there's a vaccine widely available in early 2021 that would mitigate the need for testing on a regular basis especially on asymptomatic individuals, but if the vaccine isn't approved for quite sometime into 2021, we assume there's going to be rigorous and high volume of testing that's going to occur until that time.

Q. Some of this could be that occupational testing, correct?

A. Correct.

Q. All right. Thank you. Let's now talk about L&E's position on COVID. If you go back to exhibit 10, which is L&E's actuarial memorandum -- exhibit 10 page 9.

A. Okay.

Q. So on page 9 you see a number 4 heading. It's

about four paragraphs down. It says changes to population morbidity adjustments. Do you see that?

A. Yes.

Q. So this is the section in L&E's report on COVID, correct?

A. Correct.

Q. So as I understand the pages 9 and 10 -- 9 into 10 provides a summary of MVP's positions on COVID, correct?

A. Correct.

Q. And if you would please go to the third paragraph under that number 4 heading, that third paragraph starts with as a result. Let me know when you're there.

A. Okay.

Q. And in this paragraph there's -- the second sentence makes reference to MVP relying on a Society of Actuary research. Do you see that?

A. Yes.

Q. So we relied on data from the Society of Actuaries, correct?

A. Correct.

Q. And did L&E have any objection to that reliance?

A. They did not.

Q. In fact, Mr. Dillon and Ms. Lee aren't they members of the society?

A. Yes.

Q. And then the last sentence makes reference to based on information from the company's medical management team and it goes on from there. Do you see that?

A. Yes.

Q. And did L&E object in any way with the actuaries at MVP relying on the medical management team providing that information?

A. They did not.

Q. Okay. So at the top of page 10 the first couple paragraphs are MVP considering various utilization scenarios; is that right?

A. Yes.

Q. And L&E just summarizing that, correct?

A. Correct.

Q. And then if you get to the sentence where it says L&E does not believe, about five paragraphs down, do you see that?

A. Yes.

Q. This is where we start to talk about or they start to talk about our capacity to disagree, correct?

A. Correct.

Q. Now can you read that sentence -- L&E does not

believe sentence?

A. Providers have had an opportunity to receive.

Q. I'm sorry, Matt. I'm sorry. Can you read the sentence above that please?

A. L&E does not believe that the assumption that providers will run at 110 percent capacity is adequately supported based on the following.

Q. And then there's three bullets underneath regarding L&E's assumptions; is that correct?

A. Correct.

Q. And I understand you have two problems with their assumptions; is that right? Two problems?

A. Yes.

Q. So would you please read the first bullet?

A. First bullet reads providers have had an opportunity to receive financial assistance from the government to relieve the financial hardship which reduces the financial incentive to run at greater than 100 percent capacity in the future.

Q. And do you disagree with this first bullet?

A. I do disagree with that.

Q. And why?

A. It's looking at this need to fill or have these procedures performed as purely a financial item, but it's not. It's providers and hospitals -- they want to

provide care. That's why they enrolled in the profession, being a doctor they want to help people, and there's people that needed to have a service performed or surgery performed that couldn't have it done for the few months of March, April, May, and so this assumption is disregarding that providers want to actually help people and to actually get their backlog of required procedures worked through they need to increase capacity.

Additionally, I'm not privy to these conversations, but based on conversations I have had with our contracting team we are not hearing that the provider community feels that they have been fully compensated back for cancelled or reduced procedures in those few months. So on both fronts I disagree with that bullet point.

Q. When you talked about -- I think you were talking about the desire to promptly treat patients, that's what health care employees have, correct?

A. Correct.

Q. And that's not just your opinion. That's based on information that your team has heard from medical care providers; is that right?

A. Yes.

Q. And is it fair to say you talked about the financial piece, that they do want to generate as much revenue as they can in 2020?

A. Yes. They would like -- they set a budget in 2020 and I assume they are trying to meet that budget revenue expectation.

Q. And have you heard from anybody at MVP that medical care providers tend to sit back and live on government assistance?

A. I have not.

Q. So this is the first problem that you identified with the assumptions, correct?

A. Correct.

Q. Let's go to the second and third bullets. Would you read the second bullet please?

A. There's an immense uncertainty regarding how long social distancing, cleaning, and other safety guidelines will continue into 2021 which limits provider capacity.

Q. Okay, and would you read the third bullet please?

A. Vermont had a quicker than average turn around from shelter in place to reopening which potentially sets the stage for all deferred care to be recouped in 2020.

Q. And does your second problem relate to these two bullets and what's being said there?

A. Yes.

Q. Would you please describe to the Board what

your issue is?

A. The second bullet discusses how much uncertainty there is regarding how long all our social distancing and increased cleaning -- obviously the guidelines will continue so there's uncertainty about all this, but then the third bullet is stating that because Vermont has had a quicker turn around on shelter in place reopening that Vermont providers will be able to provide as many services as needed in calendar year 2020 to recoup all their deferred care. So what is uncertainty where they are saying we don't know how long this is going to go and the other is accelerate and get it all in 2020.

Q. To be clear the second bullet says immense uncertainty, doesn't it?

A. It does.

Q. And then in the third bullet L&E is going on to make your own assumptions, correct?

A. Correct.

Q. Would you please read the sentence that starts L&E recommends under the three bullet?

A. L&E recommends that the adjustment for COVID-19 pent-up demand be reduced 0.0 percent.

Q. So is L&E recommending we do nothing with our rates as relates to COVID?

A. They are recommending that with regard to

pent-up demand that we do nothing to our rates for it.

Q. And you disagree with that, your rationale based on the two reasons we just discussed?

A. Yes.

Q. And in considering capacity pent-up demand is MVP actually contributing a number to it?

A. Yes. 1 percent.

Q. So MVP has stepped up and measured the risk, correct?

A. Correct.

Q. Let's go back to exhibit 10 and I want to talk about L&E's views on vaccines please. On page 10 where we were at the very bottom L&E at the very last paragraph starts talking about their views on the vaccine, correct?

A. Correct.

Q. And that goes on into page 11, correct?

A. Correct.

Q. And as I understand it they don't dispute any of our assumptions regarding timing and availability of the vaccine, correct?

A. Correct.

Q. Or the vaccine cost 75 dollars they don't dispute that, correct?

A. That's correct.

Q. We say there will be a 80 percent vaccine rate

and they say it will be 55 percent; is that right?

A. That's right.

Q. Let's go to that sentence please. It's the third full paragraph. Would you please read that first sentence?

A. L&E recommends the vaccine rate assumption of 55 percent consistent with flu vaccination rates.

Q. So that's consistent with flu vaccination rates, that's how they came up with the number?

A. Yes.

Q. And why do you believe -- actually I guess we've talked about that already, why you believe that's wrong, correct?

A. I think we touched on it, but essentially the flu, while it is -- it can be bad, it hasn't caused the entire world to alter the way it approaches the day-to-day life and staying at home, quarantining, so on so forth, and we expect a much higher vaccination rate for COVID than we do for the flu, but we're assuming the matches, as I mentioned earlier, for measles mumps rubella we see a higher vaccine rate, 90 percent, we're in the middle. Somewhere in the middle.

Q. The next sentence of that paragraph references reducing the rate increase from 1.7. Do you see that?

A. Yes.

Q. So as to the vaccine issue is L&E disagreeing with us? Is there a disagreement that amounts to .3 on the rate?

A. The vaccine is approximately .3 and so is pent-up demand on both.

Q. So it's vaccine issues is our dispute this year basically, right?

A. Yes.

Q. And the other half is the pent-up demand, correct?

A. Correct. I saw you hold your hand up.

MR. BARBER: Yes. We're hearing some road noise or something.

(Off-the-record discussion.)

MR. BARBER: Mr. Karnedy, proceed.

MR. KARNEDY: Thank you very much.

BY MR. KARNEDY:

Q. Matt, next I want to talk about medical assumptions. It appears we're in agreement with L&E, but let's go through that. If you would please go and -- stay with exhibit 10 and go to page 6 of the exhibit please.

A. Okay.

Q. If you look, there's an item 3, trend from '20 to '21, in the middle of the page if you can see that?

A. Yes.

Q. This is where the discussion of the trend starts. I want to go to page 7 please and you'll see a heading at the top medical unit cost trend. Do you see that?

A. Yes.

Q. I want to focus on medical trend. If you would please read the first sentence of the paragraph underneath medical unit cost trend?

A. MVP computed its allowed trend as a weighted average of the medical claim unit cost trends in 2020 and 2021 for inpatient, outpatient, and physician claims based on known and assumed price increases for MVP's prior network.

Q. Read the next sentence.

A. This approach is consistent with prior rate filings.

Q. And then go to the second paragraph and read the first two sentences.

A. Since the 2021 hospital budget review is not yet finalized, MVP has assumed that hospital increases will match the 2020 increases with a few exceptions by facility. These expected assumptions for hospital budget increases are based on information from MVP's contracting department.

Q. And then would you please read the text in the

box to the right there?

A. The header is GMCB hospital budget review. Says the overall unit cost medical trend of 6.0 percent includes (1) a trend of 6.2 percent for facilities and providers that are impacted by the GMCB's hospital budget review, and (2) a trend of 5.5 percent for all -- for other medical facilities and providers that are not subject to the hospital budget review.

Q. And would you read the sentence below the box to the left?

A. L&E believes the assumed unit cost trends are reasonable and appropriate.

Q. So we have agreement on that, correct?

A. Yes.

Q. Next I would ask you to go to page 8 please.

A. Okay.

Q. And as I understand it the second paragraph involves L&E summarizing some independent trend calculations that they did?

A. Yes.

Q. And then if you could read the third paragraph. It starts with based on.

A. Based on the above analyses, L&E considers the assumed utilization trend of 1 percent to be reasonable and appropriate.

Q. Okay. So we have agreement on that, correct?
A. Correct.
Q. And then would you please read the first sentence under total allowed medical trend?
A. Based on the information available L&E considers the total allowed medical trend of 7.0 percent to be reasonable and appropriate.
Q. So we have agreement on that, correct?
A. Yes. Correct.
Q. And then the next paragraph, the fifth paragraph on the page, would you please read the last two sentences of that paragraph starting with due to?
A. Due to the disruptions from COVID-19 it appears likely the submitted hospital budget requests will be higher than last year. If this is the case, it may mean a higher premium increase is necessary.
Q. Do you agree with that?
A. Yes. My understanding is there's an additional item included in the proposed hospital budgets to account for COVID -- one time adjustment for COVID lost revenue.
Q. And would you please describe to the Board you're familiar with the challenge of the timing of the hospital budget process and also talk about what the Board is having us do differently this year in terms of briefing

that issue?

A. Sure. So every year there's a little bit of a timeline issue where our rates are submitted in May and approved in early August and the proposed hospital budgets come in during that review period and the final approval is after rates are approved. This year due to the pandemic there's a little bit of a push -- the proposed hospital budget timeline is pushed out a little further, but it is before the approval of our rate approval will happen. So the Board is allowing carriers to provide a memorandum summarizing the impact of the proposed hospital budgets on our rates.

Q. I would like to talk about the risk adjustment. I believe there's agreement. If you go to bullet number 4 please, it's on page 16.

A. Okay.

Q. Reference the updated risk adjustment. I'm sorry. I want to bring you right to it. We agreed to a reduction of approximately 1.1 or 1.2?

A. We agreed with L&E's calculation and that was 1.1 percent.

Q. So I apologize I took you to the wrong page. Go to page 10 please. Excuse me. Page 13. That's the last mistake I'll ever make. Page 13. There it is. So on page 13 do you see an item 10 changes to risk

adjustment? Do you see that?

A. Yes.

Q. So would you explain to the Board the information that we relied on and the information that L&E relied on and then recent information that's come in on this adjustment?

A. So earlier I talked about how we have to include risk adjustment to level the playing field between the carriers to remove the impact of morbidity differences in our populations. When we set our rates in May the only information that we have is CMS's interim results. That's what MVP included in its proposed rates. After our rates are submitted shortly after that we have final files from CMS's edge server that we share with L&E as well as Blue Cross, and they compute what the risk transfer amounts will be so that we can discuss that during the rate review process. We received our actual risk adjustment results from CMS this past Friday, and L&E's calculation was within 160 dollars. So no material difference in the two calculations and we agree that we should be putting in the actual CMS results into our rates to normalize our claims for the market-wide risk.

Q. We have agreed on them after these most recent numbers, correct?

A. I did say it was 1.1 percent before. I

believe in this file it shows 1.1, down to 1.1, and then they reference 1.2. I would like to clarify I don't know the exact number, but I disagree we should be putting in the actual CMS final results, and what that impact is it's 1.1 or 1.2 percent and we agree.

Q. Matt, I want to talk briefly about administrative costs. Turn to exhibit 1 please which is our original rate filing, exhibit 1, and then go to page 119.

A. Okay.

Q. And do you see the fifth paragraph down says general administrative expense load. Do you see that heading?

A. Yes.

Q. I'm just waiting to make sure the Board has caught up, okay, and in the first sentence there's a reference to -- there's a number and reference to PMPM. Can you tell the Board what that is?

A. So PMPM represents per member per month. We take total claim dollars divided by our member months that we have available to us and compute a PMPM so that normalizes out for differences in membership, and we are proposing to charge $43.75 per member per month for administrative expenses. 49 cents of that charge is because due to the pandemic we're rolling out credit card

payments to small employers. Previously only individuals could pay via credit card. We had an uptake rate of 20 percent for individuals. We're assuming a 10 percent small employer group uptake rate will increase the admin load by 49 cents because we do have to pay 2.8 percent credit card fee.

Q. Thank you. So the PMPM for this year or for administrative expense load in our filing is $43.75 PMPM, correct?

A. Correct.

Q. And let's see what L&E said about that. If you would please go back to exhibit 10, go to page 14 talking about administrative cost. You will see heading 13 changes in administrative cost. Let me know when you're there.

A. I'm there.

Q. So there's a discussion about administrative cost and then if you would go to page 15, would you read the first full paragraph please?

A. The administrative costs assumed in the 2021 filing are consistent with MVP's recent individual and small group administrative costs as reported in the last three years of the company's supplemental health care exhibit. The company's expenses have decreased since 2013 when they were $46.57 PMPM

Q. Okay. So that $46.57 compares to this year which for 2021 which is $43.75, correct?

A. Correct.

Q. And just generally what is L&E talking about in the next paragraph -- the second full paragraph on the page?

A. They are referencing our growth in the Vermont market but our contraction in the New York market and overall how that's impacting administrative costs because a lot of our costs are fixed and spread out across both states.

Q. And would you read the last sentence of that paragraph?

A. Considering the reduced administrative costs over the recent years L&E considers the assumed 2021 administrative costs to be reasonable and appropriate.

Q. Okay. So in summary in your opinion if MVP adopts the recommendations we've identified and the resulting change from 7.34 goes to 6.06, is that rate 6.06 actuarially sound and reasonable?

A. Yes.

Q. And I want to talk about reserves insolvency. This year MVP has a CTR proposal of 1.5 percent, correct?

A. Correct.

Q. If you would go to exhibit 11, I want to see

what DFR says about that. Let me know when you're there. Exhibit 11.

A. I'm there.

Q. So this exhibit 11 is DFR's letter to Chair Mullin regarding solvency this year for MVP, correct?

A. Correct.

Q. You have reviewed this and you're familiar with it?

A. Yes.

Q. Would you turn to the second page and read the sentence under summary of opinion?

A. The proposed rate filed by MVP would not negatively impact its solvency and the company otherwise meets Vermont's financial licensing requirements for a foreign insurer.

Q. And would you please read the third bullet under -- excuse me. Do you agree with that what you just read?

A. Yes.

Q. And would you please read the third bullet under MVPHP solvency?

A. Finally, in 2019 all of MVP's Holding Company operations in Vermont accounted for approximately 5.7 percent of its total premiums rate. DFR has determined that MVPHP's Vermont operations pose little risk to its

solvency. Nonetheless, adequacy of rates and contributions to surplus are necessary for all health insurers to maintain strength of capital that keeps pace with claim trends.

Q. Do you agree with that?

A. Yes.

Q. And then would you read the sentence under impact of the filing on solvency please?

A. Based on the entity-wide assessment above and contingent on GMCB finding the proposed rate is not inadequate, DFR's opinion is that the proposed rate will not have a negative impact on MVP's solvency.

Q. So let's see what L&E says about CTR. If you go back to exhibit 10, go to page 15 and it's item 15. Let me know when you're there.

A. Okay.

Q. Do you see in the second paragraph there's a reference to a reasonableness check. Do you see that?

A. Yes.

Q. What's that about please?

A. Small group and individual QHP filings are available on the Society web site. L&E reviewed three years of rate filings. In 2020 there's 783 of them. In 2020 MVP's proposed CTR of 1.5 percent is almost 2 percent below the average CTR submitted and it would be 630th of

that 783 filings which is around the 20th percentile. Our CTR proposals in the last two years have also been in a similar percentile range, around 20th percentile. So 80 percent of the filings have a CTR that is higher than what MVP is proposing.

Q. So in your opinion did we pass the reasonableness check?

A. Yes.

Q. Would you read the last paragraph first sentence?

A. L&E CTR functions are reasonable and appropriate.

Q. So L&E agrees with us on the CTR, correct?

A. Correct.

Q. In your opinion will a decrease from our original filings of 7.34 to 6.06, which adopts all the recommendations of L&E except for COVID, adversely impact the solvency of MVP Health Care Inc.?

A. It will not.

Q. Although our proposed rates are reduced our CTR remains at 1.5 percent, correct?

A. Correct.

Q. Do you anticipate that contributions to reserves will require a change depending on the hospital budget -- talking about contributions to reserves?

A. Our rate needs to change, but the CTR load of 1.5 percent would not change.

Q. So in the framework and context contributions to reserve could you tell the Board about interplay between vaccines next year and testing and how that should be viewed in the context of the CTR?

A. Yes. CTR it's -- there's -- (1) there's minimum solvency requirements set forth by regulators and (2) the point of reserves is to be able to provide consumers with peace of mind in case of adverse claim events. The 1.5 percent in addition as claims increase, which means premiums increasing, that means our adverse risk, the magnitude of it, will increase. That's why we need to continue to add to our reserve levels. Cost of health care is very right tail skewed meaning there's a few people that incur most of the costs and those right tail events are becoming more and more challenging to predict and could be more and more impactful as there's new breakthroughs in pharmaceuticals and technological breakthroughs.

Q. I want to touch on briefly the non-actuarial issues that we need to consider -- the Board needs to consider in the hearing. If you go to your prefiled testimony exhibit A, please go to page 4 of that document and let me know when you're there.

A. I'm there.
Q. Give the Board a minute to catch up. Okay. Matt, do you see there's 16? Why don't you read that?
A. What steps have MVP taken to lower costs and establish that its proposed rates promote affordability, assess to care, and quality of care for Vermonters?
Q. Okay. So those are the non-actuarial issues, correct?
A. Correct.
Q. And in this response there's a long list. How many items are listed there?
A. 22 items.
Q. And then if you look at the list some or many of those items have a cross reference to an additional Q&A, correct?
A. Correct.
Q. And those additional Q&A's drill down on the issue. Is that fair?
A. That's fair.
Q. So were these items in your prefiled relating to non-actuarial issues evidence of some of MVP's steps to lower costs, quality of care, and access, and establish the rates proposed are affordable to Vermonters?
A. Correct.
Q. Matt, would you go back to exhibit 1. This

will be brief, it's our original filing, and go to page 112 of the exhibit.

A. Okay.

Q. So exhibit 1 page 112 and you see there's a heading for market/benefits. Do you see that?

A. Yes.

Q. And do you see the fifth paragraph down? There is a reference to a wellness benefit. Do you see that?

A. Yes.

Q. Would you tell the Board about the wellness benefit?

A. So standard plans and non-standard plans are offered in this market. Standard plans mean that all the carriers or two carriers in the Vermont market offer the same set of benefits. So we provide an apples-to-apples benefits for consumers non-standard after being medal level compliant, but they provide carriers with the ability to differentiate themselves in some way, and the way we're differentiating ourselves is through a wellness benefit which can provide up to $600 of reimbursement for subscribers that take personal health assessments, live an active lifestyle, things such as that.

Q. On the non-actuarial issues would you agree how MVP manages its administrative costs makes insurance

more affordable?

A. Yes.

Q. As it will MVP taking steps to lower costs, promote quality of care and access and to establish the rates proposed are affordable for Vermonters?

A. Yes.

Q. Do you have an opinion on whether short term "affordability" under pricing will make insurance affordable in the long run?

A. My opinion is it will not.

Q. But, Matt, each year we need to walk through the statutory criteria. I'm going to do that with you quickly and we're just about done, okay. So I want to frame these questions around the 6.06 which is the revised rate. The rate we're proposing now 6.06. Are you with me?

A. Yes.

Q. Each of these questions relate to 6.06 rate. Okay?

A. Okay.

Q. Do the MVP rates meet the standard of affordability based on the rate filing and other evidence in your testimony today?

A. Yes.

Q. Do the rates promote quality of care and

access to health care based on the rate filing, other evidence, and your testimony today?

A. Yes.

Q. Is this rate filing unjust, unfair, inequitable, misleading, or contrary to law based on the rate filing, other evidence submitted, and your testimony today?

A. No it is not.

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

A. Yes.

Q. Are the rates actuarially sound and fairly charged premium for services covered?

A. Yes.

Q. Are the rates excessive, inadequate, or unfairly discriminatory?

A. They are not.

Q. Are the rates reasonable relative to the benefits that are offered?

A. Yes.

Q. Do they provide for payment of claims, administrative expenses, taxes, and regulatory fees and have reasonable contingency and/or profit margin?

A. Yes.

Q. So they are adequate?

A. Yes.

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

A. They do not.

Q. So they are not excessive?

A. That's correct they are not excessive.

Q. Do the rates result in premium differences on insureds within similar risk categories which are not permissible under applicable law and do not reasonably correspond to differences in expected costs?

A. Can you reask that question? You cut out for a second. I'm sorry.

Q. Sure. Also the triple negatives, right?

A. Yes.

Q. Do the rates result in premium differences among insureds within similar risk categories which are not permissible under applicable law and do not reasonably correspond to differences in expected costs?

A. They are in compliance with the law.

Q. So they are not unfairly discriminatory?

A. That's correct.

Q. So, Matt, there's one last issue I wanted to touch on. Attorney Angoff referenced it in his opening

and that's the question around return on premium. So this relates to 2020 not to your rate filing, but I wanted to touch on it and have the Board hear MVP's view on any anticipated return of premium in '20.

A. Okay.

Q. So go ahead. Tell them your view.

A. It's too early to tell is generally the perspective. As I mentioned a few times we did experience reduced claims for a few months, but in June our paid level is back to where they were in January and February preCOVID-19 levels. There's also a concern about the long term implications of deferring care for members that are in a higher morbidity state. As time goes on we're going to keep reviewing the situation, monitor both those items, paid volume as well as member health, to see if we're seeing an escalation in morbidity. Until that time it's too early to assess the situation of how 2020 will play out.

Q. And, Matt, would you please go to exhibit G which is in evidence?

A. Okay.

Q. So I'm just going to identify that you confirm this is a July 7, 2020 letter to Chair Mullin. You can see that on page 1, correct?

A. Correct.

Q. And this is relates to Blue Cross Blue Shield's solvency opinion from the DFR for this year's filing, correct?

A. That's correct.

Q. And then on the last page, it's a three-page exhibit, shows the signature of Commissioner Pieciak, correct?

A. That's correct.

Q. And everything is redacted in the letter with the exception of two paragraphs that talk about this issue about the return of premium, correct?

A. Correct.

Q. These are the only two paragraphs that you're familiar with in the letter, correct?

A. That's correct.

Q. So what is -- what is the Commissioner saying about this issue?

A. So from the first paragraph the question being asked is have Vermonters overpaid for their health insurance in 2020? The second paragraph addresses that and says due to the current uncertainty around COVID-19 it is too early to answer this question with confidence regarding health insurance. Simply put, some effects of COVID-19 are clearly positive in the short term for company's solvency, while some of the longer-term effects

are likely negative. The scope of these effects are not known at this time.

Q. So generally does the Commissioner of the Department of Financial Regulation agree with us that a premium return decision is premature?

A. Yes.

Q. So, Matt, just a couple closing questions. The big issue we believe in the rate filing this year is the COVID impact, correct?

A. Correct.

Q. And there's some uncertainty about this impact on rates in 2021, correct?

A. Correct.

Q. But in your opinion has MVP reasonably assessed that uncertainty based on available data?

A. Yes.

Q. In your opinion you have also relied on the professional opinions of the actuaries at MVP like yourself, correct?

A. That's correct.

Q. That is what actuaries are required to do is measure uncertainty, correct?

A. Correct.

Q. And then would you agree with me the statutory criteria that we just went through are interrelated?

A. Yes.
Q. They are not siloed, are they?
A. They are not.
Q. And any adjustments to a rate increase for whatever reason all feed into a final number, correct?
A. Correct.
Q. It is important that final number is actuarially sound and reasonable, correct?
A. Correct.
Q. And in this case you believe that number is 6.06 percent, correct?
A. That's correct.
Q. If the Board cuts the final number on non-actuarial grounds, is there a risk that the rate could be no longer adequate?
A. Yes.
Q. In contrast based on your testimony, the other evidence that we've put in today, is the insurance product we provide affordable with a 6.06 increase and meet all the statutory criteria in your opinion?
A. Yes.
MR. KARNEDY: That's all the questions I have for Matt at this time.
MR. BARBER: Okay. I think this is a good point to take a short break before we get into

cross. So why don't we reconvene at 10:10. We're doing okay on time.

MR. KARNEDY: Thank you very much.

(Recess.)

MR. BARBER: So we are back on record in the matter of Docket Number GMCB-006-20rr MVP's 2021 individual and small group rate filing. Mr. Karnedy just finished the direct examination of Matt Lombardo and so now, Mr. Angoff, do you have cross exam questions for this witness?

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Good morning, Mr. Lombardo.

A. Good morning, Mr. Angoff. I hope you're doing well.

Q. And I you. I would like to start by asking you a few questions about the relationship between 2020 and 2021. I think you said in the middle of your testimony that it would be actuarially unsound to reduce rates in 2021 based on MVP's having paid out less in 2020 than it projected; is that correct?

A. That's correct. Rates are set so that the premiums that we're charging will cover our expected claim cost in calendar year 2021.

Q. And I was a little unclear as to what your

view was if it should turn out that 2020 -- that in 2020 MVP pays out less, let's assume substantially less, than it assumed in its rate filing filed in 2019. Are you saying -- are there any conditions under which you believe that a refund of 2020 premium would be appropriate?

A. At this time it's too early to tell. We're monitoring the situation and that's a decision that would not be made by me as the actuary. My job is to provide an actuarially sound rate, project what 2021 will look like, and that's what we're doing in our rate filing.

Q. Okay. So it's not your -- well it's the Board's decision, but you can envision a situation, can't you, under which MVP -- when all the data are in MVP will have paid out substantially less than it projected it would pay out in 2020, correct?

A. It's still too early to tell. We only have data paid through June and we did -- you know as I mentioned in my testimony, we did see a suppression of claims in March, April, and May, but June is back to preCOVID-19 levels. January and February actually ran very unfavorably for us across our enterprise. So if we look at the whole year, it's something that's unknown at this time.

Q. Okay. Then talking regarding paid claims through June 2020 could you please take a look at exhibit

1 and turn to page 113?

A. Okay.

Q. Okay. You see the chart there at the bottom?

A. Yes.

Q. Okay, and that shows paid and incurred claims between January 2019 and December 2019, correct?

A. That's correct.

Q. Okay. Just very briefly the difference between the paid claims and incurred claims is pretty nominal, but can you explain why there is that difference?

A. Yeah there can be a lag in when a claim -- when a claim is paid relative to when it's incurred. So, for example, if I were to go to the doctor today for a visit, that claim may not be paid out until August, September, October, or November, in a future month. So if we are looking at it, that visit that I have would show up in the incurred line. If there was a July 2020 it would be in that line, but it would not be in the paid line.

Q. Okay. Could you tell the Board and me where your data is for paid and incurred data to the extent it exists for 2020 by month?

A. It's not in this table because we're using 2019 data normalized for risk adjustment to set our rates.

Q. Okay. Didn't L&E ask you for that data?

A. I would have to go back into the

interrogatories and look.

Q. Can you point me to any place in your rate filing where 2020 paid data by month appears?

A. Off the top of my head I would have to go through all the exhibits to see exactly where that information is included, if it is included.

Q. Please do, and, Mr. Lombardo, so we can shortcut this if you should come to the conclusion L&E did not ask you for that data, please say so.

A. It's going to take me some time. I do not see it in the exhibits that I have reviewed.

Q. So you're reasonably certain then L&E did not ask you for the monthly paid data in 2020, correct?

A. Well there's hundreds of pages and I haven't read through all them. I don't recall that being requested throughout the review process. I wouldn't say that with one hundred percent certainty, but based on my brief review and my recollection I do not see that information.

Q. That's fine. Can you tell us now approximately how much MVP did pay out month-by-month, or if you don't have it month-by-month, for the total first half of 2020?

A. I don't have that information at my fingertips. That's not readily available. As I mentioned

January and February came in worse than expected. March, April, and May were suppressed due to COVID and June is returning to more normalized levels.

Q. Okay. So if March, April, and May were they suppressed by 20 percent?

A. I don't know the exact number off the top of my head to speak to that exactly.

Q. Could it have been more than 20 percent?

A. It could have been less it could have been more.

Q. Okay. Rather than playing 20 questions will you please submit for the Board, even though L&E did not ask for it, would you please submit for the Board's consideration your paid claims data to the extent it's available by month for 2020?

MR. KARNEDY: I'm going to object. I don't think the purpose of cross examination is to ask a witness to be submitting exhibits.

MR. ANGOFF: Well this could not be more relevant to what the Board has in front of it, and I assume that based on their expertise L&E would have asked for the monthly paid claims data for 2020. If they have not, I think it's really pretty important for the Board to consider that data.

MR. KARNEDY: I'm going to further

object on the ground L&E had an opportunity to submit interrogatories to the Board and forward to MVP. They could have asked them. They didn't. This is a tight administrative process with tight deadlines and I think it's inappropriate and I object.

MR. BARBER: So I think the question is a fair one, whether MVP would submit that data. So I would ask the witness to answer and then if we need to have a dispute about the ability to compel, we can do that. So could you please answer the question, Mr. Lombardo?

MR. LOMBARDO: We have the data. If we're required to provide it, we could provide it. It is -- but it's important to remember 2020 is not completed. There is no risk adjustment. 2020 is not part of the rate setting process for 2021 to produce an actuarially sound rate.

MR. ANGOFF: Thank you.

BY MR. ANGOFF:

Q. Mr. Lombardo, you talked quite a bit about the costs that MVP would incur based on your estimates in connection with the COVID virus vaccine, correct?

A. Yes.

Q. Okay and you hope, and boy I sure hope you're right, you hope a vaccine would be available in 2021 and

you are including in the rate filing an amount based on a vaccine being available in 2021, correct?

A. Yes that's correct.

Q. Okay, and I'm sure everybody here totally agrees with your hope that that will be the case, but we don't know that will be the case, correct?

A. It is not fully known at this time. It could be improved already.

Q. It's all in our hopes?

A. It's an assumption. Yes it's a hope.

Q. Okay, but you are charging your policyholders based on a hope, correct?

A. It's based on data that's available to us whether it's federal government funding, FDA accelerated process of expediting the approval. The fact that the science community is almost fully focused on this it seems it's based on all that data. It's not just something that's pulled out of the air.

Q. Okay, and not to be a doomsayer, but I have also heard people say, haven't you, and now I hope they are wrong, that there's not going to be a vaccine for four years. I mean you have heard those statements, right?

A. I've heard people reference the normal approval timeline of a vaccine is usually somewhere in the multiple year range, but I know this is a different

situation.

Q. Well I hope you're right.

A. Me too.

Q. You also assume that the cost of this vaccine would be paid by MVP and it would be $75 a shot, right?

A. Yes.

Q. Okay, but we don't know, do we, assuming there is a vaccine whether or not the government will pay for it, do we?

A. That's not known. I haven't seen anything come across my e-mail that has suggested that's going to be the case. I have not seen anything regarding that.

Q. Okay, but you assume the $75 cost would be paid by MVP, correct?

A. Yes.

Q. And then you also assumed 80 percent of the population would get the vaccine, right?

A. That's correct.

Q. Okay, and again I hope you're right, but you have heard about the antivaccers, right?

A. Yes.

Q. Okay. I know there's not much of an African American community in Vermont, but have you heard that among -- in the African American community there's a substantial skepticism about a COVID virus vaccine?

A. I have not heard that.
Q. Okay, but once again none of us know what percentage of people will take up the vaccine assuming that there is a vaccine, correct?
A. We do not know the exact percentage, but the fact that a vaccination like MMR, measles mumps rubella, is higher than we're assuming that would suggest to me that the antivaccer community is less than that percentage whatever the MMR uptake is.
Q. Well again I hope you're right. You talked previously a little bit about your administrative costs, correct?
A. Yes.
Q. And MVP has had very substantial growth in Vermont in the past several years, hasn't it?
A. Yes.
Q. And all things equal when a company has growth in its business, growth in its number of policies, growth in its premium, its administrative costs per member per month should go down, shouldn't they?
A. Enterprise-wide we have not experienced growth in membership. In Vermont we have, but the decreases in New York have more than offset it for decrease overall in our membership, and there's a lot of costs that are shared amongst both states and they have to be spread across both

states. I use our claims operating system, our license with Microsoft, that's not specific to Vermont. That is something that's spread out regardless of how many members we have across all states. So items such as that they have to be weighed across the entire enterprise.

Q. Okay. So you're saying Vermont policyholders, despite the fact that Vermont business of MVP has grown, will be paying your enterprise-wide administrative costs which include the New York business that has decreased, correct?

A. Yes. Vermont is part of our enterprise. Vermont members are part of our enterprise. So are New York members. So yes everybody. It is a shared cost.

Q. Do you see any practical way of separating out any of those costs so that Vermont policyholders don't pay for your entire enterprise costs?

A. Not the ones that are shared across both states. If it's something that's specific to Vermont, then yes that is something that would decrease as time goes on, but if it's -- if it's a shared cost such as, like I said, a claims operating system or a Microsoft license, that's not something -- unless we have overall increase in our membership enterprise-wide, at that point we could decrease our PMPM, and if we can decrease our PMPM we can offer an even more affordable rate, more

competitive rate, and try to gain more market share. It is our goal to work towards efficiencies and reduce cost because that flows into our premium rate and our competitive position.

Q. So do you see any practical way without unfairly affecting your enterprise-wide costs of reducing Vermonters -- the amount that Vermonters pay for administrative costs?

A. Off the top of my head it's just a matter of how are variable costs and how quickly we can adapt to our variable costs. So off the top of my head I don't have a specific item I can speak to. Again, to the extent that we can offer a more competitive administrative fee then that will help make our rate more affordable and more competitive.

Q. What was the trend assumption you used in this current filing -- total trend assumption?

A. I believe it was 7 percent. I would have to refer back, but I believe it was 7 percent.

Q. Okay and what was your trend assumption last year? What was your trend assumption in the 2019 filing for 2020 rates?

A. I don't have that in front of me so I couldn't speak to that, but our trend assumptions reflect the expected change in our costs from the base period of 2019

into 2021. That's based on known increases as well as conversations that we have had with some -- our provider partners and assumed increases which are generally set equal to for the Green Mountain Care Board hospital budget items. They are set to the prior year rate increase with the exception if we had a conversation with the facility or provider group that's indicating otherwise.

Q. Okay.

A. And that is something we do have a strong preference that the trend reflected in our rates are well aligned with the approved hospital budgets. So to the extent that information becomes available, that is our preference. If that results in a decrease of the trend, then we accept that that would still produce an actuarially sound rate. Our concern is if the trend is higher than we're predicting and an adjustment isn't made, that will produce an unsound rate.

Q. Did I ask you what your trend was for 2020?

A. Well part of our rate filing has -- so our 2020 rate filing uses 2018 base experience and has a 2019 trend component and a 2020 trend component. So that 2020 portion of our 2020 rate filing is included in our rate increases in this filing.

Q. Okay. I may have asked a bad question. Let me ask what I hope is a better question. Did L&E ask you

what trend assumption you included in the filing that you made in 2019 for your 2020 rates?

A. They did not specifically ask that, but that is available, and with that said to produce an actuarially sound rate what happened in that rate filing isn't relevant unless there's a significant disconnect between what actually -- the trend -- the actual trend is in 2020 versus what we're building into our rate.

Q. Whether or not it's relevant is something that the Board will decide. Let me just ask you then can you tell the Board right now what your trend assumption was in your 2019 filing for 2020 rates?

A. No.

Q. In this filing you assumed an utilitization trend of 1 percent, correct?

A. That's correct.

Q. Okay, and could you turn please to exhibit 10 which is the hourly report and turn the page 8.

A. Okay. I'm ready whenever you and the Board Members are.

Q. Okay, and before I ask you a question about that page let me ask you about volatility in your rate filing. You said that the volatility of the utilization trend has been too great to use for medical utilization trend purposes. Could you tell me what that means and why

that is?

A. Yes. As you reference we have grown our membership in the Vermont individual and small group market and with that we have population that's changing over time, and also with that if we only isolate the one portion of our experience that's been with us for the past 2 to 3 years, it's not representative of what we actually are enrolling -- what our population is enrolled in right now. Additionally, utilization trend is something that's more market centric than specific to the carrier. So I know last year L&E took utilization data from MVP as well as Blue Cross. They did their own independent calculations and relied on a reasonable trend assumption of I believe they referenced 1 to 4 percent and we had 0 percent last year and they recommended that we increase it to 1 percent. That's what we're assuming in our refiling for this year for similar reasons because of the volatility.

Q. I well recall L&E's recommendation that you increase your trend assumption last year. Could you read the first bullet on page 8?

MR. BARBER: What exhibit are we on?

MR. ANGOFF: That's exhibit 10, the L&E letter of July 7, 2020.

MR. BARBER: Thanks.

A. The three-year annual utilization trend was approximately 0.0 percent.

Q. Okay. So do you believe that the use of a 0 percent utilization trend in this current rate filing would be unreasonable?

A. Based on the data that L&E analyzed there was -- there's been increases in recent times of trend. If those continue, 0 percent would be unreasonable. Using L&E's four years of data to produce the last bullet, regression analysis, using all four years of data produces a utilization trend rate of approximately 1.2 percent. So we're assuming 1 percent which is below that figure.

Q. Okay. So your position is that 0 percent utilization trend would be unreasonable?

A. Based on L&E's analysis using market-wide data yes 0 percent seems like it would be a little bit short.

Q. In your rate filing what did you assume regarding the number of COVID virus cases that would occur each day in Vermont for the rest of the year?

A. In 2020?

Q. Yes.

A. I'm sorry. You're referring to a specific assumption in our rate filing. Could you just provide a little bit more clarity please?

Q. Sure. Obviously in formulating 2021 rates and

in determining how the COVID virus would affect both how much you pay out for the COVID virus claims and how much you pay out for non-COVID-19 virus claims and deferred claims you had to make some assumption, didn't you, as to how many COVID virus claims there would be in Vermont in 2020. So all I'm asking you is what did you assume as to the number of COVID virus claims per day that would occur in Vermont in 2020?

A. We didn't make any assumption about COVID virus claims per day in our rate filing. What we're looking at in our rate filing is the impact of cancelling services for two months and the impact that would have on pent-up demand that would flow into 2021 that is not specifically COVID virus related claims.

Q. But wouldn't you agree the number of COVID virus claims that occur has a relationship to the amount non-COVID-19 virus related claims that you would be responsible for?

A. I guess I'm not clear on that question. I'll answer the best I can, but we're assuming in 2021 that there will be a vaccine widely available in early 2021 which would prevent and mitigate the number of actual COVID virus claims that we would incur in 2021.

Q. Okay. So you made no assumption that the number of COVID virus claims that would occur in 2020 in

formulating your rates for 2021; is that correct?

A. Our rates are assuming that 2021 will be a normal prepandemic year. So the 2020 -- there is no adjustment for COVID virus specific claims that we had to make for that. We're assuming 2021 will be a normal year with a little bit of pent-up demand for deferred services and vaccination cost.

Q. Similarly you're making no assumption because of your -- it's unnecessary to make such assumptions regarding the number of COVID virus related hospitalizations in 2020, correct?

A. That doesn't have a bearing on our 2021 rates based on our data and our view of the world when we set our rates in May.

Q. Okay. Did you follow the same -- the same philosophy in formulating your New York rates?

A. Our New York rates assume the same COVID-19 assumptions which is pent-up demand and vaccination costs.

Q. Can I ask you please to turn to exhibit 4?

A. Okay.

Q. Okay. Mr. Lombardo, you're familiar, aren't you, with the litigation in which MVP is a plaintiff regarding the risk corridor program?

A. Yes.

Q. Okay and you're familiar, aren't you, with the

Supreme Court's decision in the industry's favor regarding the risk corridor program litigation, correct?

A. That's correct.

Q. Okay. To what extent, if any, did you include the risk corridor payments that you will receive based on that litigation in this current filing?

A. So short answer is we did not assume anything, but I think that requires you to understand what the risk corridor program -- or requires an explanation. The risk corridor program was rolled out in 2015, 2016 when the ACO rolled out. The risk program intention was because there was a lot of uncertainty about risk adjusting what the individual market with these new rules would look like, small group would look like with these new rules, and it was a really challenging time for the costs. So the risk corridor program was intended to mitigate gains against losses that would be -- that would occur because of that uncertainty. So the reason why we're due to receive this 1.785 million dollars is because we had costs, therefore, financial losses that would -- exceeded our expectations in that time period the government told us they would reimburse us for and they did not, and it's not a hundred percent of the losses recovered. It's just a portion of those losses will be recovered.

Q. Agree, but so am I correct in understanding

that the total amount that MVP is to receive based on the risk corridor litigation is 1.7 million?

A. Assuming that the Supreme Court decision doesn't face any more barriers and payments are actually distributed, which is still unclear at this time whether or not that's going to happen, we would receive 1.785 million dollars.

Q. Okay, and is that for enterprise-wide MVP or just for Vermont?

A. This is Vermont specific.

Q. Okay, and you're not including any of that in the -- in this current rate filing, correct?

A. That's correct.

Q. Okay, and you said it's not clear what's going to happen despite the fact there's been a Supreme Court decision saying you all won, correct?

A. That's correct.

Q. Okay. Well there's no appeal from the Supreme Court decision, is there?

A. That's my understanding.

Q. Okay, and then you say or your counsel says on page 3 of this exhibit -- could you please read the second sentence beginning with in complex litigation?

A. In complex litigation such as this it typically takes a great deal of time to work through a

number of procedural and process issues. It is likely there will be no resolution of the risk corridor litigation in the foreseeable future much less when or if payments will be made to health insurers.

Q. Much less when and if payments will be made to health insurers. Mr. Lombardo, will you agree with me that to put it kindly that statement is a little bit of an over reach?

MR. KARNEDY: Object to the extent that he's asking the witness to talk about litigation and legal issues. It's beyond the scope of this witness's expertise.

MR. ANGOFF: I'll withdraw the question.

BY MR. ANGOFF:

Q. Mr. Lombardo, if the proposed increase by MVP this year were approved, to what extent would that affect MVP's RBC ratio?

A. So with the adjustment from 7.34 percent down to 6.06 percent our overall enterprise-wide RBC would not be negatively impacted.

Q. Okay, and if the Board were to order no increase this year, to what extent would that affect MVP's RBC ratio?

A. It would have a negative effect on it. It certainly would. The magnitude of it I'm not sure of, but

we do set our rates to be self supporting and self sustaining so they can stand on their own.

Q. My question was to what extent would the Board not approving any increase for MVP this year affect MVP's RBC ratio?

A. It would negatively impact it.

Q. By how much?

A. I haven't done that calculation so I don't know that. It's just the fact that if claims exceed our expectations and we have no premium to cover it, that would not be an actuarially sound rate. That would have an adverse impact on our reserves levels.

Q. Would it affect your RBC ratio by 1 percent or more?

A. I can't speak to that.

Q. You don't know. Could it affect it by 10 percent?

A. That's a calculation that we could perform. It's not one that I just have off the top of my head.

MR. ANGOFF: Okay. I have no more questions. Thank you, Mr. Lombardo.

MR. BARBER: Okay. Let's move to Board questions. Before I do I just want to note for the Board there was some questions about data for 2020 claims. I expect that in past years you've issued

follow-up questions after the hearing or questions that came up. I anticipate that may be one that you consider when you're considering what followup hearing questions to ask. So with that I'm going to start with Board Member Holmes.

MS. HOLMES: Feels like a little bit of a lottery. We're never sure who's going to be called upon next. I win or not.

Thank you very much for your testimony. Very, very helpful. Appreciate it. So as you said the big issue seems to be COVID, the COVID impact, and there's a lot of uncertainty related to the potential costs of COVID. Right? We have sort of gone over that for the last few years, last few days. So my question to you is with current unemployment rates and furloughs and wage stagnation who do you think can better afford to absorb potential downside financial risks associated with the COVID uncertainty, MVP or the individual policyholder?

MR. LOMBARDO: That's a good question. Depending on the magnitude of it I mean the logical explanation would be that MVP has more money in the bank than most people, but that doesn't get to the point of what an actuarially sound rate is and that's what we're establishing is an actuarially sound rate.

Failing to increase premiums commensurate with the way claims are increasing could potentially adversely affect reserve levels and solvency issues and being able to provide members with peace of mind, but it is a really thin line that we're walking and it's challenging.

MS. HOLMES: I appreciate that. So we also heard varied assumptions about deferred care and pent-up demand and how pent-up demand may be managed over the next year. Differing assumptions and sadly pent-up demand is actually not new to Vermont at all. For years Vermonters have experienced long waits especially for specialty services. So why, if providers just have not expanded hours and worked weekends to meet excess demand that we have had in the past, do we expect them to do so now through the extended period of time of nine months?

MR. LOMBARDO: Yeah similar issue does occur in both states we operate, New York and Vermont, where it can take six months to get into a specialist. The concern is that the backlog has grown so much that it's going to be unsustainable. It's going to be kind of like an unbearable strain on the system. So that's why we're assuming this is an unique circumstance that's going to actually

accelerate and lead to increased work hours, working over weekends, such as that. It's an unique circumstance.

MS. HOLMES: Have you had specific conversations with providers and hospitals that have said they are opening up extra hours and expanding weekend hours? Do you have data to support this is actually going to happen?

MR. LOMBARDO: Personally I do not. Conversations I have had with MVP employees that do have those conversations that speak with providers, hospitals, have discussed extending hours, working weekends, items such as that.

MS. HOLMES: Switching gears a little bit has MVP tried to estimate the dollar value or the amount of waste or unnecessary care in the Vermont member population just in general? Low value care, unnecessary care, waste, any estimate of that, that you have tried to do?

MR. LOMBARDO: So we have -- I'm not familiar with us putting a dollar amount on that, but we do have a couple different items. We have a SIU unit, special investigations unit, that researches potential fraud patterns and abuse of the system. We also have quality and credentialing for our Vermont

population, and that ensures that we have -- that we're being -- strict set of quality metrics to make sure we're providing quality provider experience to our members. If providers don't meet those minimum requirements, then they are not allowed in the network, and to actually be able to identify specific cases, I'm not aware of any analysis, but we do have the work in place to ensure that we're not letting bad actors into the system other than through our SIU unit.

MS. HOLMES: So with that SIU unit can you tell me a little about the percentage of claims that you typically recover as a portion or a part of that SIU unit, you know, percentage of claims you might recover from fraud or abuse and also what you're anticipating for 2020 -- 2021?

MR. LOMBARDO: So I don't know those numbers off the top of my head, but I do remember that question being asked last year and the followup was that it was not a really large number. It wasn't something that would swing the percentage increase by -- you know, by a significant amount. We could follow up with additional information for the current year, but if it's consistent with what we've seen in prior years, it's a not zero amount, but it's not an

amount that is actually going to swing our rate increase to be something materially different than what it already is.

MS. HOLMES: I would really appreciate an historical look back at the percentage of claims you do recover with that SIU unit and what you're anticipating for this year, what's baked into your rate would be appreciated. What annual increase in wages and salaries is assumed in the 2021 administrative expenses?

MR. LOMBARDO: That detailed item I would have to follow up with our financial planning team. I know that there is a small increase, but I'm not sure what that specific number is.

MS. HOLMES: Okay. I would appreciate that followup as well. Another question in the -- if you could go to exhibit 6 page 2, make sure I'm on the right page, this is the answer to a question about the comparison of actual to expected pharmacy allowed trend over time, and just in looking at this the actual realized trend is significantly less than the expected trend year after year after year by a fairly large margin with the expected trend rates seem to be overestimated year after year and those are presumably baked into premium rates. So can you

speak to me about why the miss is so long and why we should believe whatever the expected pharmacy allowed or pharmacy trend for 2021 is?

MR. LOMBARDO: Yes. So it's a great question. The pharmacy trend in and of itself is not telling. So when we produce our trend, when we receive our trend forecast from our PBM it's assuming a static population where we're not -- basically whoever we had in the -- I believe it's based on 2019 data. So assuming there won't be any changes to that population in 2020 or 2021. Because we've grown and our risk profile has changed those trend figures -- the actual trends need to be normalized out for risk adjustment changes. Unfortunately risk adjustment doesn't get to just the specific -- one specific item you can say this is pharmacy related. Everything is kind of interrelated, but what I can speak to is the fact that our actual trends have come in favorable yet our risk adjustment payments have increased over time. So what that's telling me the morbidity of our population is healthier. So that would lead to a lower trend, but then we're paying back into risk adjustment a larger amount to normalize ourselves back. It's something that you can't really decouple it into one item. Everything is intertwined, but it

has to be looked at with market or morbidity changes of our population as well as risk adjustment.

MS. HOLMES: And there's no way to quantify the net effect?

MR. LOMBARDO: I would say that's not that I'm aware of and I have thought about it and my team has thought about it and there's not a specific way that we've figured out to identify that.

MS. HOLMES: If you could turn to exhibit 9, another set of questions, pages 17 at the bottom, really the top of 18 in which MVP talks about the significant cost savings that have been materializing because of the high use of telemedicine, in particular, the substitute of a telemedicine visit for urgent care visit or an emergency room visit, substantial cost savings, significant cost savings to use your words, and I'm just wondering how you factor that into your cost estimates, medical cost utilization estimates for 2021. Assuming telemedicine is here to stay how is that factored into your trend going forward in 2021?

MR. LOMBARDO: So we have seen an uptick in telemedicine usage as the COVID pandemic has broken out. It is still not -- relative to our overall cost of our book of business it's still a

very small amount, and we are assuming that once as people are learning how to navigate through the pandemic more intelligently we're assuming that 2021 is going to look more like 2019. So as a result there isn't any sort of explicit adjustment being made for continued higher utilization of telemedicine. Even with that I would say that the overall cost relative to the total projected claims for telemedicine, if we did assume increased utilization, I wouldn't anticipate an overall material reduction to claims in the aggregate.

MS. HOLMES: Even though you talk about here a significant cost savings associated with telemedicine?

MR. LOMBARDO: In a total dollar amount it can be -- it can appear to be something like a substantial number on a percentage basis, and when you spread it out over 35,000 members it's a much smaller figure.

MS. HOLMES: Okay. My last question was did you factor in any additional administrative cost to implement the separate abortion billing that at the time you submitted this filing -- MVP submitted this filing it was referenced but has now changed. I'm wondering is there a specific administrative cost

associated with separate abortion billing.

MR. LOMBARDO: I know that is something that was considered. I don't know specifically how much that is actually worth in the overall projection. I would have to follow up with our financial planning team on that.

MS. HOLMES: Okay. That would be great. I have some questions that are in some of the confidential materials, but I'm assuming we'll go into an executive session so I will hold off on that. Does that sound good, Mike Barber?

MR. BARBER: Yes. Let's get through all the non-confidential questions you have and then we'll go through the steps of going into executive session for any confidential questions.

MS. HOLMES: Okay. Then I am done. Thank you.

MR. LOMBARDO: Thank you.

MR. BARBER: Just to let Board Members know the order is however you are organized on my screen. So the next up is Robin.

MS. LUNGE: Great. Hi Matt.

MR. LOMBARDO: Hi Robin, how are you?

MS. LUNGE: I'm great. Thank you. So I just have a couple followup questions which overlap

with the areas Jess just asked about. So just to start with telehealth you in your actuarial memo provided some information about web site traffic and number of sessions. Actually I'm sorry. That's in your prefiled testimony. Do you have data on how many of the visits are with Vermont providers as opposed to either MVP staff or out-of-state providers?

MR. LOMBARDO: That is not something that I've seen that breakdown. That doesn't mean it's not available if requested. It's just not a breakdown I have seen.

MS. LUNGE: Okay, and so it would be interesting to know that because I understand from your list of 22 that promoting primary care and care coordination is something you're committed to. So understanding how your promotion of telehealth would direct that priority would be helpful, but I'll wait for a followup.

MR. LOMBARDO: I'll just add to that in a little bit. In the past so there's kind of two not physical visits you can have. One is we classify as telemedicine. The other one is telehealth. Telemedicine is using MVP's My Visit Now app which is using the online care group which is a national set

of providers. Telehealth is a replacement for a physical visit with the PCP or the specialist that's in your community down the street from your house. So we do -- we have seen an increase in both of those during the pandemic. The exact splits I can't speak to though.

MS. LUNGE: Okay. Great. Thank you.

MR. LOMBARDO: Yes.

MS. LUNGE: And I would -- I can also do this I think as a followup given your response to Jess, but it would be interesting to have the dollar figures and the percentage that you referenced in your answer to her question about the magnitude, but we can include that in a followup.

MR. LOMBARDO: Okay.

MS. LUNGE: Do you know how many MVP policyholders have COVID related claims?

MR. LOMBARDO: Across our enterprise I do not.

MS. LUNGE: I'm specifically interested in Vermont of course.

MR. LOMBARDO: I know that we have somewhere around 50 patient admissions related to COVID as of the end of June for Vermont commercial members.

MS. LUNGE: Great. Jess asked a lot of my same questions so I'm just jumping through them. So then to follow up on your answer related to the source of information about providers working nights and weekends, I know you didn't speak to them personally, but do you have information or data from your medical management team in terms of who they spoke to in Vermont? Which providers? How many providers?

MR. LOMBARDO: That's something I would have to speak specifically to other people at MVP about.

MS. LUNGE: Okay, and then the last question I have I think, it's not specifically in the confidential material so I'm going to ask the question and then have you pause so that your attorney can indicate whether or not this should be a confidential answer because I don't want to bring it out if it's supposed to be confidential, but I'm not sure. So I know that MVP has been moving towards implementation of an ACO program. I was interested in your future plans around participation including potential changes to your payment methodologies and your rates.

MR. KARNEDY: I wonder -- not knowing

what my esteemed witness is going to say in response to that, I wonder if we could just add that question in the confidential session if we're going to be doing that if that's possible.

MS. LUNGE: For Mike's benefit the reason why I thought it might be included in the confidential portion is because in the answers to some of the questions about the ACO program things like the risk orders and the type of arrangement were marked as confidential. So I think it's similar.

MR. BARBER: Yeah I think you're right. We do need to figure that out before we go into executive session, though, because we should not be asking questions that call for non-confidential responses in the executive session. So, Amerin, does that sound right to you as the one whose been kind of working on the confidential requests?

MS. ABORJAILY: Yes it does and I would say a non-confidential answer during the executive session we can reask the question when we're back out.

MR. KARNEDY: I think that sounds like a good approach. Thank you.

MS. LUNGE: Okay. Let me just check my -- I did have one more question about the medical

trend. So, Matt, you had indicated in your testimony that you used the information you had about the Green Mountain approved hospital budget rates with some exceptions with information from your contracting department. I believe that one of those exceptions related to the UVM Health Network.

MR. LOMBARDO: I think that's something that's in the confidential section.

MS. LUNGE: Okay. Sorry. All right. Well then I will ask about that specific negotiation in the confidential section. So that's my last question.

MR. LOMBARDO: Thank you.

MR. BARBER: Okay. Maureen.

MS. USIFER: Great. Thanks. Hi Matt.

MR. LOMBARDO: Hi.

MS. USIFER: I have something that would also go into confidential, but the ones that aren't can you give an idea what percentage of management costs are fixed?

MR. LOMBARDO: I believe that's something that L&E had asked us to provide in their memo data set and it is around 50 percent.

MS. USIFER: 50 percent. Okay. That's what I would -- that seems like a fair number. Can

you tell me what does one percent hospital -- for the Vermont hospitals what does a one percent hospital rate increase translate to, to a total rate increase?

MR. LOMBARDO: I would have to pull up our exact utilization. We do have that. It's not -- it's going to be something that's less than one percent obviously for each year.

MS. USIFER: Right.

MR. LOMBARDO: To simplify it approximately 80 percent of our claims are processed through are medical claims, 20 percent are pharmacy give or take 5 percent, and then there's a subset of them that are subject to the Vermont hospital budget. So it would be something -- one year is something less than one percent. One percent impact on trend on the hospital budgets for one year would be something that's less than .8 percent is my approximation. Probably .5 to .7, but that's an estimate.

MS. USIFER: I think it may be .3 to .5 because you would also have to remember that only half of your volume comes from Vermont hospitals I think, right?

MR. LOMBARDO: So --

MS. USIFER: Whatever you take I'm

saying for Vermont hospitals there's a 1 percent increase, but if you can get back to us on the number?

MR. LOMBARDO: Yup.

MS. USIFER: You know what I mean. I'm saying I think you have about half outside of Vermont and maybe a little less than that.

MR. LOMBARDO: Yeah. My mind was going to UVM physicians because I know they are subject to it and they do take up a physician cost, but that's a calculation we could do. It doesn't seem unreasonable around a half percent.

MS. USIFER: Right, a little lower, but we'll get the number in. And then just I guess -- and maybe this was a followup that we're going to get, but on the June preCOVID-19 we know it's not -- it's back to almost preCOVID-19 levels, but is it 80 to 90 percent? Is it -- we're not seeing Vermont hospitals back near a hundred percent. So they are coming back for sure, but I haven't heard of any in June that were at a hundred percent. There were many at 70, 80 percent. So just trying to get a read on what percent increase that maybe would have been a followup from Jess's questioning earlier, but just want to make sure we get that number.

MR. LOMBARDO: Okay. It's something we can provide.

MS. USIFER: And then on the schedule we looked at before under A18 we talked a little bit about this I think last year too where members can compare prices.

MR. KARNEDY: Which exhibit are we referencing? I apologize.

MS. USIFER: Sorry. 8 page 18. It refers to the telemedicine we were talking about.

MR. KARNEDY: Exhibit number 8?

MS. USIFER: No. A as in Alfred. I guess it's 8A. Sorry. You're right. 8A page 18.

MR. BARBER: I don't have a 8A.

MS. USIFER: The question is really the consumers have the ability to check prices before they go to providers. I think we talked a little bit about that and as we know we're saying everyone's pocketbook is stretched. We have encouraged consumers to do that more to the extent it's so convenient for them to find a provider in their area at maybe a lower price because often that impacts what they pay for deductibles and out of pockets, but then it should also carry forward to what MVP is paying. So you know what types of savings are you

seeing there and how can we push that? How can you guys push that harder so it should help everybody?

MR. LOMBARDO: Yeah so there's a few items to pack in there. First is there isn't a way -- it's a separate system. The online cost tool calculation is different from our claims system. So tying those items back to one another is not something that is -- it would take a huge manual effort to identify that, but we are promoting alternative ways of accessing care, whether it's through our Tri Cal Medicine First web site or it's just through member communications because I agree as members make more intelligent decisions in terms of cost that will reduce costs overall and will pass on to premium rates in future years.

To specifically identify how much that's going to impact it we don't have the ability to do that based on the way our systems are set up.

MS. USIFER: Thank you, and can you talk about any other major cost saving initiatives that are in the works and when we would expect to see the benefits of those?

MR. LOMBARDO: So from an administrative perspective we're taking on a lean initiative to identify areas where we can replace manual

intervention with a computer or behind the scenes. So something like a case manager or it's someone in the claims processing area rather than them having to physically take copies and fax them or print them we're automating those types of items in a hope to reduce admin in the future. So those assumptions are definitely taken into consideration when we look at our 2021 cost, staffing levels that will fluctuate as a result of that, and you know that's definitely a major initiative that we're undertaking to help reign in administrative costs.

We've also reviewing any contracts that we have because we've been -- we rolled out Microsoft Teams about a month before the pandemic broke. It worked out pretty well for us. So we have had a pretty good transition to working from home and we're reviewing contracts and how are we going to approach our business in the future. There are -- what I have heard based on conversations is some of the contracts and leases that we signed are not short term. They are longer term projects. So it may not be realized any time in the next year or two, but that is something that we are considering as an organization is how do we approach work in the future post pandemic.

MS. USIFER: Okay. And then just back to the chart on 62 page 2, the pharmacy trend, you talked a little bit about the growth in the number of people, but it's still growing but it's a little more stable I would think. So it would seem -- and you said that basically it gets made up for in the risk transfer, but -- if you have it wrong, but if you got the pharmacy trend right or closer to being more accurate to reference what's been happening, then would the -- wouldn't that make the risk adjustment less when it came to pass? I think it would be better to try to get, you know, this as close as you can, and if the trend has been better each year, you know, I don't think the risk adjustment -- the forward risk adjustment would already be picking that up. So I have to understand wouldn't this just be an offset if this were a trend at the end of the year? There's a lot that goes into the risk adjustment.

MR. LOMBARDO: So the question was cut out a little bit, but I'm going to answer it as best I can based on what I heard. Our rates are set to a 2019 experience and then normalizing for risk adjustment. That's projected to 2021 which is implicitly assuming there won't be a population change, but because of risk adjustment we are

agnostic to population changes. So if we do enroll a healthier population in 2021, then our claims will come down, but in theory when we receive 2021 risk adjustment it will be a higher payment to normalize us back up to that level. So I hope that answers your question, and if you asked anything differently that I didn't hear, please let me know.

MS. USIFER: I guess it's just if we know -- if we believe that the trending for pharmacy has been better each year, wouldn't that come -- wouldn't that change some of the assumptions that you have just as you do for utilization trends and on the medical side?

MR. LOMBARDO: If we were to reduce our trend expecting a healthier population, we would have to make a corresponding increase to our risk adjustment payment which would basically put us back at the same point. So the fact is that we're assuming a static population that's normalized for risk adjustment and that makes it -- if we were to assume population changes, we would have to also make a corresponding risk adjustment to each.

MS. USIFER: Okay and then I understand, you know, that this is for 2021 and electives may come back from '20 into 2021. That's the filing

we're looking at, but can you just, I guess, give me a yes or no answer to any benefits that occurred in '20 for Vermonters that didn't happen, how that will impact the surplus for 2021. So if we end up being favorable at the end of the day, which I know you said is too early to call right now, that would impact the surplus; is that correct?

MR. LOMBARDO: If claims come in favorable, then that does fall to the bottom line in the short term.

MS. USIFER: Okay. That's all I have. Thanks.

MR. LOMBARDO: Thank you.

MR. BARBER: Tom, do you have questions for Matt?

MR. PELHAM: I do. Just a few. So my first one is just a very top side question. Oh good morning.

MR. LOMBARDO: Good morning.

MR. PELHAM: It's a very top side question, and if you turn to page 3 of the first exhibit, and I'm just looking at the written premium for this program at 248.9 million dollars. So that I'm just trying to make sure I understand what that is. So that is your estimate, your projection, at

this point in time or when this filing was made of the premium to be garnered from the 2020 approved rates?

MR. LOMBARDO: I would have to look if that is the projection for 2020 or 2021.

MR. PELHAM: Well the 258 is I think 2020 because if you add the 18.2 million on to it, you come to the 267,204,274 number exactly which is your 2021 number.

MR. LOMBARDO: Yes I agree page four does break it out. So the 2020 figure is 248 million.

MR. PELHAM: Right, and so when that rate was approved last August, this time last year, the projection was 207.7 million dollars and that number -- also I can give you an exhibit where that number can be found. I am -- I'm not sure this is confidential or not, but this is off our web site. So I'm just wondering what are the moving parts between a -- I know some of it is membership, but between a 207.7 million dollar projection after going through all this actuarial scrubbing which it did and now we're at 248.9 million as a projection which is a 20 percent difference.

MR. LOMBARDO: That is driven by

membership changes. So our projecting claims at the time is our membership snapshot times our target loss ratio because we don't have a revised estimate when we're submitting our rates. Our membership increased by approximately 20 percent which is why the premium is also increasing by 20 percent. If it's not exact, it could be because benefits changed a little bit. You know maybe we saw a shift in our membership from distribution of gold versus silver versus bronze, things like that, but in general it's just reflecting our target loss ratio times our projected premium as of February 2020.

MR. PELHAM: And in these actuarial projections I mean there are estimates about what the membership will be. So it all gets translated to a per member per month basis, but you think most of that difference is explained by the actual membership that showed up?

MR. LOMBARDO: Yes. You reference 20 percent gain in -- or 20 percent increase in premium and/or in incurred claims. That's -- I have 20 percent in my mind for the membership increase approximately. So that goes together for me.

MR. PELHAM: And just a quick question when you're -- at this point in time we're looking at

a 6.06 percent increase. That still is kind of out of alignment with the all payer model hope of three and a half percent total cost of care by 2022, and do you have any insight or any thoughts about that or is your actuarial analysis as it should be just completely independent of the fact that the State of Vermont has signed an agreement with the federal government for the all payer model?

MR. LOMBARDO: It's our rate is set based on our projection of incurred claims from 2019 to 2021. Our best estimate of what will actually happen in 2021 is what's captured in our rates. The three and a half percent figure that would be great if we can achieve that. You know if we arrive at that, that's fantastic because that will make premiums more affordable, more competitive, but our rate is set so that's actuarially sound and our best estimate that is 6.06 percent.

MR. PELHAM: Okay. So my next question is a quick one on just what I call the premium cliff and I just want to give an example. The data is on exhibit 1 page 110. You don't have to go there if you don't want to, and the other is the federal poverty guidelines in exhibit 21. So I'm looking at a -- at your chart on exhibit 1 page 110 that talks

about the 2021 exchange rates, and I'm looking at a specific amount associated with a couple that is an analysis that DVHA actually did on this exact plan for 2020 over 2019, and so the rate for a couple there is $1,020.56 a month for an annual amount of $12,246, and at 400 percent of poverty the income is $68,960 which means that rate is a 17.8 percent -- 17.8 percent of the couple's income, and at $69,800 that's a couple one making 30, one making 40, maybe they are younger than I am, but in their late 40's or 50's. They might have a kid in college trying to save for retirement. I'm trying to put some feeling to it. Do you think that that 17.8 percent rate is affordable?

MR. LOMBARDO: That rate is -- the rate is set to be affordable in the sense that it is an actuarially sound rate where we are doing everything we can to manage costs to be as low as possible and that's what we're doing, and I recognize how large those claims can seem -- or how high that premium can seem, but it goes back to what I commented how skewed toward the right tail costs are, and I recognize that most people pay a significant amount of premium and don't incur a comparable amount of claims, but every year there are some people and there's others with

chronic conditions that every year continue to drive the bulk of that in this case 2020 rate, and our rates are being set to be actuarially sound, and as much as that 17 percent figure is intimidating that is the cost of covering our block of business and providing these benefits.

MR. PELHAM: Now maybe you're not familiar with this, but there was this study that was done by DVHA and DFR this last year. It was called the 2019 Report on Health Insurance Affordability and Merged Markets, and the report cites MVP as one of its contributing stakeholders. So are you familiar with that report at all?

MR. LOMBARDO: I'm not familiar with that.

MR. PELHAM: Okay. Then it just has some -- it is done by Wakely and it has profiles of some options that will help flatten the premium cliff, and a couple of them are pretty cheap relative to the problem.

So in terms of looking at your trend analysis do you have a sense of what percent of the claims are associated with independent providers -- providers that are independent of hospitals?

MR. LOMBARDO: We do have that

breakdown. I believe it's provided in one of the confidential exhibits. I just would have to refer to it.

MR. PELHAM: If you can point me to it. You don't have to do it right now. We can do it later on in the confidential session, but let's see. I have asked probably my last question. Mike will be happy. I'm looking at this wellness benefit in addition at the $600 bonus benefit. I started to ask Blue Cross Blue Shield about it yesterday, but then I realized it was you guys. So I wasn't clear where it talks about 88 cents per member per month whether that applied to all 443,766 member months or was that just applied to people who invoked the rider.

MR. LOMBARDO: If you purchase a non-standard plan, it's automatically included in your benefits and that 88 cent load is a plan specific adjustment. So if you purchase a standard plan, that load is not included in your rates. If you purchase a non-standard plan, it is included in the rates.

MR. PELHAM: Okay. Thank you. That's all. Thank you.

MR. LOMBARDO: Thank you.

MR. BARBER: Mr. Chair.

CHAIRMAN MULLIN: Thank you. Good morning, Mr. Lombardo. Can you refresh my memory does MVP own or lease the corporate headquarters in Schnectady?

MR. LOMBARDO: We lease them.

CHAIRMAN MULLIN: Okay, and you said that you had long term obligations on that. So I would -- like the rest of the world many people are trying to figure out who needs to go back to the office, but that's a sticky issue as far as still having to have the responsibility for the space.

MR. LOMBARDO: Yes. I don't know a ton of details about it, but yes that is something that we have a COVID-19 work force task planning committee that is looking at what does the future look like, what does the post pandemic world look like, and these are all items that we're considering.

CHAIRMAN MULLIN: And did MVP see a significant drop in expenses related to, for example, travel to conferences, use of the copier, those type of things, office supplies?

MR. LOMBARDO: Those -- yes there were decreases to cost. Those are good examples. We did cancel conferences and travel and copying. I'm in the office for the first time since mid March and

there's only one other person on the floor that I have seen. So yes reduced copy costs, but there are increased costs for other items. I know we had to boost our BPN. The BPN we had prior to the pandemic that wasn't something that could support 95 percent of our work force -- 95 percent plus working from home. So as much as there are decreases in costs for certain items there are offsets in other places.

CHAIRMAN MULLIN: Okay. You know everything we try to focus on actuarial value and yet clearly this year the theme is uncertainty. Everything is somewhat speculative in nature. You've created a scenario based on how you will seek pent-up demand going into the first few months of 2021 and a resumption to more normal times and that you kind of refer to how things seemed to normalize in June, but it couldn't just be that June was making up for two and a half months previous, and couldn't a likely scenario be a possibility, I'm not saying it's a probability, but a possibility that people will have fear to go back to medical settings so utilization will be reduced, especially in settings like the ER. With the cancellation of fall sports and not just for students, but adults and things like that, that there would be a lot less orthopedic procedures and

carrying that forward even those initial plans may fall into 2020, the PT and things going into 2021 may be reduced, could we likewise see a reduction in infectious disease because people are washing their hands, people are being socially distant, they are not driving as much, things like that. So couldn't just as likely a scenario be a reduction?

MR. LOMBARDO: It's -- there's a lot of scenarios that can take place. Based on our -- what we're seeing, our conversations with providers, with our internal folks, we're expecting 2021 -- our scenario, best estimate, our 2021 will look like a prepandemic world, but we do recognize there could be cancellations or reductions because there are fewer people that are going to be skiing this year that could blow out their knee, stuff like that, but assuming that the vaccination is approved in early 2021 we expect for the most part 2021 will have a higher -- will just be a more normal year.

CHAIRMAN MULLIN: Have you seen any increase in retirements from older providers?

MR. LOMBARDO: That's not something I know off the top of my head. That would be something we would have to -- I would have to follow up with our provider team. I don't know if that's something

they track. I can't guarantee we can get that information, but the fear of COVID is definitely a very real issue, and recognizing that the elder population is higher risk that's something, though, that I don't know off the top of my head.

CHAIRMAN MULLIN: So we get to see -- this has no relationship to the hearing today, but we get to see Vermont numbers, we get to see North Country numbers, we get to see State of New York numbers. I'm just curious how you in the Capital District are doing. Do you feel safe walking the streets down there?

MR. LOMBARDO: Yeah thanks for asking that. It's where I live. You know it depends where you are. Where I grew up it's much more urban. Where I currently live is much more like Vermont where most of Vermont where there's space between the houses, right, and I feel a little bit safer walking outside there. It's still not -- I haven't hung out with any of my friends. All I've seen is my parents and my in-laws. It's a weird world. We're just trying to be as cautious as possible as a family, be cognizant of the people around us. Not just myself, my wife and two kids, but also my family. You know it's -- I hope you guys are doing well too. It's

just such a strange world. Just want to get over it so people get back to normal and be healthy again and not worry and live in fear.

CHAIRMAN MULLIN: I think for the majority we all feel very grateful that we live in an area where there is social distancing just because of our rural nature. So we're blessed that. I have no further questions. Thank you.

MR. LOMBARDO: Thank you and I appreciate you asking that question. Appreciate that.

MR. BARBER: So before we go through the mechanics of an executive session, Mr. Karnedy, do you have any redirect for Matt on the non-confidential questions and answers?

MR. KARNEDY: I just have one question.

REDIRECT EXAMINATION

BY MR. KARNEDY:

Q. How much time have you had to spend with your in-laws?

A. I mean, you know, this is -- I actually have a great relationship with my in-laws. I enjoy them, but thanks for trying to corner me.

MR. KARNEDY: Thank you.

MR. BARBER: So we did this yesterday so

I think you're familiar with the Open Meetings Act and the two bases that you guys voted to go into executive session on yesterday were the confidential documents exception or provision, sorry, and contract negotiations. I've heard some of you had questions about the confidential materials. So it sounds like that's a basis that you might want to go into executive session for. I don't know that you also have questions generally about contract negotiations.

MS. LUNGE: I think my question that I asked related to some of the unit cost assumptions could veer into contract negotiations.

MR. BARBER: Okay. That's helpful because to go into executive session on that basis we need a finding that premature public knowledge would place a person at a substantial disadvantage. In this case MVP. So do you feel comfortable finding that or do you need testimony to establish that fact? I think just generally based on common sense and your experience I think you might be able to find that, but that's really a question for -- to make a motion and the Board.

MS. LUNGE: So since I'm assuming I will be the maker of the motion why don't I just ask Matt one question related to that which is earlier on,

Matt, I started to ask you a question related to contract negotiations with the UVM Health Network. Could you briefly describe how it might put your company at a disadvantage if we were to ask you about those contract negotiations in a public setting?

MR. KARNEDY: I'll just, Matt, caution you to the extent this does get into confidential information please answer the question at a high level without identifying any confidential information.

MR. LOMBARDO: Sure. Our contracts are contracts -- our discount rates are -- it's kind of like in a poker game. If you were showing off the cards that you were holding, it would give the competitor or the other opponents an advantage on you, and in this case it's not something -- if Blue Cross is on the phone and they hear anything about that, that's something that they could leverage in their contract negotiations with UVMMC and try to get a leg up on us from a competitive standpoint.

MS. LUNGE: Thank you. I'm comfortable with that answer. As the maker of the motion can I ask if other Board Members need more?

MS. HOLMES: No.

MS. LUNGE: Seeing no's. Okay. So why

don't I go ahead and make a motion that we go into executive session for the purpose of discussing contract negotiations with a finding that public disclosure of that information would constitute -- would create harm for MVP given the premature public knowledge.

MS. USIFER: I'll second it.

MR. BARBER: Is there any discussion? Those in favor please signify by saying aye.

(Board members respond aye.)

MR. BARBER: Any opposed?

(No response.)

MS. LUNGE: And then I need to make a second motion that we also in our executive session discuss the information related to confidential materials provided in the filing.

MS. HOLMES: Second.

MR. BARBER: Any discussion? All those in favor please signify by saying aye.

(Board Members respond aye.)

MR. BARBER: Any opposed?

(No response.)

MR. BARBER: Okay. So the Board has moved to go into executive session to discuss contracts and confidential exhibits and binders or

materials in the binders. The next step I think is to determine who needs to be in that executive session. So obviously the attorneys for the parties, the witness, the Board Members, board staff, and Lewis & Ellis witness and will be bound by confidentiality in these proceedings. Anyone else we need to include in the executive session, Mr. Karnedy or Mr. Angoff?

MR. KARNEDY: I don't believe so.

MR. ANGOFF: No, sir.

MR. BARBER: Okay.

MR. KARNEDY: Actually I'm sorry, Mr. Barber, (interruption) may be on the line as well, well known by the Board. You might want to have her in the confidential session as well.

MR. BARBER: I agree and obviously the court reporter. So I don't think there's anything -- just obviously as we discussed yesterday I'll caution everyone that really the questioning has to stick to the confidential materials. If there's anything that comes up that's not confidential, we can go back into the open session and discuss that. So with that if everyone could -- sorry. I'm getting a text suggesting we might want to go to lunch and then do this.

MS. USIFER: Maybe do this and go to lunch. That way you can tell people when to come back.

MR. BARBER: Yes I agree with you. Okay. So if everyone could hang up this line, we'll obviously keep the line open for the public and then we'll call into the other line.

MS. LUNGE: Mike, do you want to say what time we'll reconvene for the public?

MR. BARBER: Thank you for reminding me. Once we vote to go out of executive session why don't we take a lunch, half hour, and reconvene at -- I'm guessing the executive session will last maybe until 12:30. So 1:30. I think we're doing okay on time.

MR. KARNEDY: I wonder if 1 might be a better number.

MS. USIFER: Split the baby. 1:15.

MS. LUNGE: I don't care.

MR. BARBER: Let's take 1:15.

CHAIRMAN MULLIN: We have to end at 4:30. I think the 1:15 gives us that extra 15 minutes.

MR. BARBER: Let's hang up, go to executive session, take a lunch, and come back.

(Executive Session begins at 11:45 a.m.)

MR. BARBER: Okay. It's 1:15. I'm going to resume the MVP 2021 individual and small group rate filing hearing. Ms. Carson, can you just confirm you're here?

(Court reporter confirmed.)

MR. BARBER: Okay. So where we left off we just finished testimony of MVP's sole witness and now the next item is to hear from DFR. So Jesse Lussier is here for DFR. Mr. Lussier, can you please raise your right-hand?

(Mr. Lussier was duly sworn.)

MR. BARBER: Okay. I think as in past years if you just want to start.

MR. LUSSIER: Okay. Can you hear me okay?

MS. BARRETT: Excuse me, Mike. I think Robin is sending a text.

MR. BARBER: My apologies. I forgot to check to see if every board member is on. So let's wait for Robin to join in.

MS. BARRETT: She's going to join right now.

MR. KARNEDY: And, Hearing Officer Barber, you may want to swear him in too.

MR. BARBER: I just did that.

MR. KARNEDY: Oh you did. My apologies.

MR. LUSSIER: I'm running on DSL right now so if I cut out let me know.

MR. KARNEDY: I'm having a hard time hearing the witness.

CHAIRMAN MULLIN: As am I.

MR. LUSSIER: How about now?

CHAIRMAN MULLIN: Better.

(Off-the-record discussion.)

MR. BARBER: You did answer yes to the oath. I kind of lost track.

MR. LUSSIER: Okay. Yes I did.

MR. BARBER: Go ahead.

MR. LUSSIER: All right. Good morning everyone. My name is Jesse Lussier. I work as an insurance examiner for the Department of Financial Regulation. I've been working for the Department for about nine years now. We've reviewed the Department's role regarding solvency in these hearings, and so for the sake of time I'm going to skip that piece unless anybody has any questions. As we've also stated in the past, we're an insurance regulation state based with every state being responsible for those companies that are domiciled in their states. MVP's primary regulator is New York.

We rely on New York to notify us of any solvency related concerns related to MVP.

With respect to our filing it's similar to previous filings. The one noticeable exception is on the first page. The last two paragraphs deal with the uncertainty surrounding the COVID-19 pandemic. We've also discussed that on numerous occasions so I'm going to skip over that unless anybody has any specific questions, but again predominantly it's the discussion revolves around the uncertainty of claims and deferred claims and when they might be returning back.

I will skip down to the final part of the solvency opinion which remains consistent with previous opinions that I'll just read the final impact -- final paragraph. Based on the entity-wide assessment above, and contingent upon GMCB and the actuary's finding that the proposed rate is not inadequate, DFR's opinion is that the proposed rate will not have a negative impact on MVPHP's solvency. I will leave it at that and open it up to questions. Thank you.

MR. BARBER: Mr. Karnedy, do you have questions for this witness?

MR. KARNEDY: I do. Thank you very

much.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Good afternoon, Mr. Lussier. How are you?

A. Good. How are you?

Q. Can you hear me okay?

A. Yes.

Q. So you're employed at DFR you said for the past nine years? Time flies.

A. Correct.

Q. If you could please turn, you made reference to it, it's exhibit 11, it's the DFR solvency letter and that's dated July the 7th, correct?

A. Correct.

Q. And do you adopt this testimony on behalf of the DFR -- excuse me. Do you adopt this exhibit as your testimony on behalf of the DFR, correct?

A. Correct.

Q. So would you please read the summary of your opinion at the top of page 2? Read that sentence underneath that heading.

A. The proposed rate filed by MVPHP would not negatively impact its solvency and the company otherwise meets Vermont's financial licensing requirements for a foreign insurer.

Q. Do you stand by that opinion today?
A. Yes.
Q. And would you please read the three bullets under the MVPHP solvency opinion heading?
A. Sure. DFR has been in communication with MVPHP's primary solvency regulator, the New York Department of Financial Services, and has not learned of any solvency concerns.

Further, MVPHP currently meets Vermont's foreign insurer licensing requirements.

Finally, in 2019, all of MVP Holding Company's operations in Vermont accounted for approximately 5.7 percent of its total premium written. DFR has determined that MVPHP's Vermont operations pose little risk to its solvency. Nonetheless, adequacy of rates and contribution to surplus are necessary for all health insurers to maintain strength of capital that keep pace with claims trends.

Q. Okay. So even though Vermont is a small percentage of MVP's total premium you still look at its Vermont premium and this rate filing to determine adequacy, correct?
A. Correct. Normally you would want to see filings and rates kind of stand on their own.
Q. And this letter, exhibit 11, is based on DFR's

review of MVP's original filing, correct?

A. Correct.

Q. And it sought a contribution to reserves of 1.5 percent which the DFR found based on this exhibit to be adequate, correct?

A. Correct.

Q. And you have heard testimony here today -- you attended this morning, you heard the testimony from MVP?

A. Yes.

Q. And you heard that based on L&E's recommendation MVP has decreased its rate proposal from 7.34 to 6.06. Did you hear that testimony?

A. Yes.

Q. Do you have an opinion that this decrease and a revised lower rate of 6.06 will likely have the impact of sustaining MVP's current level of solvency?

A. Yes. My understanding is that except for one component, which is maybe a half a percent, the rates have been agreed on by the actuaries. So as long as the actuaries testified --

Q. I believe they are .6 apart based on the testimony this morning. So that wouldn't change your opinion, is that what you're saying?

A. Correct.

Q. And when it comes to solvency do you believe

it's a good idea to kick the can in later years, perhaps have a lower contribution to reserves of one year, say one percent, with the hope you could simply have a contribution of 3 percent the next year to catch up? Do you believe that's a good approach?

A. Generally speaking no.

Q. I believe you testified in prior years that the DFR's review of solvency does not end with RBC, that it reviews a large amount of data, correct?

A. Correct.

Q. And if you go to page 2 please, the first paragraph under background, would you please read the second and third sentences?

A. Whether an insurer is solvent is more complex than simply determining whether at any given moment the insurer has more assets than liabilities. Rather, it is an intricate analysis of many factors to discern how close or far away from insolvency the insurer is and in what direction it will move in the future.

Q. So it's not just RBC from the Vermont Department's perspective in measuring solvency, correct?

A. Correct. RBC is one component.

Q. And in this year's rate filing you have conferred with the New York regulators and they confirm their review of relevant data regarding solvency?

A. I communicated with them in June and once in July I believe. The June e-mail was asking if there were any solvency related concerns and they said no.

Q. Okay. Thank you, and do you recall last year you and I talked a little bit, but do you recall last year reviewing L&E's actual annual memorandum where they did a reasonableness check of MVP's proposed 1.5 percent contribution to reserves. Do you remember that?

A. Faintly.

Q. Do you remember reviewing that document and reviewing the reasonableness check?

A. Again it was a year ago so I don't have a good recollection of it.

Q. Okay. Well let me ask you about this year. Did you review this year L&E's reasonableness check review in their actuarial memorandum?

A. Yeah I reviewed their memorandum.

Q. And did you find that information on their reasonableness check CTR data nationally -- did you find that information supported the reasonableness and adequacy of the 1.5 CTR?

A. Yes. Based on my understanding that 1.5 percent is in the 80th percentile -- or 20th percentile meaning they are better than 80 percent of the other companies.

Q. And that independent analysis by L&E lends further support to the Department's opinion the rate is adequate, correct?

A. Correct.

MR. KARNEDY: Thank you very much.

MR. LUSSIER: Thank you.

MR. BARBER: Mr. Angoff, do you have questions for Mr. Lussier?

MR. ANGOFF: Just a couple.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Mr. Lussier, am I pronouncing your name correctly?

A. Yeah that's pretty good.

Q. So I should pronounce it as if it were L-E-I-S-U-R-E?

A. The French way is Lussier, but in Vermont we just say Lussier.

Q. Let me just ask you a couple questions. Number one, does Vermont have any requirements that would require MVP or any other foreign insurer to allocate a certain surplus to Vermont?

A. There are requirements for overall surplus and there's RBC requirements. I'm not aware of a specific amount allocated to a state.

Q. Okay, and can you -- you didn't make a determination as to whether or not the rate MVP is seeking is excessive, did you?

A. No. Our main focus is solvency. So that the -- our focus is whether or not the rate is inadequate.

MR. ANGOFF: No more questions.

MR. BARBER: Do any Board Members have questions for Mr. Lussier?

MS. LUNGE: No.

MR. BARBER: Anyone? Okay. Then thank you.

MR. LUSSIER: Thank you.

MR. BARBER: I think the next witness is Jackie Lee from Lewis & Ellis.

MS. LEE: Can you hear me okay?

CHAIRMAN MULLIN: I can. I'm just trying to find you and pin you on my screen.

MS. LEE: I need to do the same, otherwise, I'm staring just at Jay. Hi Jay.

MR. BARBER: I'll give you a minute to do that.

MS. LEE: Thank you. Good. Hi everyone.

MS. ABORJAILY: Jackie -- has she been sworn in?

MR. BARBER: She has not.

JACQUELINE LEE,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. ABORJAILY:

Q. Thank you. Jackie, could you please state your full name for the record?

A. Yes. It's Jacqueline Lee.

Q. And where do you work?

A. I work at Lewis & Ellis.

Q. And what's your position at Lewis & Ellis?

A. I am a vice president and principal of Lewis & Ellis.

Q. And could you please turn to exhibit 15 of the binder?

A. I am there.

Q. Okay. Jackie is working off an electronic binder so she may get there faster than I do.

A. I have been practicing.

Q. Do you recognize exhibit 15?

A. Yes. This is the prefiled testimony that I prepared.

Q. Okay and can you briefly describe the information contained in this document?

A. Sure. It includes my background. It talks about the process in which we look at filings and how we keep up to date with our health care reform issues. It talks about our standards of review in the State of Vermont and the filing process, how here at L&E what we do to review a filing when it comes in the door.

Q. And is the information in this document accurate and correct to the best of your knowledge?

A. It is.

Q. Is there any information in this document that you would like to change or clarify at this time?

A. There is not.

Q. And do you wish to adopt this prefiled testimony as part of your testimony today?

A. I do.

Q. So I know you did cover this in your prefiled testimony, but for those listening today could you briefly explain your role in L&E's review of this filing?

A. Sure. This is a similar process that we use with most of our filings that we do at L&E. It's a process that we've used also in the State of Vermont for many years now. We have a three tiered approach where we have an associate actuary who is an Associate in the Society of Actuaries do the primary very technical review handling a lot of the direct correspondence with the

carrier. That this year was Traci Hughes.

Then we have a peer reviewer, who is myself, making sure that I'm working with Traci, working with the carrier on any complex issues, making sure that we're accounting for all of the various aspects of the filing, and then there's the third level which is the high level peer review that was done by David Dillon this year, and the main purpose of that role is (1) just to have another set of eyes, but also since there are two carriers in this market we like to ensure there's consistency in our questions and in any decisions that we're making that they are applied equally between the two carriers and nothing is missed over the course of the peer-to-peer review between the two filings.

Q. And how do you submit your recommendations to the Board?

A. So each filing has a pretty strict timeline. We are required on the 60th day after the filing has been submitted to provide a report and recommendation to the Board based on any conclusions and findings that we have during the process.

Q. I believe that the report for this filing is exhibit 10 of the binder. Could you please turn to that?

A. Yes certainly. I am there to your point faster and probably want to check on the Board too,

although the most favorite exhibit today has been 10.

Q. We have heard some testimony today about affordability. Just to be clear did L&E review this filing for affordability?

A. We did not. A little bit slower. On page 3 of exhibit 10 it lists our -- the standard of the review of the Board which includes multiple items that are not actuarial in nature that the Board must consider. We are primarily concerned with whether or not the rates are actuarially sound and which the definition includes not excessive, not inadequate, and not unfairly discriminatory.

Q. Great. Thank you. So have you reviewed anything -- reviewing this filing under these standards did you make any recommendations to modify this proposed filing?

A. Yes. On page 16 of our exhibit 10, our report, we list out five recommendations. The first recommendation is to consider updated hospital budget information. We talked at length about this today and yesterday during the Blue Cross testimony that this year the hospital budget submissions are later than normal. So to the extent that information has not been properly reflected in any estimates that MVP has made or not made those be reflected in the final rates.

The second recommendation is to reduce the COVID-19 adjustment that was made by MVP.

The third is to move a reinsurance factor on the URRT. This is a federally required document that is required to be submitted and it has no impact on rates, but is more of a reporting issue that we noted on our end.

We also recommended to update the risk adjustment. Matt Lombardo testified that on Friday the updated risk adjustment information was officially published. Prior to that L&E had done an independent calculation based on confidential data provided by both MVP and Blue Cross so that the carriers would have ample time to consider how this possibly would be incorporated into their rates. So we are recommending that the CMS values that were published on Friday be incorporated into the rate, and then finally there is a very minor adjustment for the actuarial value basically in pricing due to benefit changes as required by a form issue that was found in a different review outside of the scope of this particular review.

Q. So if all of your recommendations were to be implemented, can you explain what the ultimate projected rate increase would be?

A. Sure. I have listed on page 16 of our report that the approximated rate change is 5.5 percent, however,

as part of the procedure this year one of the items we have always added in front of that is approximately because we are not the holders of all information in order to calculate the impact of each change as accurately as the carrier. So this year as part of the process the carriers had an opportunity to reply to our estimates and MVP replied stating that our calculation was a little bit off based on our COVID recommendations and they are recommending the rate increase be about 5.4 percent. So just a little bit different than ours.

Q. And do you find the 5.4 reasonable?

A. I do.

Q. And why is that?

A. They have more information than we do. They have the numbers out to a bunch of digits. They actually included an extra digit in the calculation of 5.38 percent and so we rely on the carrier to ensure that they -- if we make -- we try to be explicit in the recommendation we're making and then make an approximate estimate on how the rate would be impacted, and so we in turn ask the carrier to actually make those changes and then what the appropriate rate change would be.

Q. Thank you. If you could turn to page 17 of exhibit 10.

A. Okay.

Q. There is a chart here that Mr. Lombardo was looking at this morning. There seem to be maybe a little confusion about the risk adjustment line, line 10 of the bottom chart, and I just wanted to confirm with you whether the numbers in this chart are accurate?

A. They are accurate.

Q. Okay. So any confusion over the 1.1 versus 1 could you --

A. Yeah I think the confusion lies in two places. One, a direct subtraction would be 1.1 in the situation, but if you kind of high tail back one page to page 16, we say the rates decrease by approximately 1.2. I think that is more accurate because it's multiplicative, and the final confusion is that number is very similar to the original number. So I think that's where the confusion was lying in just trying to quickly estimate, but we stand by the new recommendation .1 and the rates decrease by 1.2, and based on the prefiled calculation by Matt and his team at MVP they agreed with that. So I think we were good.

Q. Thank you. You also stated in your prefiled testimony that you reviewed several ACA filings in a year and I was wondering if you could give us a brief summary of what other carriers are assuming regarding the impact of COVID-19 for 2021?

A. Sure. We have seen a wide variety of impacts that are also changing by state as the virus has impacted states very differently. So that's one thing I want to point out is that we did do a lot of review during our actual analysis to really incorporate Vermont, but as to other filings I would say the majority of the carriers are assuming between 0 and 3 percent. We have had some outliers that have included some that are higher than 5 percent, but it's really been -- that's really been primarily focused on one parent organization and all its affiliates that are filing that relatively high outlier. So I would say that's what we have seen to date.

Q. And turning to this filing, what was L&E's recommendation in the report regarding MVP's assumption for the impact of COVID-19?

A. We recommended two changes. I'm flipping back to -- they start on really page 9 of our exhibit and then go forward into all the way through page 11, but the primary recommendations we make are regarding the pent-up demand. We disagree with the assumption that there will be pent-up demand in 2021. Therefore, we have recommended that this be reduced to 0 percent. We have also made a change to some of the assumptions made regarding the vaccinations and the costs that MVP would incur during 2021. We felt that the assumption of 80 percent of the

MVP's population would be vaccinated within 2021, we thought that 80 percent was not adequately supported. Therefore, we recommended a reduction to that as well. The combined reduction of those two is where our calculation is different. I believe it increases rates 0.6 percent versus what we have quoted in our report as 0.5 percent. So I think we were -- that's where we were slightly off.

Q. So since your report was issued to the Board MVP has submitted some more information about its COVID-19 assumptions in their prefiled testimony and I was wondering if you had a chance to review those post memo submissions?

A. I have. It was submitted pretty late on Friday, but I took some time over the weekend to look through all the extra exhibits and most of which were included and stipulated earlier today.

Q. Including Mr. Lombardo's prefiled testimony?

A. Correct. Yes.

Q. And were you listening to all of the testimony today so far?

A. Yes I was.

Q. Having reviewed those submissions and having heard Mr. Lombardo's testimony is there anything that you wish to amend or add to L&E's recommendation around the

COVID-19 impacts?

A. No I do not wish to change any of our recommendations.

Q. So turning briefly to contributions to reserves, which has been a discussion that's gone on a lot today, in the analysis for your memo do you review for solvency and contribution to reserve?

A. Yes. We just heard from DFR. They do the primary review and really dive in deep about all things regarding solvency for each of the carriers. However, since it is an assumption within the rate development we do look at it and our report goes into some of the reviews that we perform to make sure that the assumptions are not out of line with what we're seeing in the industry and don't threaten solvency such that it makes the rate inadequate.

Q. And so did you hear in Mr. Lombardo's testimony that the carrier is asking for a 1.5 percent contribution to reserve for this filing?

A. Yes. That's correct. I heard that this morning.

Q. And do you find that to be reasonable and appropriate?

A. Oh yes I do.

Q. So after reading the carrier's prefiled

testimony and all of the materials that have been submitted so far in the filing and then listening to today's testimony is there anything you wish to add or change to your five recommendations we've covered so far?

A. No I do not.

Q. And if your recommendations as of today are implemented, do you believe that rates would be excessive?

A. No.

Q. Do you believe they would be inadequate?

A. No.

Q. And do you believe they would be unfairly discriminatory?

A. No.

MS. ABORJAILY: I have no further questions at this time.

MR. BARBER: Thank you. Mr. Karnedy, do you have questions for Ms. Lee?

CHAIRMAN MULLIN: Gary, you're on mute.

MR. KARNEDY: Well that would have been a great way to ask questions.

MS. LEE: I thought so, although I was panicking on my end that my headphones went out or something.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. If you would go to exhibit 10 please and page 17 of that exhibit.
A. Yes.
Q. Are you there?
A. I am.
Q. Okay. So there's the table at the bottom that adds 16 rating components, correct?
A. That's correct.
Q. And based on your report and the subsequent testimony filings by MVP and what you heard today it appears MVP and L&E agree on 15 of these 16 rating components that have been identified, correct?
A. That's correct.
Q. We only disagree on item number 4 which relates to the COVID, correct?
A. That's correct.
Q. And this July 7th letter is a recommendation by L&E to the Board on MVP's proposed rate increase, correct?
A. Yes. That is the purpose of our report.
Q. And you're recommending that the Board approve MVP's rate increase proposed today with the exception of the COVID difference you have with MVP, correct?
A. Sorry. Say that again please.
Q. Sure. Let me do it slowly.

A. Yes. I'm sorry.
Q. And L&E is recommending that the Board approve MVP's rate increase proposed today with the exception of the COVID difference of opinion that you have with MVP, correct?
A. I'm recommending that they incorporate all of the changes we have recommended. Does that answer your question?
Q. I think so.
A. Okay.
Q. The one thing I think that we'll talk more, but the one thing we disagree on is COVID. Everything else basically is agreed to, correct?
A. That is correct. Yes.
Q. And if you go to page 3 please of exhibit 10, page 3, let me know when you're there.
A. I am there.
Q. And do you see this standard of review and there's a paragraph below that cites the statute and the rule and lists all the various criteria. Do you see that?
A. Yes I do.
Q. And it's my understanding that if you apply this standard of review to your opinion, it's primarily focusing on those factors that are actuarial in nature?
A. That's correct.

Q. And would you agree with me that the statutory items listed in the standard of review are interrelated and the Board's decision on each of them all ultimately impact the total rate increase amount?

A. Yes. That's fair.

Q. So said another way if the Board review reduced the proposed rate by say five percent on the statutory ground that it was excessive, that reduction could impact the question of whether the proposed rate is statutorily inadequate, correct?

A. That's correct, yes.

Q. And when you consider, for example, excessive or inadequate you're considering whether the final total rate increase is excessive or inadequate, correct?

A. That's correct. Yes.

Q. So if the Board reduced the final rate by say 5 percent based on a non-actuarial statutory criteria such as affordability, that could make the proposed rate that you had identified adequate no longer adequate, correct?

A. Yes that's correct.

Q. So these statutory factors are all interrelated?

A. They are.

Q. And at the rate -- if that 5 percent reduction became inadequate, as an actuary you could not support

that change as actuarially appropriate, correct?

A. That's correct.

Q. So let's talk about what we have agreement on and I think you went through it. I just want to confirm it and that's the agreement on math. If you go to your prefiled testimony exhibit 15, and go to page 6 line 21 -- bear with me I'm trying to shorten this a little bit because you said a lot of things we already talked about.

A. I'm there.

Q. Okay. Great. So the last three questions relate to your proposed rate of 5.5 and the reduction to 5.38, correct?

A. I believe that's on page 7.

Q. Yes. 6 going into 7. Pardon me.

A. Oh I'm sorry. Yes I see that now.

Q. I'm just trying to be general now because I think you testified to a lot of this and MVP is recommending a 6.06 rate increase, correct?

A. Yes. That's correct based on today's testimony.

Q. Right, and L&E is recommending a rate increase of 5.38 this year, correct?

A. I prefer 5.4, but sure. Don't need to be too precise.

Q. That's fine. So we have a delta of around .6

I think you testified to; is that right?

A. Yes.

Q. And that relates to this COVID disagreement we're about to talk about, right?

A. That's correct.

Q. Okay, and before we get there I want to talk about something else that we appear to have agreement on and that's administrative cost. Would you go to exhibit 10 page 14 please and let me know when you're there? You see item 13 which is changes in administrative cost?

A. Yes I'm there and I see it.

Q. So you reference that MVPHP is proposing a $43.75 PMPM, correct?

A. Yes.

Q. And would you go -- turn the page and would you please read the first full paragraph that starts with the administrative costs?

A. The administrative costs assumed in the 2021 filing are consistent with MVP's recent individual and small group administrative costs as reported in the last three years of the company's supplemental health care exhibits. The company's expenses have decreased since 2013 when they were $46.57 PMPM

Q. Okay. So that number compares to the $43.75 for this year's rate filing, correct?

A. Yes it does.
Q. And you stand by what you just read in that paragraph?
A. I do. Yes.
Q. Would you please read the second full paragraph? Read that.
A. L&E notes that while enrollment in Vermont has been increasing MVP's overall enrollment, including enrollment in New York, decreased by 4 percent in 2018, decreased by 4 percent in 2019, and decreased by another 1 percent as of March 2020. Many of the administrative functions are shared between Vermont and the much larger New York block of members. Therefore, the increased membership in Vermont does not directly result in a decrease in administrative costs. Considering reduced administrative costs over recent years L&E considers the assumed 2021 administrative cost to be reasonable and appropriate.
Q. And you stand by what you said in that paragraph?
A. I do.
Q. Okay. Next I want to turn to hospital budgets. If you go to page 7 of exhibit 10, page 7, so as I understand it the first part of this under medical unit cost trend is you summarizing MVP's assumptions about

hospital budgets. Is that fair?

A. That's correct. Yes.

Q. And would you please read in the second paragraph the first two sentences?

A. Since the 2021 hospital budget review is not yet finalized MVP has assumed that hospital increases will match the 2020 increases with a few exceptions by facility. These expected assumptions for the hospital budget increases are based on information from MVP's contracting department. The overall increase for hospital based costs differs from the Board's Vermont-wide projections for several reasons. Would you like me to read them?

Q. No thank you, but generally you go on to summarize MVP's hospital costing, correct?

A. Yes we do.

Q. And then would you read the last sentence below the box to the left? It starts L&E.

A. L&E believes the assumed unit cost trends are reasonable and appropriate.

Q. So MVP's assumptions on hospital budgets are reasonable and appropriate, correct?

A. Yes.

Q. And then if you go to page 8 please, and there's a paragraph with a heading on it total allowed

medical trend, do you see that?

A. I do.

Q. Would you read the sentence underneath there please?

A. Based on the information available L&E considers the total allowed medical trend of 7.0 percent to be reasonable and appropriate.

Q. Do you stand by -- you stand by that, correct?

A. I do.

Q. So you have agreement with MVP on that, correct?

A. Yes we do.

Q. And then if you go down underneath that heading, the next paragraph starts updated. Would you please read the last two sentences of that paragraph?

A. Due to the disruptions from COVID-19 it appears likely that the submitted hospital budget requests will be higher than last year. If this is the case, it may mean that a higher premium increase is necessary.

Q. So L&E is indicating that the COVID-19 disruptions may require a rate increase higher than what's being requested, correct?

A. For the hospital budget submissions and unit costs, yes.

Q. My question goes to the overall rates. Aren't

you saying that it may mean that there's higher premium increases necessary, is that what you're saying?

A. Yes. We're saying that if the hospital budgets come in, that would increase the unit cost which would therefore increase the total rate.

Q. So -- thank you. That's very helpful. So the rate could be, if that happened as you described, higher than your 5.4, correct?

A. 5.4. Yes. It could be higher. Yes.

Q. And it may be higher than MVP's 6.06, correct?

A. That's correct.

Q. Next I want to confirm agreement on CTR testing clause. If we go to page 15 of exhibit 10, and I believe it's item 15, do you see the heading it says changes in contribution to reserves. Do you see that?

A. Yes I do.

Q. MVP is looking for or requesting a 1.5 CTR this year, correct?

A. That's correct.

Q. And would you please read the first sentence of the last paragraph on this page?

A. The L&E believes?

Q. Yes please.

A. L&E believes the CTR and bad debt assumptions are reasonable and appropriate. Additionally, L&E

recommends that any solvency analysis performed by the Department of Financial Regulation be considered.

Q. So we have agreement on the CTR between L&E and MVP this year, correct?

A. Yes we do.

Q. You also make a reference to bad debt -- as the actuary included MVP's bad debt assumptions are also appropriate and reasonable, correct?

A. Correct.

Q. I wonder if you could, if you go back up again under number 15, the second paragraph talks about a reasonableness check. Do you see that?

A. Yes.

Q. Would you please tell the Board a reasonableness check as it relates to 2018, 2019, and 2020?

A. Sure. The Center for Consumer Information and Insurance Oversight, also known as CIIO, has public use files with a lot of various information in it. We reviewed over the last several years the information for the QHP filings that comes from that. So in 2020 we reviewed 783 QHP filings and what we found was -- this is for 2020 -- the average submitted CTR was 3.45 percent and a median of 3.24 percent. Based on this MVP's request of a CTR of 1.5 would rank 630 out of those 783 filings. We

had similar findings for 2019 and 2018 that you can see in those reports, and you can see the details in those reports if you pull them up, but here we've outlined that in all instances MVP's request of 1.5 percent was in the lower bound of all filings submitted regarding QHP.

Q. Thank you, and as an actuary you want to be conservative considering CTR so you set aside sufficient money. Is that fair?

A. That was fair.

Q. As an actuary you don't want to set aside too much or too little, correct?

A. That's correct. You're trying to strike the best balance.

Q. You don't want to be an outlier on a bell curve in contribution to reserve, right?

A. No you don't.

Q. So you're in Texas, correct?

A. I am.

Q. And I think I know that because on direct exam you said -- what was the phrase you said -- high tail it back?

A. I did say that. I thought that sounded a little too southern. Sorry.

Q. Don't be sorry. It's great. Okay. Now in Texas we've seen an uptick -- we've seen an uptick in

people contracting coronavirus?

A. Unfortunately we have.

Q. And an uptick of the testing in Texas as a result?

A. Yes.

Q. And Vermont has been hit less hard by COVID virus, correct?

A. That's true, yes.

Q. But if we see a surge like Texas we would need more testing, correct?

A. That's true. Yes.

Q. Do you agree with me that MVP did not include testing costs in its rate increase report, correct?

A. I agree that's not included.

Q. But if in fact testing does increase, that would be an added cost that was not factored into the rate increase request. Am I right?

A. If it's covered by MVP, yes.

Q. All the more reason to support a CTR of 1.5 percent rather than some lesser amount. Do you agree?

A. That's correct. Yes.

Q. Would you agree with me that Vermont has the best doctors in the country?

A. No, but I'm sure they are wonderful. I'm sure they are great.

Q. Would you agree with me that Vermont has terrific caring doctors?

A. I would agree that there are terrific doctors in Vermont.

Q. Thank you, and you would agree with me that -- I guess I won't ask you about the best hospital in the country, but would you agree with me Vermont has a terrific caring hospital, health care climate?

A. There are terrific hospitals in Vermont.

Q. And the people who work there, provide health care, are caring people, correct?

A. I do not know the people who work at those hospitals.

MS. ABORJAILY: I don't believe she has personal knowledge of the doctors in the State of Vermont.

BY MR. KARNEDY:

Q. You would agree with me health care providers put their patients' care first and foremost?

A. I don't know the answer to that.

MS. ABORJAILY: Objection. Same basis.

MR. BARBER: You need to establish she has some knowledge of the things you're asking her about.

BY MR. KARNEDY:

Q. You would agree with me generally based on your experience that health care providers put their patients' care first and foremost in your mind?

A. Most of the time I would like to hope so.

Q. You would agree with me if a doctor has identified a need for a surgical procedure, they are not going to make a decision about when that procedure will be performed based on how much money they are making at a given moment?

MS. ABORJAILY: Objection. Asking the witness to speculate what doctors would do or not do.

MR. BARBER: Sustained.

BY MR. KARNEDY:

Q. Would you agree --

MR. BARBER: Ask questions Ms. Lee has knowledge of.

BY MR. KARNEDY:

Q. Would you agree with me that medical doctors aren't making medical decisions on timing of procedures based on the rise or fall of their stockholders?

MS. ABORJAILY: Objection. Asking the witness to speculate.

MR. BARBER: Sustained.

MR. KARNEDY: The witness in evidence -- what's in evidence has indicated that doctors are

considering receipt of government assistance and impacts her opinions. I think these are fair questions.

MR. BARBER: You can ask her about the basis for her opinion surely, but I think you were getting into speculation.

BY MR. KARNEDY:

Q. Well let me ask another question then. Would you agree with me that a medical doctor or hospital making a decision on timing of a medical procedure isn't basing that decision on whether they are receiving government financial assistance?

A. I don't know.

Q. So if you would go to exhibit 10 page 10.

A. I'm there.

Q. I'm going to read you the first bullet. Providers have had an opportunity to receive financial assistance from the government to relieve financial hardship which reduces the financial incentives to run at greater than one hundred percent capacity in the future. Did I read that correctly?

A. You did.

Q. That is an incorrect statement. You don't know, do you?

A. That was in direct response to an

interrogatory which is found in exhibit 2A that we asked MVP. It's on exhibit 2A page 3 where there is a list of an entire list of reasons how the doctors are financially incentivized. So we are saying that there were other factors at play. That's what we were saying.

Q. So this isn't based on your knowledge or your data, that's what you're saying, something that MVP told you, is that it?

A. It is based on an argument that MVP made about the reasons for operating at 110 percent of capacity.

Q. And you heard Mr. Lombardo's testimony this morning about health care providers wanting to provide care as soon as they can to their patients. You heard that, right?

A. I heard that.

Q. And you disagree with that?

A. I'm not sure that that was placed -- that was not a response in direct when we asked that question directly earlier as I stated in the first question, but I don't overall disagree with it, but I -- that was not what was the original argument that was posed and this was our response to that argument.

Q. I'm just asking whether you heard him, you said you did, in testimony today and whether you generally agree with the notion that health care providers want to

get people treatment as soon as they can?

A. Generally yes.

Q. Would you agree with me that individuals are not charged for a delayed elective surgery but when the surgery actually occurs, correct?

A. That's correct. Yes.

Q. If your surgery is scheduled for 2020 but doesn't occur for whatever reason until say March of 2021, you don't get billed for it until after the surgery, right?

A. You're billed generally based on date of service with a few exceptions.

Q. They are providing service and then you get paid for it, right?

A. That's correct. Yes.

Q. And you would also agree with me that formulating a total allowed medical trend for 2021 MVP should be considering all the claims from surgeries that will occur in 2021, correct?

A. That's correct. Yes.

Q. Each year we do these rate filings the question for the actuaries is what will happen in that rate year. In this case 2021, correct?

A. Correct. 2021.

Q. It's a question about that 12-month period,

isn't it?

A. Yes that's correct.

Q. Okay. So now let's talk about the flu vaccine issue which I think we have a friendly dispute on.

A. It's the COVID vaccine.

Q. Well we'll get there. Go to exhibit 10 please, go to page 11, and I want to go to the third full paragraph. Let me know when you're there.

A. L&E recommends.

Q. I'm going to read that first sentence to you. L&E recommends a vaccination rate assumption of 55 percent consistent with flu vaccination rates. Did I read that correctly?

A. You did, yes.

Q. And according to the second sentence the difference of opinion on this vaccine rate amounts to .3 percent, correct?

A. Yes that's correct.

Q. Where we have a roughly -- I know there's rounding, but where we have a .6 dispute this year half of it is on this vaccine issue. Is that fair?

A. Yes that's correct. Yes that's a fair statement.

Q. And where the first sentence that I read says consistent with flu vaccination rates, that's the 55

percent rate for flu vaccinations, right, that comes from the CDC?

A. Checking. Yes the CDC.

Q. Great. So your 55 percent is based on aligning with the flu vaccine, correct?

A. Yes.

Q. You didn't reduce it below the 55 percent flu vaccine rate because of assumptions you made on any restrictions on supply once the COVID vaccine is available, correct?

A. No that was in part of the reason. We didn't think that the 80 percent had enough -- we thought it was too high. So one of the reasons we came up with the flu vaccine was because it was -- you know it's one of the wide vaccines that you get frequently each year and we were worried about supply issues being one of them. We were also worried about the quoting of early 2021, there was a lot of considerations that we made, but we ended up landing on the flu vaccine.

Q. Okay. You say that, but the number 55 percent aligns with the flu vaccine, correct?

A. It does. It does, yes.

Q. You didn't go below it? You didn't go to 54 percent, did you, or 53 percent, correct?

A. No.

Q. You just aligned with the flu vaccination rate to come up with 55 percent, didn't you?
A. Yes.
Q. Now you disagreed with MVP's assumption that 80 percent of the covered population will receive the vaccination in 2021, correct?
A. Correct.
Q. You believe it will be the 55 percent you just talked about?
A. In 2021, yes.
Q. Yes, and that relates to the flu vaccine, right?
A. Still does.
Q. Okay. I appreciate your patience.
A. Yeah.
Q. Have you seen the news each day how many people are contracting the coronavirus in Texas, in the country, in the world?
A. I'm most familiar with Texas and Vermont these days, but generally speaking yes. Less so the world.
Q. It's scary, isn't it?
A. Uh-huh.
Q. I'm sorry. I didn't hear your response.
A. I'm sorry. Yes.
Q. Have you seen the news each day how many

people are dying from the COVID virus in Texas, in Vermont, in the country, and in the world?

A. Roughly, yes.

Q. That's scary too, isn't it?

A. It's not -- it's not good. No. I wouldn't define it as scary, but --

Q. People are dying, correct?

A. Correct.

Q. Have you seen in the news each day how many people are contracting the flu in Texas, in Vermont, in the country, and in the world?

A. Since it's not flu season, no.

Q. Have you seen in the past year information in the news about people contracting the flu in Texas, in Vermont, in the country, or in the world?

A. In Vermont, in Texas, yes I do see it on the news.

Q. Have you seen the news each day how many people are dying from the flu in Texas or Vermont or in the country or the world?

A. I have researched that, yes, but I wouldn't say I see it in the news. I'm not sure what you're trying to get at, but I am aware a lot of people do die from the flu.

Q. That wasn't my question. It was whether you

saw it in the news?

A. In the news, no.

Q. Are you working -- excuse me. When you talk to co-workers and family about daily events in the past few months are you talking about the COVID pandemic or the flu?

A. COVID.

Q. Are you working remotely?

A. Yes. Do you like my office?

Q. Lovely. I like the tractor behind you there.

A. You can see it? It's my husband's.

Q. Are millions of Americans, including Vermonters, working remotely?

A. A lot of people are working from home. I don't know the exact quantity.

Q. Are we working remotely because of the COVID pandemic or because of the flu?

A. COVID pandemic.

Q. And is the concern and why you're testifying remotely today the flu or the COVID pandemic?

A. The COVID pandemic.

Q. Wouldn't you agree with me it's a general proposition that Vermonters are more scared about contracting COVID than they are about contracting the flu?

A. That's probably fair.

Q. And wouldn't you agree with me that Vermonters are generally more scared about dying from COVID than they are about dying from the flu?

A. Yes.

Q. If you would please go to exhibit 15, which is your prefiled, and go to page 3, I'm going to ask you a few questions and I would just reference see how there's the little numbered lines to the left?

A. Yes.

Q. So first it's generally you, like David Dillon, are a principal of L&E, correct?

A. Yes.

Q. And you're a Fellow of the Society of Actuaries?

A. Yes that's correct.

Q. And he is too, right?

A. He is too.

Q. And I'm referencing line 12, but I'll just ask you you're the Chair of the SOA Health Section?

A. I am.

Q. Looking at line 13 you're involved in SOA COVID-19 education and distribution of information, correct?

A. That's correct.

Q. And you hold David Dillon in high regard?

A. I do.

Q. And he signed off back on the actuarial memorandum which is exhibit 10. It's his signature on the back of it, right, along with yours, correct?

A. Yes. That's correct. Yes.

Q. In all the years you've worked with him has he ever held an opinion that you felt was not actuarially sound, reasonable, and appropriate?

A. No.

Q. If he authors something, you would agree with his opinions being actuarially reasonable, correct?

A. I would agree with that.

Q. And he was recently one of the authors of the recently released June 2020 -- it was released in June of 2020. It's called the 2021 Health Care Cost Model. I think you make reference to that here in your prefiled, correct?

A. He was not an author. He was on the project oversight group which means he was a peer reviewer. The authors I believe were Wakely and Novaris.

Q. His name is on the document, correct?

A. Yes.

Q. Okay. So let's go -- let's go to that exhibit then. It's exhibit F. Do you have that handy, exhibit F?

A. I do.

Q. All right, and have you seen this document before?

A. Yes.

Q. This is the 2021 Health Care Cost Model that I just referenced, right?

A. That's correct.

Q. And if you go to page 2 of this document --

A. Sorry. Page 2?

Q. Page 2. At the very top is Dave Dillon's name. They spelled it wrong apparently. Let me know if you see that.

A. He goes by Dave Dillion sometimes.

Q. All right.

A. I don't know. You started echoing a bit.

Q. Okay. Let's go please to page 110 of the document please, and do you see where it says the main effects of the health outbreak on health care services? Section 3?

A. Yes.

Q. Would you please -- in the second full paragraph it starts thus. I would ask you to read the second sentence, thus in the coming months. Read that sentence.

A. In the coming months, however, as social distancing policies are relaxed utilization of elective

services is likely to increase and may temporarily peak above normal historical levels as providers and patients reschedule some of their services that were previously postponed.

Q. So it says utilization may peak above the historical levels for a period, right?

A. Yes.

Q. Would you go to 114 please? Let me know when you're there.

A. I am there.

Q. Do you see there's two paragraphs below that table? Would you read the first sentence that starts across in the first paragraph?

A. Across -- I'm sorry. I'm reading the first sentence or the first two sentences?

Q. Just the first sentence.

A. Across all scenarios relative to a baseline in which the outbreak never occurred the projected health care costs decline in 2020 relative to the baseline but rebound in 2021. Table five.

Q. Thank you. So the SOA in this report is indicating -- or this model is indicating that they are expecting a decline in 2020 followed by a rebound in 2021, correct?

A. They are with the one exception of successful

suppression which does not have rebound in 2021. That would be number one also the blue line.

Q. Did I read the sentence correctly?

A. You did read the sentence correctly.

Q. And you read the sentence?

A. Yes I read the sentence correctly.

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

MS. LEE: Thank you.

MR. BARBER: Do any Board Members have questions for Jackie? Sorry. Mr. Angoff, your turn.

MR. ANGOFF: Thank you, Mr. Hearing Officer.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Just a few, Ms. Lee. Good afternoon.

A. Good afternoon.

Q. Were you here this morning? Did you hear Mr. Lombardo testify?

A. I did. Yes.

Q. Okay, and do you remember that he testified that he had a hope that there would be a vaccine available in 2021. I assume you share that hope?

MR. KARNEDY: Objection. He didn't say just hope. I think that's a mischaracterization of

his testimony.

MR. BARBER: Could you restate the question?

BY MR. ANGOFF:

Q. Yeah. I assume you heard Mr. Lombardo testify this morning and I assume that you heard him testify that he had a hope that there would be a vaccine available in 2021?

MR. KARNEDY: Same objection.

MR. BARBER: Overruled. What was your understanding of the witness's testimony, Ms. Lee?

MS. LEE: Me? You said me, right?

MR. BARBER: Yes.

MS. LEE: I understood they were assuming that Mr. Lombardo was assuming that there would be a vaccine in early 2020 to the best of his knowledge and research.

BY MR. ANGOFF:

Q. Early 2021, correct?

A. Early 2021. Sorry. Yes.

Q. Okay and he testified that MVP was including a component in its rate filing that would charge people based on the assumption that a vaccine would be available in 2021, correct?

A. Yes.

Q. Okay, and do you accept that assumption?
A. That there will be a vaccine in 2021?
Q. Yes.
A. I think there will be a vaccine in 2021.
Q. You do. What do you base that assumption on?
A. Similar research that Mr. Lombardo included in his initial filing as well as our own, and I also -- you know, I know he did say we all hope it comes. I do hope it comes. I just am less optimistic early, though I hope I'm wrong.
Q. Your less optimistic. I'm sorry. You're less optimistic than what?
A. About the early 2021.
Q. Miss Lee, in the course of your review of this filing did you ask MVP to submit paid claims data for the year of 2020 by month to the extent that it was available?
A. We did. We have a couple of places where we asked for that. Would you like me to point them out in the binder?
Q. Yes I certainly would.
A. So in the binder if you go to exhibit 2A which is confidential -- it is a confidential exhibit though I believe this is a safe area -- I'm sorry. Maybe it was 2. Let me double-check. Okay. So exhibit 2 page 8 and 9 you can see that we asked about emergency room department and

they talk about the average claims March '20, March 2021.

I did find another example. Let me find it real quick where I had monthly data a little bit closer to what you're talking about, however, we asked for it through March and they were only able to provide it -- okay. Oh goodness. I believe I am in exhibit -- no that's not the right one, but that is the -- I do have -- they did provide it through February. It was normalized to help us work with the utilization trend and I thought I had written it down correctly, but I apparently didn't and I apologize for that. Okay. Here we go. No. That's not it either. I also have listed exhibit 5 pages 3 and 4. So we did ask for it. They were only able to provide it on a monthly basis for up to February, though, because they said they could not provide March.

Q. So they only provided paid claims data for January and February of 2020?

A. That's correct.

Q. And that paid claims data all occurred before the COVID virus pandemic hit, correct?

A. Yes that's correct.

Q. Okay, and you would expect that claims data would be substantially lower in the months of March, April, and May, correct?

A. Yes, and that exhibit 2 page 8 and the 9 kind

of shows that. It's more from an emergency room department, but that's again when, you know, to kind of understand we asked that question and then exhibit 5 also dives into kind of what they were seeing from a standpoint, and then Mr. Lombardo in his testimony this morning also talked about the lowered numbers in I believe March, April, and May.

Q. But you didn't ask them, did you, for lowered paid claims data by month after February?

A. They said they couldn't provide it after February. We did ask for March at the time and they said they couldn't provide it. So sort of we did, but they couldn't provide it.

Q. Okay and -- fine. Could you turn to exhibit 10 page 8 please?

A. Okay.

Q. And do you see the paragraph on top is talking about utilization trend, correct?

A. Yes.

Q. Okay, and could you please read the first sentence?

A. This produced?

Q. Please.

A. This produced a wide -- a very wide range of forecasted utilization trends with a tenth percentile of

minus 7.6 percent, a mean trend of 0, and a 90th percentile of 4.9 percent.

Q. Okay. So based on that, based on this wide range of utilization trends, do you believe that a trend that's selecting a trend in the middle of that -- those extremes either the mean or the medium would be a reasonable selection?

A. No.

Q. Why not?

A. Well, number one, that was based on MVP's analysis. We just had access to it. We then did some other analyses which are the following paragraph that we outlined to talk about what we looked at, and again MVP had a slightly different approach than we did. So we came up with several different results, and so therefore no I would not agree with that top sentence which is why we didn't recommend they reduce their utilization trends to say zero.

Q. The trend that they recommended and which you agreed with was 1 percent, correct?

A. That's correct.

Q. And that was their trend that they used -- that was the trend that was approved in the last filing, correct?

A. That's correct.

Q. And that 1 percent was not what they originally filed, but rather what you recommended, correct?

A. Will you clarify which filing we're talking about?

Q. Yes. In last year's filing isn't it true that they assumed a 0 percent utilization trend?

A. Yes that's true.

Q. Okay and you thought that zero -- that 0 percent utilization trend was too low so you recommended a 1 percent trend, correct?

A. That's correct. Yes.

Q. Okay, and could you read the first bullet on page 10 please -- I'm sorry. First bullet on page 8 of exhibit 10.

A. The three-year average annual utilization trend was approximately 0.0 percent.

Q. Okay, and based on that bullet you still don't believe that a 0 percent trend would be reasonable in this case?

A. No I don't.

Q. Okay. Could you turn please to exhibit 5? Are you there?

A. Yes.

Q. Okay. Then, Ms. Lee, you -- your

responsibility in this proceeding is limited to determining whether or not a rate is excessive, inadequate, or unfairly discriminatory, right?

A. That's correct. Yes.

Q. You're not opining on whether a rate is affordable?

A. No.

Q. You're not opining on whether a rate promotes quality of care?

A. No.

Q. You're not opining on whether the rate is good overall policy, correct?

A. No.

Q. Okay. Could you read on page 4 of exhibit 5 question 9? This is a question that you were asked -- that you asked to MVP, correct?

A. Correct. This was a question we asked.

Q. Okay. Could you read that question please?

A. Describe what Vermont consumers were considered in light of the current savings due to COVID-19 pandemic in this unprecedented time.

Q. Could you please explain to me what relevance that question had to whether a rate is excessive, inadequate, or uncaring?

A. It would answer the question of whether or not

they were excessive, if they wanted to consider it, how recent events are changing or if they wanted to pose something that was affordable.

Q. Well how does it -- I understand what you're saying about that affordability, but you're not concerned -- as an actuary you're not concerned with affordability, correct?

A. That's correct, but we act on behalf of the Board and I know this is a question the Board would have liked to see the answer to. So we are also allowed to ask questions that have -- that are under the standard of review, but our recommendations do not have to follow that same standard, the expanded standard of review, but that doesn't mean we can't ask that because we know that the Board has to make decisions based on that, and we are the primary vehicle in which questions are asked, and so therefore we have been asking these types of questions to all the carriers that we have.

Q. Okay. You didn't, though, ask questions, did you, about the adverse effects that a rate increase would have on Vermonters, did you?

A. No.

MR. ANGOFF: That's all the questions I have. Thank you very much, Ms. Lee.

MS. ABORJAILY: Thank you.

MR. BARBER: Any Board Members have questions for Jackie?

MS. HOLMES: I do.

MS. LUNGE: Me as well. You go first, Jess.

MS. HOLMES: Is that okay with you, Mr. Hearing Officer?

MR. BARBER: Sure is.

MS. HOLMES: Okay great. Jackie, could you just turn to exhibit 6 page 2?

MS. LEE: Certainly. Okay. I am there.

MS. HOLMES: Okay. This was the subject of questions by both Maureen and I this morning and I'm wondering the question was about the large discrepancies between the actual pharmacy trend and the expected pharmacy trend whereby the actual trend was significantly lower than the expected for several years in a row and we heard some testimony from Mr. Lombardo. I'm just curious as to your reaction to this table and how we should interpret it and how we should think about pharmacy expected trends going forward since they have been so far off in previous years?

MS. LEE: Yes. This table definitely shows that there, over the years, have been deviation

between the two. However, I would say from based on my knowledge the actual trends that MVP has seen are extremely low for pharmacy trend in the industry, and so I would feel uncomfortable and kind of back to actuarial soundness approving, you know, a proposed trend of 3.6 let's say, for example, to be consistent with the most recent year because I don't believe that's an accurate representation of the future. I do agree, though, that it calls into question kind of the overall methodology and thought process of, you know, how they are getting those trends, but again I would feel very uncomfortable approving a trend this low in the pharmacy realm just based on industry standards and even the other, you know, carriers too involved in this. It makes it difficult to approve something this low.

MS. HOLMES: But if it's just one year I can understand it might be an anomaly, but it's year after year after year and so there's something different about the population. Do the standards not apply to this population? At what point do we say the actual experience of MVP has to trump the industry? How many years do we have to see this before we say okay let's look at actual experience?

MS. LEE: Yeah I think another thing I

would add to that as credibility is concerned they have not only -- like you could look over this like combined all the years and to your point the result would show it was significantly lower actually. Even if you combine all the years together, however, they did experience a lot of growth over these time periods.

So I will still call into question some credibility, and I would think then you would want a little bit more time because their population has changed so significantly over the last couple of years, but I do think if this continued into future years that would definitely be a question, and I would be maybe even looking into how the PBM is, looking at their trends because I think they get a lot of information from them, but again if you're thinking about Vermont, I question the overall. Even if you combined the entire QHP block in Vermont, you're talking about just pharmacy which is generally speaking 20 percent which makes a small amount even smaller, but I agree, but there is one year where they were pretty close.

MS. HOLMES: That was the longest time ago.

MS. LEE: Right it was, and it was when

they were extremely small because back then they had a much smaller market share for sure.

MS. HOLMES: So you wouldn't make any adjustments for this year based on this chart?

MS. LEE: Based on this chart alone no I would not.

MS. HOLMES: Is there any additional information that you would need to make an adjustment based on what we're seeing here?

MS. LEE: I mean I think we dove into that given we obviously asked this question and they responded and we reviewed what they were talking about, but I mean they even say up there they had a lot of membership growth, and I tend to rely on trends for PBM versus looking at actual to expecteds because that can cause problems, but if you really wanted to dig into it, I would want to really dive into what is the PBM, how is the PBM calculated, what type of population is using, how big is that population, how many years are they looking at. You also have specialty is a concern. Over the years it's continued -- it's been large for a long time now, but those are the types of things I would dig in more deeper if you want to go down that road.

MS. HOLMES: Okay. My second question

is both carriers have acknowledged that there are significant cost savings associated with increased telemedicine in usage largely through this reduction in ED and urgent care center usage. The other carrier testified yesterday that they have included this cost savings in their filing in their trend calculations. This morning Mr. Lombardo testified he did not. He assumed that there would not be an impact in 2021. It would revert back to prepandemic usage. So as an actuary how might you adjust this filing to account for the acknowledged cost savings associated with telehealth usage and telemedicine usage.

MS. LEE: I would definitely consider it from potential savings for like emergency department reductions, however, I do believe that some of those have returned unfortunately unlike what we would have anticipated, but the other problem with -- that I see with telemedicine, and while you want to be able to decrease rates for it, typically it's reimbursed at the same rate as an office visit, and the entry to barrier -- the barrier to entry is quite small. So utilization can actually be higher because now you don't have to take a half day off work to go to the doctor. You just get in the waiting room and on your

cell phone and pick it up.

So what I have done and Traci who is on this call wrote an article about telemedicine is that there's not a significant cost savings aside from that emergency department, and if that's not being seen or reflected -- being seen, then I don't know that it should be reflected in the 2021 rates.

MS. HOLMES: Thank you.

MR. BARBER: Robin.

MS. LUNGE: Thank you. Hi Jackie. You were involved in reviewing the Blue Cross Blue Shield filing as well, weren't you?

MS. LEE: Yes. That's correct.

MS. LUNGE: So you're familiar with the approach that Blue Cross took and the assumptions that they made in relationship to the COVID-19 cost?

MS. LEE: Yes.

MS. LUNGE: They in fact had a 0 rate increase; is that right?

MS. LEE: That's correct.

MS. LUNGE: Did you find or did L&E find that approach to be reasonable?

MS. LEE: We did.

MS. LUNGE: So let me give you a hypothetical. If MVP had taken the same approach and

included a 0 percent rate increase, would you have found that to be reasonable?

MS. LEE: Yes I do.

MS. LUNGE: In terms of the hospital budget filings are you expecting to have the Board's approved budget filings by the time decisions are made in this rate filing?

MS. LEE: No we will not.

MS. LUNGE: So we'll have what the hospitals have submitted as a request; is that right?

MS. LEE: Yes that's correct.

MS. LUNGE: So in your prior reviews of the budget impacts has the Board typically approved the budgets as filed every year?

MS. LEE: No. They are not typically approved as filed.

MS. LUNGE: Thank you. That's all my questions.

MR. BARBER: Maureen.

MS. USIFER: Just one question. If we talk about administrative costs and if an insurance carrier only had one book of business and the book of business grew by 20 percent and fixed costs were fixed half of the administrative and the rest were variable, would that generate about a 10 percent

reduction in administrative costs?

MS. LEE: I think if I followed you -- yeah if I followed your math correctly, I think so. I think you said a 20 percent increase and then half of that would be attributable, but I think yeah that's what you're saying.

MS. USIFER: Okay. All right. That's what I thought. Thanks.

MR. BARBER: Tom.

MR. PELHAM: I was just looking something up. I want to follow up on Robin's question about the proposed hospital budgets and you know that we'll not have decided by the time necessary what the actual budget will be, but I do want to note that our budget guidance for 2021 does specify a target of 3 and a half percent. So that does give some sense and the Board has voted on that. So yes it's possible we'll be seeing many new budgets, but we have set a target. Whether or not we stick to it is another issue, but it's all up to conjecture on both sides I think.

MR. BARBER: Mr. Chair.

CHAIRMAN MULLIN: No questions.

MR. BARBER: Amerin, do you have any redirect.

MS. ABORJAILY: Yes I do. Thank you.

REDIRECT EXAMINATION

Q. Hi Jackie.

A. Hi.

Q. Could we move to -- back to exhibit 10 page 10?

A. Yes.

Q. Maybe I don't need page 10. I lost my place here. Page 11. I apologize.

A. Okay.

Q. So you were asked some questions on cross about the L&E's use of the flu vaccination as an estimate, and I was wondering if you could explain a little bit more about why you felt the flu vaccination would be a good comparison for this assumption?

A. Sure. The 80 percent that MVP assumed in their original filing was based on a report published by Wakely. We definitely thought that, you know, at the time that was one of the first to come out, but it was very illustrative in nature which was why we did a separate analysis on what would we have assumed if we were in MVP's shoes about what the vaccination would look like. So we went about many different scenarios in our minds as well as I'm sure MVP did, and we also utilized the SOA model when it was published. It was published after the

submission of MVP's filing, but it did come out in the middle of June and so we looked at that. We looked at some varying assumptions about what percentage we would put in there based on when a vaccine would come into play, and we also had significant concerns about the supply of such vaccines, that vaccine being able to be widely available in early 2021 which is what they had indicated in their filing, and so we went through all of that and then basically came to an assumption that was very close to the 55 percent which also correlated with the flu vaccination rate. So based on all those things that we just settled on the flu vaccination rate.

Q. So when looking at this issue were you comparing the flu as a virus to COVID-19 as a virus from a health perspective?

A. No. I mean there are similarities, but obviously we know much more about the flu, but no it really wasn't a direct comparison between the two viruses and how the two viruses have handled one another. No. It was more about trying to find the best assumption for the rate in which people would be vaccinated.

Q. And could you talk a little bit more about what the supply concerns might be?

A. Sure. I mean I think we've all been a part of where is the toilet paper, now we don't have masks, and I

just think it's very obvious that there's going to be issues with being able to widely -- make this widespread -- in the earlier cross it was about, you know, the whole world has been impacted. So we're not just talking about just the United States. We're talking about the entire world and from our research and our learnings of it there's going to be a priority system that comes out making sure that, you know, the people who are in the greatest need and the highest risk categories are going to get the vaccine first.

So as of right now that would be the older population, it would be like the Medicaid population, Medicare population would be first, then you would have probably health care workers after that, and then even further those with underlying conditions, but the young and healthy individuals are going to be last on this list; and additionally MVP does have the younger and healthier members based on the risk transfer assumption and adjustment that they end up paying out. So in general we thought it was really aggressive to assume 80 percent would get vaccinated, and so again more than what our report implies we did a lot of research on what the vaccination rate should be during our analysis.

Q. Thank you. Could you turn to exhibit F next?

A. Exhibit F, yes.

Q. And could you please go to page 114?
A. Yes.
Q. Now Mr. Karnedy asked you a few questions about -- well he asked you to read a sentence from this.
A. Yes.
Q. And this was not something we had covered earlier. I was wondering if there was anything else you would like to say about that sentence and how it relates to the chart above?
A. Yeah. I would say in general I don't really like how this sentence was written. It is clear that across all scenarios that is not a true statement because directly above it there is a scenario in which the health care costs they do decline in 2020, but then they do not rebound in 2021. So I think that sentence is not properly stated because there is a scenario, and again if you utilize the model and put that information into the SOA model, you do get a lot of scenarios where whether it's called successful suppression you can't have the pent-up demand be accounted for within 2020 and not go into 2021.
Q. Could we go back to page 110 in exhibit F please?
A. Okay.
Q. And again you were asked questions -- well you were asked to read sentences from this page and I was

wondering if you had anything to add having read those sentences?

A. No. I mean I think they are accurate, but it doesn't express any information about timing. So the utilization of services are likely to increase, but it doesn't -- and peak above normal levels, but it doesn't mean that's necessarily going to happen in 2021 because it certainly doesn't say that and it doesn't give any sort of time from around it. It could be much later than that. There are just -- there's a lot of uncertainty about it and picking a couple of sentences out of this entire report just really doesn't do the entire report justice.

Q. And, lastly, if we could turn back to exhibit 10, page 8, this is on the utilization trends.

A. Yes.

Q. Mr. Angoff was asking you some questions about the 0 percent from the 2019 filing, MVP's original filing, in 2019 and this year's filing, and you looked at .1, the first bullet point here, on page 8, and I was wondering if you wanted to explain how you came to the conclusion that a 1 percent would be reasonable and appropriate?

A. Right. Like I've already addressed there were analyses that did produce a 0 percent as a potential utilization trend. However, given the enrollment increases that MVP has seen it's not appropriate. Just

like when I talked with Jess about the pharmacy trend it's not appropriate to really take those things at face value. You have to really consider what's happening over the entire time frame, and for utilization trend, especially as they have increased enrollment, they have started to show much higher utilization trends. In fact, for 2018 to 2019, that's bullet point number 3, outlines it's approximately 2.5 percent. So if we wanted to pick a particular assumption, we could have also possibly recommended 2.5 because it's in the realm of reasonable, but again we were worried about credibility. It's a fast growing block and so we preferred the analysis that was based on all four years of data and something that was in line with prior years, and we will continue to monitor this assumption because as we've seen across all of Vermont there's certainly a positive utilization trend, but we do recognize that there are differences in the populations between the two carriers that could cause the gap that we're seeing, but certainly not to the point where there should be no utilization trend assumption at this point.

Q. Thank you, Jackie. I have no further questions. Thank you.

MR. BARBER: Thank you. Mr. Karnedy, any additional cross on the redirect?

MR. KARNEDY: Yes.

RECROSS EXAMINATION

BY MR. KARNEDY:

Q. If I might, I just want to clarify you asked more questions about a particular page of exhibit F. Jackie, if you could go there please. I'm sorry, Ms. Lee.

A. That's fine. You can call me Jackie since I can call you Gary.

Q. I didn't ask you about it. You made reference to the table above the three scenarios squiggly lines. Do you see that?

A. I do.

Q. And you said I think your point was it's not across all scenarios, right? If you look up there, the blue line goes back to the baseline in 2020, correct? Is that your point?

A. That's my point, yes.

Q. Okay, but just to be clear the red line or maybe that's orange, hard to tell, and the green line, the red line doesn't get back to normal until September and the green line is not until November, is it?

A. That's correct.

Q. And MVP's assumption is April, isn't it?

A. It is April.

MR. KARNEDY: Thank you very much.

MS. LEE: Thanks.

MR. KARNEDY: No further questions.

MR. BARBER: Mr. Angoff, any further questions?

MR. ANGOFF: No questions.

MR. BARBER: Great. Then I think we can move on to our last witness Mike Fisher. Thank you, Jackie. Take a minute, and Mr. Fisher -- Jay, I assume you won't be asking Mr. Fisher questions. He will just be providing comments as in prior years?

MR. ANGOFF: Yes, sir.

MR. BARBER: Gary, I understand your issue with objections as in past years. Do we need to talk about that at all?

MR. KARNEDY: I just would -- I think Mr. Fisher's done a good job of being careful, and if I had to interrupt, I'll do it respectfully if that makes sense. I haven't had to in prior years.

MR. BARBER: Mr. Fisher, could you please raise your right-hand?

(Michael Fisher was duly sworn.)

MR. BARBER: Thank you. Go ahead.

MR. FISHER: Good afternoon. Thank you again for another riveting day, and I guess I want to -- I really do want to take a moment to appreciate

this process. It is painfully slow and it is difficult, but I think it's also very important and I just think it's very important, and I also recognize that I often, as the Health Care Advocate, am critical of the decisions made at tables like this. I'm critical often because of the outcome for Vermont families and for Vermont small businesses. I know that many Board Members share my critique that insurance rates are already too high for a broad set of Vermonters, and therefore -- that's not a train in my neighborhood in Lincoln -- that any increase is unaffordable, and I fully recognize that the reasons for much of this have nothing to do with MVP or any insurer. It is all of the health care decisions put together.

As I listened to the testimony this morning I got the impression that MVP's perspective of the course of the coronavirus, this has been talked about just recently, it was quite positive that the virus had played out significantly. The statement that 2021 is predicted to be a normal year was said over and over again this morning, and wow while that felt great, I had a moment of hopefulness listening to that, but then during lunch I did what I do too often. I went and checked the news and I went

and checked the numbers and I went and checked some of the discussion about the challenges in front of us and my optimism was crashed a little bit. I know that none of us can have confidence about how the spread of coronavirus will be in 2021. Each of us, or maybe more accurately each of you, have to evaluate your prediction because none of us can know about how reasonable it is that 2021 will be a normal or a preCOVID-19 year. I honestly hope I'm wrong and -- but I just feel the need to say that.

There was an interesting juxtaposition between that discussion that the fear that led to so many people not getting care was something in the past and then there was -- we had a brief distraction this morning and a lighthearted chat about how the impact of the virus was affecting our own personal lives, and I thought that was an interesting juxtaposition. Forgive me for a slight distraction. It reminded me of this incredible disconnect that we're in right now taking place about whether schools should go back to in-person instruction. In community after community decision makers are meeting remotely to decide whether schools should meet in person. I'm married to a school employee.

So from the advocate's perspective the

fear that led to so many people avoiding care in the last few months is alive and well, and that if we continue to have a very low incidence of the disease here in Vermont, my prediction is that that fear will abate, but if the virus comes back with any increased numbers, that fear will again result in reduced non-COVID-19 claims.

I'll skip that part. So thank you to the more than 800 Vermonters who commented so far to you. I look forward to sitting with the Board tonight to hear more comments. Those comments don't come with any analysis of industry standards or how MVP or the other insurer compares to other insurers. They don't base their perspectives having talked to actuaries or having any concept of actuarial standards. They come with an expertise in their own lives, an expertise in their own budgets, and expertise in how the coronavirus is impacting them.

Long and short Vermonters can't afford any increase. Vermonters need a break particularly while they are under such overwhelming pressures. There is a great deal of unpredictability every year, but this year especially. MVP says because there's such unpredictability that they should get a rate increase and that they should be able to put more

money in their reserves. As the advocate I have to say because there's such unpredictability about the virus and because there's a great deal of very predictable sacrifice on the part of Vermonters that I have to call for Vermonters to get a break from any rate increase this year. Thank you.

MR. BARBER: Thank you, Mr. Fisher. So I think there's no more witnesses today so we'll move on to closing statements. Does anyone need a couple minutes before we do that or everyone ready to go? Gary, you will be first.

MR. KARNEDY: I'm ready.

MR. BARBER: Okay. Go ahead.

MR. KARNEDY: I'll try to be brief. First of all, I want to thank the Board for their time and attention today. I would note it's 3:07. It's not 8:07 at night. So I hope we get points for that all of us. 6.06 proposed rate increase for MVP is supported by the evidence and I want to make four points about that.

First, and then this relates to vaccinations, this is a .3 percent issue. A .3 percent issue. I think the evidence has shown that the notion the people of Vermont are going to get vaccinations for this pandemic which is killing

people, that only 55 percent of Vermonters will get the vaccine because it's like flu shots they get each year, that denies the evidence and defies common sense. 80 percent will. Look at the measles, look at the mumps which are greater than 90 percent. That's the first one.

Second, I've got two points on the pent-up demand issue. Pent-up demand issue is a .3 percent issue. If you look at exhibit F, which you just heard Ms. Lee testify to that apparently L&E relied on and used that model in their modeling and their conclusions on pent-up demand, if you go to page 114 of that exhibit F, you look at this graph we were just talking about a moment ago, we've got three scenarios; one is get back to the baseline at the end of 2020, the other two scenarios we don't get back to the baseline until September or November. This is something that they relied on. This is something that Matt Lombardo relied on. The point is MVP has a reasonable position saying end of April. We'll be back to the baseline at the end of April. That's a reasonable position. It's in the middle.

The second point on pent-up demand is this notion that doctors and hospitals would make a medical care decision on the timing of treatment for

their patients based on whether they are receiving government assistance or not is simply not credible. MVP's estimate of the catch-up period at the end of this year and beginning of next year is credible. It's reasonable. It's based on credible evidence.

Fourth point. Any decision on a final rate by the Board should, of course, take into consideration the interrelationship of the statutory criteria to ensure a reduction on any one criterion doesn't result in rates being inadequate. Thank you very much for your time today.

MR. BARBER: Thank you, Mr. Karnedy. I just realized that I did not give the Board an opportunity to ask questions of Mr. Fisher. I think in my mind I was remembering to yesterday and there were no questions. I feel the need to check. Does any board member have any questions for Mr. Fisher?

MS. LUNGE: I don't have a question, but I would make the same briefing request which I think you guys can do.

MR. FISHER: Absolutely. Thank you, Robin. We would be happy to respond to that question.

MR. KARNEDY: I don't know what you're talking about.

MR. BARBER: So let me explain. I think in connection with Mr. Fisher's suggestion that the Board should approve no rate increase Robin's request was that in the briefing HCA explain how that complied with ACA requirements and the Board's standard of review. Is that correct, Robin?

MS. LUNGE: Yes. Thank you.

MR. KARNEDY: Thank you for clarifying.

MR. BARBER: I apologize for that oversight. Mr. Angoff, proceed.

MR. ANGOFF: The Board said it better than I can or better than I have. Much less long winded way than I have. Member Holmes said the key question is who can better bear the loss. The Chair said aren't there assumptions that are just as likely as the assumptions that MVP made.

In answer to the question who can better bear the loss obviously we're not -- this is not -- we're not asking -- we're asking for a 0 percent rate increase. We're not asking for nothing. We think there are assumptions that are just as likely and we will show in our post hearing brief what those assumptions are. They easily produce a 0 percent rate increase. We think there are other assumptions that can produce a decrease.

The assumptions that they make are always in their favor. The assumption of about when a vaccine is going to be available. Sure we all hope one will be available in 2021 but we don't know that, but based on that hope they are charging their policyholders. They are assuming that providers will be at a hundred percent -- 110 percent of capacity beginning in August of this year through April of next year. 110 percent capacity is a lot, particularly in August. I think that assumption is just patently unreasonable, but they included it in their rate filing. They say 2021 will be like 2019. Maybe it will, maybe it won't, but we don't know, and at this time we don't have the luxury of adopting assumptions that are going to raise the rate when there are other reasonable assumptions that will reduce the rate compared to the way they treat -- they adopt assumptions that are highly doubtful that benefit them. They disregard not just assumptions but facts that benefit the policyholder. I was floored when Mr. Lombardo said we're not including the 1.7 million bucks that we get because the Supreme Court ruled for the industry in the risk corridor litigation. The 1.7 million dollars is not all the money in the world, but the difference in how quick

they are to adopt assumptions that raise the rate for the public and how adopting assumptions and in some cases in fact that reduce the rate for the public to me is striking. Both Mr. Lombardo and Ms. Lee acknowledged that there are lots of other scenarios that could take place.

One final consideration. MVP is no longer just a small part of the market. MVP is almost half the market. So what the Board does with this filing is very, very significant. Much more than it's been in any past year. I think also the significance of a 0.0 percent increase is very important. I plead with the Board not to cut -- not to cut the rate increase to 3.5 or 2.8 but -- or 1.7 but to 0.0. I think it's very important to send a message to the carriers, send a message to actuaries, and send obviously most important a message to all Vermonters that rates -- there is no natural law that rates must increase every year.

The question who can better bear the loss that is a question that is irrelevant to actuaries. Ms. Lee so testified. Everybody knows that. Who can better bear the loss is irrelevant to actuaries. It is not irrelevant to the Board. So I ask the Board to disapprove MVP's proposal, disapprove L&E's

recommendation, and adopt a 0.0 percent increase for this year's rate. Thank you very much for your patience. I appreciate it.

MR. BARBER: Thank you. So there's a couple procedural matters I want to talk about before we wrap up the hearing and move to public comment. I see Gary stepped away from his desk for a minute so we'll just give him a minute.

MR. KARNEDY: I just grabbed my calendar in case we're doing any dates and discussions.

MR. BARBER: I really just wanted to give you both notice that while the hearing was going on DFR issued two bulletins, Bulletin 214 and 215. 214 is the final version of the draft policy or bulletin I guess. Final version of the draft bulletin that's in the binder. Bulletin 215 is about resumption of provider audit activities. I'm giving you notice now that I plan to take judicial notice -- administrative notice of these bulletins and you have until the end of the week to let me know if you have any objections to that. I think they are appropriate subjects for judicial notice.

MR. KARNEDY: May I just speak briefly on that point? It might help to cut to the chase. I believe we may be in agreement on it which is we have

a record in this proceeding, we have exhibits in this proceeding, and it seems to me that for purposes of briefing we could reference these bulletins, but I don't see how they are part of this record and they are put at the end of the evidentiary hearing. I just don't see how that works. We can brief them as they are effectively a form of law we can cite to as opposed to taking judicial notice as exhibits in this proceeding.

MR. BARBER: If you agree they are essentially law, then I guess they are not adjudicative facts they are legislative facts and we can just proceed that way.

MR. KARNEDY: I think that would be the better approach unless Jay disagrees or are smarter than I on this.

MR. ANGOFF: I don't have a strong feeling.

MR. BARBER: Okay. So they are essentially law so the parties can cite them in their briefs and the Board can treat them as such. Is there anything else we need to talk about? That's the only thing I had before we wrap up and move to public comment.

MR. KARNEDY: I did -- if it's

appropriate, we can just talk scheduling for a moment, and that is I believe, Hearing Officer Barber, you were preparing a list of follow-up questions for MVP, and in the past -- I may not have this quite right -- you will send an e-mail in a day or two with the list and then we're given some time to respond to it. I don't remember the exact dates. I remember it was kind of do it in five days or relatively quickly. So I just wanted to confirm that you'll be forwarding an e-mail in contrast to us trying to figure out from our notes what we're supposed to do.

MR. BARBER: That's correct. We will be reviewing our notes of the hearing making sure we have things correct and sending you a formal request for followup items with a deadline.

MR. KARNEDY: The last thing on my list was just asking JoAnn when she would have the transcripts done.

(Off-the-record discussion.)

MR. KARNEDY: That's all I had. Thank you.

MR. BARBER: Okay. So are there members of the public who are present who would like to make a comment regarding this filing? (No response.) I

don't hear anybody. If there is anyone on the line, again we're having a separate meeting from 4:30 to 6:30 specifically for public comments. The information regarding that meeting is on our web site so that's another opportunity for people to comment. So again if there's no comments from the public, then I think we can all turn back over to you, Mr. Chair, to adjourn the meeting.

CHAIRMAN MULLIN: Thank you, Mike. Thanks for two great days of serving as a Hearing Officer. These meetings went very orderly. Yesterday was a little long and we're very grateful for today. Fortunately Gary did take off his jacket so probably sped things up. With that is there a motion to adjourn?

MS. HOLMES: So moved.

CHAIRMAN MULLIN: Is there a second?

MS. USIFER: Second.

CHAIRMAN MULLIN: All those in favor signify by saying aye.

(Board Members respond aye.)

CHAIRMAN MULLIN: Any opposed?

(No response.)

CHAIRMAN MULLIN: So I'll see everybody back here at 4:30. Thank you.

(Adjourned at 3:25 p.m.)

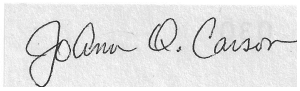
C E R T I F I C A T E

I, JoAnn Q. Carson, do hereby certify that I recorded by stenographic means the hearing re: Docket Number GMCB-006-20rr via Microsoft Teams on July 21, 2020, beginning at 8 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting, and the foregoing 225 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 Burlington, Vermont, this 23rd day of July, 2020.



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