

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-005-19-rr

VERMONT HEALTH CONNECT RATE REVIEW HEARING
(MVP HEALTH PLAN, INC.)

July 22, 2019
8 a.m.

115 State Street
Montpelier, Vermont

Hearing held before the Green Mountain Care Board, at the Vermont State House, Room 11, 115 State Street, Montpelier, Vermont, on July 22, 2019, beginning at 8 a.m.

P R E S E N T

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A P P E A R A N C E S

MVP Health Care

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1 CHAIRMAN MULLIN: So good morning
2 everyone. It's my understanding that a fifth board
3 member has run into a little bit of a delay, but we
4 are going to get started anyways.

5 And so at this point in time, I'm going
6 to appoint Michael Barber as the hearing officer, and
7 Mike will run the hearing from here.

8 MR. BARBER: Thank you, Mr. Chair. So,
9 good morning. As the Chair said, my name is Michael
10 Barber. I have been appointed as the hearing officer
11 for today's hearing. The purpose of this hearing is
12 to take evidence and argument on the 2020 Vermont
13 Health Connect rate filing submitted by MVP Health
14 Plan, Inc. The Docket Number in this case is
15 GMCB-005-19-rr.

16 The Green Mountain Care Board has
17 jurisdiction over this matter pursuant to Title 18 of
18 the Vermont Statutes Annotated Section 9375(b)(6) as
19 well as Title 8 Section 4062(a).

20 Representing the carrier MVP are Gary
21 Karnedy and Ryan Long of the law firm Primmer, Piper,
22 Eggleston & Cramer, PC. Representing the office of
23 the Health Care Advocate are Jay Angoff, Kaili Kuiper
24 and Eric Schultheis. I also want to recognize the
25 board's Associate General Counsel, Amerin Aborjaily,

1 who will be leading the examination of the board's
2 actuaries, Lewis & Ellis.

3 We are recording today's proceedings.
4 We have a court reporter here as well who will
5 transcribe the proceedings. And we will provide the
6 parties with the transcripts as soon as we receive
7 them. I think I recognize most of the faces in the
8 audience, but if we have members of the public here
9 today, welcome. We will be taking public comment at
10 the close of the proceedings today. There is a
11 sign-up sheet or there should be a sign-up sheet
12 outside the room if you would like to take advantage
13 of that opportunity. However, I can't say when we
14 will get to the public comment portion of the
15 meeting. And if you don't want to sit through
16 several hours of testimony from actuaries to make a
17 comment, we are having a meeting tomorrow from 4:30
18 to 6:30 p.m. at the Montpelier City Hall. And that
19 meeting will be dedicated exclusively to hearing from
20 the public. Additionally, you can always submit
21 written comments to the board via its website or by
22 regular mail. And finally, you can call our offices
23 to make a comment, if you would like. We will be
24 accepting public comments through July 25.

25 Before we begin, I want to remind the

1 parties and the board that some of the materials that
2 MVP has submitted in this filing are confidential.
3 And you should exercise caution in discussing
4 anything that has been marked confidential in these
5 binders as they can't be discussed in a public
6 setting.

7 At this point, I think I would like to
8 swear in the witnesses. So absent any rebuttal
9 witnesses, we expect to hear from Matt Lombardo,
10 Michael Fisher, Jacqueline Lee, and Jesse Lussier who
11 I don't see in the audience. So if I called your
12 name, if you could please stand and raise your right
13 hand.

1 MATTHEW LOMBARDO

2 MICHAEL FISHER

3 JACQUELINE B. LEE

4 Having been duly sworn, testified
5 as follows:

6 MR. BARBER: Thank you. You may be
7 seated. Now that we have sworn in the witnesses, we
8 have a binder of exhibits that the parties have
9 stipulated to. I understand the binder contains 12
10 MVP exhibits which are marked 1 through 12. And 16
11 exhibits from the office of the Health Care Advocate
12 which are marked 13 through 28.

13 Mr. Karnedy, Mr. Angoff, am I correct
14 that the parties have stipulated to the admissibility
15 of those documents?

16 MR. KARNEDY: We have.

17 MR. ANGOFF: That's correct.

18 MR. BARBER: And at this point I'm
19 going to admit those documents into evidence.

20 MR. KARNEDY: Thank you.

21 (Exhibits marked MVP 1-12 and HCA 13-28
22 were admitted into the record.)

23 MR. BARBER: Does either party have
24 anything we need to discuss before we get to opening
25 statements? Mr. Angoff?

1 MR. ANGOFF: No, sir.

2 MR. BARBER: So Mr. Karnedy, if you
3 could make your opening statement.

4 MR. KARNEDY: Thank you very much. As
5 you've already indicated, my name is Gary Karnedy,
6 and I represent MVP again this year in this rate
7 filing. I have with me my associate, Ryan Long. As
8 you've already indicated Matt Lombardo is the senior
9 leader of actuarial services from MVP. We will hear
10 from him today as well.

11 MVP's original May 10th rate filing
12 sought an increase of 9.4 percent based on a
13 multitude of issues. The evidence will show that L&E
14 has recommended an increase of 10.5 percent. Again,
15 based on a multitude of issues. The evidence will
16 show that MVP agrees with all of L&E's
17 recommendations.

18 You will hear evidence also that based
19 on recent hospital budget proposals, MVP is
20 increasing its proposed rate to 11 percent. We do
21 not yet know L&E's position on the new hospital
22 budget information, but we should hear more about
23 that today.

24 Consequently, the totality of evidence
25 will show that all the expert actuaries in this case

1 agree on virtually everything, agree on virtually all
2 of MVP's proposed 11 percent increase.

3 The Health Care Advocate is not
4 offering an expert actuary as it has in prior years,
5 so no other expert actuaries will be testifying today
6 in support of some substantially different, lower or
7 higher figure. As a matter of law, the decision by
8 the board must be based on evidence, not on
9 speculation of non-expert witnesses. The proposed
10 premium should be found to be sufficient to pay for
11 the services and products covered. They should be
12 actuarially sound and statutorily adequate.

13 It's important to recognize that
14 interrelationship of all statutory criteria. Because
15 of this interrelationship, although it is true that
16 the board is not limited to actuarial considerations,
17 in exercising its discretion, it should consider
18 whether a change of rate based on a non-actuarial
19 ground will run afoul of the actuarial data. Said
20 another way, reductions should not ignore the math or
21 ignore the actuarial evidence on what is needed for a
22 statutorily adequate rate. A non-actuarial change in
23 the rate still impacts the actuarial soundness of the
24 rate filing. It's all interrelated.

25 MVP recognizes the difficult choices

1 the board has to make each year in balancing -- in
2 balancing the statutory criteria.

3 We respectfully submit that in
4 considering other statutory criteria such as
5 affordability, in exercising its discretion, the
6 board should consider the rate within what is
7 actuarially sound and reasonable and statutorily
8 adequate. The board should endeavor to avoid an
9 unintended consequence if a rate decision is not
10 actuarially sound or reasonable.

11 Actuaries are very Zen-like in
12 calculating rate increases. Let me give you an
13 analogy. If you walk on most any trail in Vermont,
14 you're going to come upon at some point the stack of
15 odd stones that are stacked by somebody, and somehow
16 they are balanced. The rocks are stacked on top of
17 each other to find just the right balance to stand
18 and not fall over. Each stone is like a statutory
19 criteria. And the evidence will show that MVP and
20 your actuaries at L&E have found just the right
21 balance to meet all the statutory criteria. You
22 might be able to make a small adjustment to take a
23 stone near the top and still maintain the balance,
24 but if you pull a large stone from the middle of that
25 pile, they all come tumbling down. The rates would

1 no longer be adequate.

2 So in considering the evidence, the
3 board needs to keep an eye on all of the interrelated
4 statutory factors on the stack of statutory stones to
5 maintain the balance. Thank you very much.

6 MR. BARBER: Thank you. Mr. Angoff, do
7 you have an opening statement you would like to make?

8 MR. ANGOFF: Yes, I do. Thank you very
9 much. It's no secret to the board that Vermont is
10 unique in several ways. One of the ways it's unique
11 is in the standard and the process that we go through
12 in this proceeding. And in all other states, there
13 is no big hearing process like this. There are some
14 states where there is prior approval, where the
15 company has to file its rates with the insurance
16 department, and those rates can't take effect unless
17 the insurance department approves them, but there is
18 no hearing process like this. So this is the most
19 expansive hearing process in the country.

20 Vermont is also unique and this is even
21 more important, in the standard that you all must use
22 to determine whether or not a rate should be
23 approved. In other states the standard is, is the
24 rate excessive, *inadequate* or unfairly discriminatory.
25 That's the sole standard. And that's what actuaries

1 determine. You have a much tougher job than any
2 regulator in any other state. Because you not only
3 have to determine whether or not the rate is
4 excessive or inadequate or unfairly discriminatory
5 which is what the actuaries and expertise is confined
6 to, but also you've got to determine whether the rate
7 is affordable, whether it promotes quality of care.
8 Those are things that the actuary -- no actuary
9 whether it's the MVP actuary or L&E or anyone else,
10 those are things that are just not within an
11 actuary's competence.

12 In addition, although we use the term
13 actuarial science, what actuaries do is not a
14 science. The one thing we know about whatever the
15 actuaries' projection of the rate increase should be,
16 is that it's almost certain to be wrong. There is a
17 big range within which people can disagree as to
18 whether or not a rate increase is likely to be
19 excessive, inadequate or unfairly discriminatory.
20 MVP -- sorry L&E to its credit notes that there are
21 many different methodologies that can be used. And
22 they picked one, and MVP picks one. MVP also -- and
23 MVP to its credit acknowledges that in the past, last
24 year, for example, the assumptions -- some of the
25 assumptions they made and some of the assumptions L&E

1 made were wrong. So all this is certainly not a
2 reason to not have this hearing. What the actuaries
3 have to say is important. It's necessary. But it's
4 not sufficient.

5 MR. BARBER: So Mr. Karnedy, call your
6 first witness.

7 MR. KARNEDY: We call Matt Lombardo,
8 please.

9 (Ms. Lunge arrived).
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MATTHEW LOMBARDO

Having been previously duly sworn,
testified as follows:

MR. LOMBARDO: Good morning.

MR. BARBER: Morning.

EXAMINATION

BY MR. KARNEDY:

Q. So I would say good morning to you before we spend time together, but as I ask you questions over the next hopefully not multiple hours, but over the next time, please respond towards the board so they can hear you okay. All right?

So would you state your name for the record?

A. Matthew Lombardo.

Q. And Matt, who is your employer?

A. MVP Healthcare.

Q. And I understand the filing was made by MVP Health Plan, Inc. What is MVP Health Plan, Inc., and how does it relate to MVP Healthcare?

A. It's MVP's HMO subsidiary. It's a legal entity, it's a non-profit HMO company that falls under the umbrella company of MVP Healthcare.

Q. What's your position at MVP?

A. Senior leader of actuarial services.

Q. And are you a member of any professional

1 associations?

2 A. Yes. I'm fellow in the Society of Actuaries
3 and a member of the American Academy of Actuaries.

4 Q. And how long have you been employed in the
5 health insurance industry?

6 A. Around 14 years.

7 Q. And what are your job duties as senior leader
8 of actuarial services?

9 A. In addition to overseeing premium rate
10 setting, I'm also responsible for reserving our IBNR,
11 financial forecasting, financial competitive intelligence,
12 and also value-based contracting or risk share
13 arrangements with provider groups.

14 Q. Matt, I would refer you to the binder in front
15 of you. I would ask you to open it. You'll find a
16 stipulated exhibit list in the front of the binder. Do
17 you see that?

18 A. Yes. Yes.

19 Q. I just want to walk through this and just
20 identify some things. Starting with Exhibits 1 through 8.
21 You'll see Exhibit 1 is the original rate filing; correct?

22 A. Correct.

23 Q. And then Exhibit 2 is the amended rate filing;
24 correct?

25 A. Correct.

1 Q. And then after that, through 8, are a series
2 of responses by MVP to questions from Green Mountain Care
3 Board; correct?

4 A. Correct.

5 Q. And then Exhibit 9 that's L&E's July 16
6 actuarial opinion; correct?

7 A. Correct.

8 Q. Okay. And then Exhibit 10 is DFR's solvency
9 analysis letter; correct?

10 A. Correct.

11 Q. Exhibit 11 is MVP's filing on July 11 of a
12 Non-standard Gold Design; correct?

13 A. Correct.

14 Q. And then finally Exhibit 12 is your CV;
15 correct?

16 A. Correct.

17 Q. And the balance of the exhibits are HCA
18 exhibits; correct?

19 A. Yes. Correct.

20 Q. And you've reviewed all of these exhibits and
21 adopt them as your testimony with the exception obviously
22 of the DFR exhibit and the L&E exhibit; correct?

23 A. Correct.

24 Q. But you reviewed those two exhibits and are
25 familiar with them; correct?

1 A. Correct.

2 Q. And then next, Matt, I just ask you to open up
3 the first exhibit to any page and look on the bottom
4 right-hand corner. And you'll see a darker number. Do
5 you see that?

6 A. Yes.

7 Q. So these are the page numbers that we put on
8 all the exhibits. And I'd ask you as we talk I'll refer
9 to those pages. If you could do the same as well. Okay?

10 A. Okay.

11 Q. All right. So let's start with an explanation
12 at a high level of the rate increases. Matt, go to
13 Exhibit 2, please. Page 15.

14 A. Okay. I'm there.

15 Q. And do you see under -- there is three words
16 "field name, requested change" and "prior value."

17 Do you see that?

18 A. Yes.

19 Q. So would you tell the board what -- I'm sorry.
20 And then go down to the bottom of the exhibit by the
21 number 15. And do you see that date over to the left?

22 A. Yes.

23 Q. What's that date?

24 A. May 23, 2019.

25 Q. Okay. So this is the amended filing by MVP on

1 that date; correct?

2 A. Correct.

3 Q. Okay. So going back up to where I was
4 referencing, can you tell the board what the original
5 filing rate increase request was and how it's changed in
6 reference to those numbers, please?

7 A. Yes. When we initially submitted rates on May
8 10, we proposed an average rate increase of 9.38 percent.
9 Upon review of an interrogatory from L&E we identified a
10 discrepancy that we used the proposed hospital budgets for
11 2019 rather than the approved hospital budgets. And we
12 made that change on May 23. The result was a decrease in
13 the overall proposed rate increase of 8.45 percent.

14 Q. Thank you. Would you go to Exhibit 9, please.
15 Exhibit 9. This is the L&E report dated July 16; correct?

16 A. Correct.

17 Q. This is their amended report; correct?

18 A. Correct.

19 Q. And would you go please to page 15 of that
20 exhibit. Page 15.

21 A. Okay.

22 Q. And do you see that there is 7 bullets on that
23 page below recommendations?

24 A. Yes.

25 Q. And these show some increases and some

1 decreases to the rate that's proposed by L&E; correct?

2 A. That's correct.

3 Q. And would you read the last sentence, please,
4 on the page?

5 A. "After the modifications, the anticipated
6 overall rate increase will increase from 9.4 percent to
7 approximately 10.5 percent."

8 Q. Do you agree with that increase after
9 reviewing L&E's report?

10 A. Based on the 7 bullets, yes, I agree with
11 that.

12 Q. And Matt, as I understand it, MVP received
13 some additional hospital budget proposals on July the
14 16th; is that correct?

15 A. That's correct.

16 Q. And did MVP make any adjustments to the
17 proposed rate above this 10.5 percent as a result of that
18 hospital budget proposal information?

19 A. Although we didn't submit an amendment, we did
20 run through the calculations on our own. And when we
21 updated our trend assumptions to reflect the proposed
22 hospital budgets that were released on July 16, the 10.5
23 percent increase changed to 11.0 percent.

24 Q. So the rate increase that MVP's proposing as
25 you sit here today is 11 percent; is that correct?

1 A. That's correct.

2 Q. And do you know what L&E's position is on
3 moving from their 10.5 to the 11?

4 A. I do not.

5 Q. We will go through it in greater detail in the
6 hospital budgets. I would like to go back to Exhibit 2,
7 please, which is the amended rate filing. Just walk
8 through it on a few issues.

9 Would you please go to page 15.

10 A. Okay.

11 Q. That's the page we were at before. And do you
12 see where there is references to maximum percent change
13 and minimum percent change? Do you see that?

14 A. Yes.

15 Q. Would you please explain the change of those
16 numbers from what we originally filed to the amended
17 filing?

18 A. Yeah. The original range was 5 percent to
19 23.7 percent. The requested change column represents 4.1
20 percent to 22.6 percent for an average of 8.5 percent. I
21 will caveat that since we submitted the amended filing,
22 DFR has come back and asked us to amend a plan design.
23 That was the plan design that was receiving the 22.6
24 percent increase. So that figure is actually going to go
25 down the max to something about, you know, in the ball

1 park of 10 percent less than that.

2 Q. Thank you. And if you would go just down
3 below there there is a couple of -- I guess it's columns
4 if it's this way, I'm not sure. You see where it says
5 "Product, Product Name," and so on it. Says "Number of
6 Covered Lives." Do you see that?

7 A. Yes.

8 Q. There is two references to number of covered
9 lives, one above and one below. Do you see that?

10 A. Yes.

11 Q. Can you explain those, please?

12 A. The Vermont Health Connect market is a merged
13 market of individual policyholders and small group policy
14 holders. In the individual market MVP has 14,491 members
15 or people covered. In the small group market 16,396
16 members.

17 Q. Thank you, Matt. Would you please go to page
18 22 of Exhibit 2?

19 A. Okay.

20 Q. Is this the actuarial memorandum that explains
21 the rate filing?

22 A. Yes.

23 Q. And Matt, if you would please go to the fourth
24 paragraph under market/benefits. Let me know when you're
25 there.

1 A. Okay. I'm there.

2 Q. And the first sentence says: All essential
3 health benefits are covered.

4 Do you see that?

5 A. Yes.

6 Q. Can you explain that, please?

7 A. One of the aspects of the Affordable Care Act
8 was to ensure that adequate services were being rendered
9 or covered under insurance policies that were ACA
10 compliant. That list of benefits is called the essential
11 health benefits.

12 The federal government sets the floor for a
13 minimum that can be covered, and then every state has the
14 ability to actually define what the essential health
15 benefits are. So all the benefit plans included in this
16 filing are ACA compliant and cover all the essential
17 health benefits in the State of Vermont.

18 Q. Thank you. And Matt, in the next paragraph it
19 starts with the non-standard plans.

20 Do you see that paragraph?

21 A. Yes.

22 Q. Can you explain non -- how non-standard plans
23 deal with this EHB?

24 A. Yeah. Non-standard plans also have to cover
25 EHBs, so there is -- I'll go back. There is two types of

1 plans being offered; standard plans and non-standard
2 plans. Standard plans provide consumers with an apples to
3 apples shopping experience between carriers. And then
4 non-standard plans cover -- give the carriers the ability
5 to offer something a little different. Maybe it's
6 different cost sharing elements, like deductibles or
7 copays, or you can offer additional benefits. In this
8 case MVP is offering a wellness benefit in our non-
9 standard products that are -- cover up to 6 hundred
10 dollars of reimbursement to policyholders that are -- that
11 meets our criteria.

12 Q. Thank you. And Matt, would you go to the last
13 paragraph on the page 22. And you'll see there is a
14 reference to policyholders, subscribers and members.
15 Would you please describe to the board what the difference
16 is between those three categories in the number there
17 referenced?

18 A. Sure. I'll just read the sentence first.
19 "The book of business affected by this rate filing is
20 11,696 policyholders, 20,156 public subscribers, 30,887
21 members based on February 2019 membership."

22 So in the individual market, policyholder is a
23 contract holder, which we will talk about more, and the
24 subscriber number. And then in the small group market the
25 employer is the policyholder. We offer single, double,

1 parent-child and family contracts. In the case of a
2 parent-child contract, for example, the adult holding the
3 -- that holds the contract is considered the subscriber,
4 and then the children plus the contract holder are all
5 members. So members are people. Subscribers are
6 generally the person that is the 00 subscriber member ID
7 on the plan.

8 Q. Great. Matt, would you go to page 23, please.
9 And do you see in the second to last paragraph it makes
10 reference to a CSR subsidy program.

11 A. Yes.

12 Q. So that's something that you considered in
13 this amended filing; correct?

14 A. Correct.

15 Q. Would you please explain the CSR subsidy
16 program?

17 A. The CSR subsidy program was a feature of the
18 ACA to help policyholders in the individual market that
19 met certain income restrictions to help alleviate some of
20 the pressure of cost sharing. So cost sharing being
21 deductibles, co-insurance or copays. The federal
22 government, plus there is an additional subsidy from the
23 State of Vermont. We're funding -- it was funding the CSR
24 program. State of Vermont is still funding their portion
25 of the CSR program, but the federal government stopped

1 funding the program in October of 2017. And it's still
2 not funded as of today.

3 Q. Thank you. Matt, would you go to page 26,
4 please, of the exhibit. And do you see in the second to
5 last paragraph there is a reference to line 19 Adjustment
6 for Association Health Plans.

7 Do you see that?

8 A. Yes.

9 Q. So Association Health Plans were considered in
10 this rate filing; correct?

11 A. Correct.

12 Q. Would you please go to Exhibit 6. Exhibit 6.

13 A. Okay.

14 Q. This is a response to an objection question by
15 L&E, so it's a response by MVP to a question from L&E;
16 correct?

17 A. Correct.

18 Q. And if you reference number two. Do you see
19 where it makes reference to the AHP market?

20 A. Yes.

21 Q. So would you please explain what was happening
22 with the Associated Health Plans this year and how MVP
23 addressed those?

24 A. Beginning in 2019, associations could band
25 together smaller -- their smaller member groups and

1 purchase non-Vermont Health Connect policies. MVP did not
2 offer any of those policies in 2019. And based on our
3 analysis we estimate that approximately 20 percent of the
4 4,869 members that left the exchange market to go to
5 Association Health Plans were from MVP.

6 We analyzed the morbidity historical claim
7 cost with risk score adjustments, for that -- for the
8 population that left MVP versus who remained, and we found
9 that generally speaking the population that left was much
10 healthier. Since then, on June 13, 2019, DFR bulletin 205
11 declared that in 2020 Association Health Plans will not be
12 offered in Vermont. As a result, MVP is retracting the
13 adjustment which was on line item, I don't recall which
14 line item, but we were retracting the adjustment which was
15 worth close to 1 percent.

16 Q. And that's reflected in the 11 percent we are
17 seeking today; correct?

18 A. Correct.

19 Q. Okay. Now I know I'm having you shuffle back
20 and forth, but would you mind going back to Exhibit 2,
21 please. Page 31. Are you there, Matt?

22 A. Yes.

23 Q. So do you see down the last heading on the
24 bottom is "General Administrative Expense Load, including
25 QI component." Do you see that?

1 A. Yes.

2 Q. And there is a reference to 42 PMPM in the
3 first sentence. Do you see that?

4 A. Yes.

5 Q. Would you please explain what that is?

6 A. \$42 PMPM. PMPM is per member per month. The
7 proposed rates included in this filing assume that
8 administrative costs such as overhead, maintaining claims
9 operating systems, and so on so forth, will be
10 approximately \$42 per member per month.

11 Q. And you've reviewed L&E's filing; correct?

12 A. Correct.

13 Q. And did L&E find the administrative expense
14 load and this 42 PMPM number reasonable and appropriate?

15 A. Yes.

16 Q. We will talk more about that later.

17 Let's go to page 32, please. And you see at
18 the top it says: Contributions to Reserves/Risk Charge?

19 A. Yes.

20 Q. What is MVP proposing for a CTR this year?

21 A. 1.5 percent.

22 Q. And what did MVP propose last year?

23 A. 2 percent.

24 Q. And what did the board approve last year?

25 A. 1.5 percent.

1 Q. And just above that, do you see there is a
2 reference to bad debt expense?

3 A. Yes.

4 Q. So last year Board Member Usifer asked you
5 about bad debt expense, so I thought we could touch on
6 that briefly now.

7 What is bad debt expense?

8 A. Bad debt is the risk of the policyholder not
9 paying a premium. The way that we develop a rate is that
10 we start with claims, and then project them forward to
11 arrive at our claim projection for the projection year of
12 2020 in this case. There are instances where
13 policyholders aren't actually paying premium, and we are
14 still covering claims for a time period even though we
15 haven't collected premium for them.

16 So in our rate development there is no
17 contemplation of a policyholder not paying premium. And
18 this adjustment, which is based on historical averages, it
19 accounts for the fact that we are paying claims. Yet we
20 are not collecting premium for everyone.

21 Q. When you say "this adjustment," is that the
22 .4 percent?

23 A. Correct.

24 Q. And that's based at least in part on prior
25 years; is that right? Historical data?

1 A. Yes.

2 Q. Why is the bad debt number, why is that on a
3 separate line in the rate filing, separate from CTR?

4 A. It's a separate charge. It's separate and
5 distinct from contribution to reserves or any other
6 portion of the rate build up.

7 Q. So CTR is based on monies for claims and the
8 other things you identified, and this is based on -- the
9 bad debt expense is based on people not paying their
10 premium; is that right?

11 A. That's right.

12 Q. Having those items separate, is that
13 actuarially sound?

14 A. Yes.

15 Q. Matt, would you turn please to Exhibit 11.

16 A. Okay.

17 Q. This is a July 11, 2019 letter from MVP;
18 correct?

19 A. That's correct.

20 Q. You signed it; correct?

21 A. Yes.

22 Q. And there is a reference in the second
23 paragraph to Gold 2 Non-standard Plan. Do you see that?

24 A. Yes.

25 Q. So would you please explain what the purpose

1 of this filing is?

2 A. After our submission, DFR upon review of
3 modification to the Non-standard Gold 2 Plan found that it
4 was out of compliance with CMS's regulation of uniform
5 modification of coverage. As a result, we are going back
6 and modifying our plan design to be much more similar to
7 the plan that is being offered in 2019.

8 The changes that we were offering were to try
9 to remove the deductible from the plan. We have an \$850
10 deductible in place today. MVP's proposed plan was to
11 offer a zero deductible plan. Because the change was so
12 large, it fell outside the range of uniform modification
13 of coverage which is resulting in us having to refile this
14 plan design.

15 Q. And Matt, is this something that was required
16 by DFR; correct?

17 A. That's correct.

18 Q. Okay. And would you please read the first
19 sentence of the last paragraph?

20 A. "The first document confirms that the updated
21 plan design fits within the Gold Metal Level and satisfies
22 federal AV requirements."

23 Q. You would agree with that; right?

24 A. Yes.

25 Q. And then let's go down to the second to last

1 sentence that starts: "Consistent with." Would you
2 please read that sentence?

3 A. "Consistent with the calculation performed by
4 L&E and the actuarial memorandum dated July 9, 2019, the
5 impact of this plan design change on a contract weighted
6 rate increase is a decrease of approximately 0.2 percent.

7 Q. Okay. So the Gold 2 Non-standard Plan
8 modification, the design resulted in an overall rate
9 decrease of .2 percent; is that correct?

10 A. On the overall contract rated rate increase.
11 Yes. The actual plan change Gold 2 Non-standard is much
12 larger.

13 Q. And would you read that last sentence, please,
14 on that issue?

15 A. "The Gold 2 Non-standard rate increase for
16 2020 is now proposed to be 10.4 percent reduced from the
17 22.6 percent increase in the amended filing."

18 Q. Thank you, Matt. Okay. I would like to pivot
19 to L&E's recommendations this year. Would you go to
20 Exhibit 9, page 15, please.

21 A. Okay.

22 Q. And we looked at this briefly earlier. You
23 see there is 7 bullets regarding recommendations. Do you
24 see those?

25 A. Yes.

1 Q. I want to go through each one. But overall,
2 does MVP agree with L&E's recommendations?

3 A. Yes.

4 Q. Let's start with the first one. Cost trend
5 from 2018 to 2020. Do you see that?

6 A. Yes.

7 Q. What is the cost trend?

8 A. Cost trend is just general inflation. So if a
9 service costs \$100 in 2018, and we anticipate the cost to
10 be \$110 in 2020, then that represents a 10 percent trend
11 over both years.

12 Q. And there is a reference to the hospital
13 budgets in that paragraph; correct?

14 A. Correct.

15 Q. So are hospital costs part of the cost trend?

16 A. Yes.

17 Q. And I believe you testified to this earlier,
18 but MVP in its original filing used -- original rate
19 filing rather -- approved hospital budgets; is that right?

20 A. Yes.

21 Q. And so this first bullet, what does it result
22 in terms of change?

23 A. It's a reduction of 0.9 percent. It's the
24 same 0.9 percent that we discussed, the impact of the
25 proposed filing to the amended filing.

1 Q. Thank you. So we agree with this
2 recommendation; correct?

3 A. Yes. Correct.

4 Q. Let's go to the second bullet please. Cost
5 trend from 2019 to 2020. Do you see that?

6 A. Yes.

7 Q. Would you read the first sentence, please?

8 A. "If updated information regarding unit cost
9 trends are known at the time of the board order, L&E
10 recommends updating the assumed unit cost trends in the
11 2020 premium rate calculations."

12 Q. And do you agree with that recommendation?

13 A. Yes.

14 Q. And are there challenges in considering unit
15 cost trend relating to hospital budgets here in Vermont?

16 A. The time line -- the time line of the hospital
17 budget approval isn't aligned with when rates are proposed
18 or decisions are rendered. So we submitted our initial
19 rate filing on May 10th. We had not received the final
20 proposed hospital budgets until July 16. A rate decision
21 will be rendered sometime in early to mid August. And we
22 don't anticipate to receive approved hospital budgets
23 until sometime after that.

24 Q. So that's a challenge.

25 A. Yes.

1 Q. And in April or thereabouts this year, the
2 board made some rate changes for several hospital
3 facilities; is that right?

4 A. That's correct. There were adjustments made
5 from the approved hospital budgets for two hospitals after
6 the initial decision rendered in the fall.

7 Q. So that was not contemplated at the time of
8 the hospital budget approval last year; correct?

9 A. Correct.

10 Q. And all that poses a second challenge;
11 correct?

12 A. Correct.

13 Q. And then third, are there facilities that are
14 not under the Green Mountain Care Board's jurisdiction?

15 A. Yes. MVP's benefits and products offered in
16 this filing cover a nationwide network of providers and
17 facilities and pharmacies. So MVP contracts directly with
18 most facilities in upstate New York and providers. We
19 also contract with Dartmouth Hitchcock in New Hampshire.
20 And after that, we rely on a national carrier to use their
21 network. So that if a Vermonter is vacationing in Arizona
22 or California, and they need medical care, they can access
23 a provider facility with an in-network provider with no
24 additional cost sharing above and beyond what's in their
25 benefits if they saw a provider right up the street.

1 Q. Thank you, Matt. Would you please go -- in
2 that exhibit go to page 5, please. Page 5.

3 A. Okay.

4 Q. And do you see there is a bullet on the
5 bottom. Do you see that?

6 A. Yes.

7 Q. Would you read that, please?

8 A. "Approximately 40 percent of medical services
9 are provided by hospitals not subject to the Green
10 Mountain Care Board hospital budgeting process."

11 Q. Now originally in L&E's first filing did they
12 have a different percentage there?

13 A. Yes.

14 Q. And what was that percentage?

15 A. I believe it was 55 percent.

16 Q. So they -- they clarified that error; correct?
17 With this filing on July 16; correct?

18 A. Yes. Correct.

19 Q. And by making that change, does that change
20 your agreement with L&E on their ultimate conclusions?

21 A. It does not impact the proposed rate change.

22 Q. Okay. And then in -- there is a little blue
23 box next to the bullet. Do you see where it says GMCB
24 hospital budget review?

25 A. Yes.

1 Q. And there is a number two there. Would you
2 read that, please?

3 A. "A trend of 5.5 percent for other medical
4 facilities and providers that are not subject to the
5 hospital budget review."

6 Q. And does this figure change based on L&E
7 making the one change 40 to 55 percent?

8 A. It does not.

9 Q. Now you referenced earlier on hospital budget
10 proposals on -- that came in -- the last one came in on
11 Tuesday, July the 16th; correct?

12 A. Correct.

13 Q. And that's similar to last year they kind of
14 came in just prior to the hearing?

15 A. Yes.

16 Q. And what did you indicate MVP is doing based
17 on that data?

18 A. We updated our trends to reflect what's in the
19 proposed hospital budgets and is having an overall impact
20 on the proposed rate increase of an additional increase of
21 0.5 percent to go to an 11 percent in total.

22 Q. Now coincidentally what did MVP do last year
23 to adjust based on the hospital budget proposals?

24 A. It -- coincidentally it was the same figure of
25 0.5 percent.

1 Q. And do you recall what L&E did last year?

2 A. L&E reviewed historical differences between
3 what was ultimately approved and what was proposed. And
4 their overall recommendation was to look at the historical
5 averages, and it was something greater than zero but less
6 than 0.5 percent.

7 So our opinion is that we should be working
8 with the information that's known at this time which is
9 why we are building in the proposed hospital budgets for
10 this year.

11 Q. And last year where did L&E land in terms of
12 what the percentage should be in there?

13 A. If I recall, it was 0.2 percent.

14 Q. And as you sit here today, not knowing exactly
15 what L&E's going to do with this hospital budget issue,
16 but as far as you know that's the only potential dispute
17 we have with L&E this year?

18 A. Yes. There is risk in making that adjustment
19 because historical -- historical adjustments may not be
20 consistent with what happens for this year's hospital
21 budgets. Last year, as we mentioned earlier, we did
22 experience an increase in the spring which wasn't
23 contemplated in the initially approved hospital budgets.
24 So there is some risk in following historical averages.

25 With that said, we are again building in 0.5

1 percent which is our -- the data that's known at the time
2 as of right now.

3 Q. Thank you. Matt. Would you go back to the
4 summary page. Page 15, please.

5 A. Okay.

6 Q. The third bullet references medical
7 utilization trend. Do you see that?

8 A. Yes.

9 Q. What is medical utilization trend?

10 A. Medical utilization trend is just a change in
11 the number of services we rendered. So there is two
12 components to get to a total dollar trend. One is on
13 inflation, which we discussed earlier, and the other one
14 is on frequency which is utilization.

15 L&E's recommending that the medical
16 utilization trend be increased from MVP's proposal of 0.0
17 percent to 1.0 percent per year which will increase rates
18 by approximately 1.5 percent.

19 Q. And do you agree with that recommendation?

20 A. Yes. L&E -- MVP has experienced a lot of
21 growth in this market in the last few years. L&E has the
22 ability to analyze data from both sets of carriers, so
23 they have a whole snapshot of the QHP market, so their
24 data and analysis is more robust and more comprehensive
25 than what MVP has at its fingertips for utilization trend

1 purposes.

2 Q. Great. Let's go to page 6 of the exhibit,
3 please, on that point. At the very bottom of that page
4 there is a sentence that starts "Because." Do you see
5 that?

6 A. Yes.

7 Q. Would you read that sentence, please?

8 A. "Because of the atypical results produced by
9 MVP's analysis using their own data, L&E analyzed
10 utilization trends by using market-wide utilization data.
11 I.e., combination of utilization data from both QHP
12 carriers."

13 Q. And that's what you were talking about a
14 moment ago; correct?

15 A. Yes, correct.

16 Q. If you go to page 7 at the bottom. You'll see
17 a bullet. And then you'll see two bullets that go into
18 page 8. Do you see those?

19 A. Yes.

20 Q. Please read those.

21 A. First bullet: "L&E notes MVP's utilization
22 trend has oscillated in recent years and has increased in
23 2018."

24 Next bullet: "The increase assumption is more
25 reflective of market-wide data which is less impacted by

1 significant shifts in membership between carriers."

2 Next bullet: "L&E believes this assumption is
3 based on more credible data than MVP's closed cohort
4 analysis."

5 Q. And the last sentence makes reference to the
6 rate increase of approximately 1.5 percent; doesn't it?

7 A. Yes.

8 Q. And you agree with that; correct?

9 A. Yes.

10 Q. Great. Let's go back to page 15 and go to the
11 next one, please. The next one on page 15, the next
12 bullet is "AHP Morbidity Impact."

13 Do you see that?

14 A. Yes.

15 Q. What is L&E recommending there, please?

16 A. L&E is recommending we remove the HP morbidity
17 load on claims which we discussed earlier, which will
18 reduce the projected premiums by approximately 0.8
19 percent.

20 Q. And we discussed that earlier, and MVP agrees
21 with that; correct?

22 A. Correct.

23 Q. Okay. Do you see the next bullet: "High-cost
24 Member Program."

25 Do you see that?

1 A. Yes.

2 Q. What is the program, please?

3 A. There is a national high-cost reinsurance pool
4 that exists because at a certain level risk adjustment --
5 risk adjustment is used to normalize morbidity of
6 populations, but at a certain claim level risk adjustment
7 just doesn't work on the outlier claims.

8 So CMS identified this as an issue. If a
9 carrier has a disproportionate share of high-cost claims
10 in excess of a million dollars, they will receive 60
11 percent of those dollars back through this national
12 reinsurance program. Carriers are assessed a fee based on
13 their percentage of total nationwide premium.

14 So in this case, MVP didn't have any members
15 that were eligible for a recovery over a million dollars
16 in the Vermont exchange market, but we are paying into the
17 program because we have to pay our share of the nationwide
18 premium.

19 Q. Okay. If you go back to the bullet for high-
20 cost member program. What does the last clause say?

21 A. "L&E recommends that the assumption for the
22 federal high-cost member program be moved to the
23 URRT from risk adjustment to net reinsurance which has no
24 impact on the rates."

25 Q. So the last clause they say no impact on

1 rates. Do you agree with that?

2 A. Yes.

3 Q. The next bullet is "Changes to Risk
4 Adjustment." Do you see that?

5 A. Yes.

6 Q. And what does L&E say there, please?

7 A. L&E is recommending that change to a risk
8 adjustment from what was initially proposed in our rates
9 to our final results with an adjustment for 2020 risk
10 adjustment coefficients is an increase of approximately
11 1.5 percent.

12 Q. Thank you. Would you please go to page 11,
13 please.

14 A. Sure. Okay.

15 Q. And do you see at the bottom there is a
16 numbered paragraph 10 which references change to risk
17 adjustment. Do you see that?

18 A. Yes.

19 Q. And this explains the rationale that L&E used;
20 correct?

21 A. Correct.

22 Q. Okay. So the second sentence describes the
23 data that MVP had at the time of the filing; correct?

24 A. Correct.

25 Q. Would you read that sentence, please?

1 A. "The most recent data available at submission
2 was the interim report published by CMS in late March and
3 the confirmation of the number of months each carrier has
4 submitted for the interim report."

5 Q. So late March data; right?

6 A. That's correct.

7 Q. Okay. And then if you turn to page 12.

8 A. Okay.

9 Q. That first paragraph at the top, what did L&E
10 first do?

11 A. L&E requested that both carriers provide final
12 CMS risk adjustment data in the form of the RATEE filing,
13 risk adjustment transfer elements extract. They gathered
14 MVP's data, plus Blue Cross's data, and computed what risk
15 transfer payments and receipts would be for the 2018 plan
16 year.

17 Q. So they used more data from both carriers;
18 correct?

19 A. Correct.

20 Q. And in the second paragraph, what happened on
21 June 28?

22 A. CMS released the final risk transfer results
23 for the 2018 plan year which is the same set of data that
24 we are using to set our premium rates for 2020.

25 Q. Did that data -- does L&E indicate that that

1 data confirmed their prior calculus we just talked about
2 in the first paragraph?

3 A. Yes. The calculation change was immaterial.

4 Q. And then there is a paragraph after that. It
5 says: "Additionally." Do you see that paragraph?

6 A. Yes.

7 Q. So what else did L&E do after receiving the
8 CMS information?

9 A. In addition to the CMS information and the
10 final results, CMS is changing the coefficients or the
11 weights for certain disease states or age gender factors
12 in 2020.

13 So for example, a 40-year-old single male on a
14 Platinum plan in 2018 may have been a risk score of X. In
15 2020 that may be .9 of X. When you take both sets of data
16 from the carriers and simulate it using the 2020
17 coefficients instead of using the 2018 coefficients, the
18 risk transfer results change. And the adjustment of which
19 is worth approximately -- it's going from MVP paying 55.61
20 per member per month into risk adjustment to 64.15 per
21 member per month. 64.15 PMPM is more representative of
22 what we would anticipate to happen in 2020 because of the
23 updated coefficients.

24 Q. And Matt, the reference to -- read the
25 clauses. "Because MVP has a disproportionate share of

1 lower risk or lower benefit members."

2 Why is that significant in the study they did
3 on diagnosis and enrollment data?

4 A. Because the shift in the 2018 to the 2020
5 coefficients, the result -- so in risk adjustment,
6 healthier policyholders are paying into the program while
7 higher risk policyholders are receiving money to end up at
8 a zero sum game. The changes between 2018 and 2020 is
9 going to result in the lower morbidity population paying
10 more into risk adjustment, which is why MVP is seeing a
11 big increase due to the fact that we do enroll more low
12 risk and low benefit members.

13 Q. And that portion of this analysis reflected an
14 increased rate of 1.8 percent; is that right?

15 A. Yes. That's correct.

16 Q. And then read the last sentence, please.

17 A. "Combined with the first recommendation, the
18 overall recommended change to the risk adjustment transfer
19 projection results in a 1.5 percent increase to the 2020
20 premium rates."

21 Q. And you agree with that 1.5 percent increase?

22 A. Yes.

23 Q. Simply put, did L&E have significant more data
24 to come up with that increase?

25 A. That's correct.

1 Q. Okay. Matt, let's go back to page 15. We are
2 making progress. "Changes to Actuarial Value."

3 Do you see that last bullet?

4 A. Are we in Exhibit 15?

5 Q. No. Page 15. Exhibit 9.

6 A. Okay.

7 Q. Sorry if I misspoke.

8 A. Let me go back.

9 Q. Do you see the last bullet, "Changes to
10 Actuarial Value"?

11 A. Yes.

12 Q. Okay. So would you just identify what that
13 change is? The amount, and what it is?

14 A. The changes to actuarial value will reflect a
15 0.2 percent decrease from -- to the overall book of
16 business proposed rate increase. This is the Non-standard
17 Gold 2 benefit design change that we had discussed
18 earlier.

19 MVP initially proposed a benefit design that
20 would have no deductible. In 2020 the current plan design
21 for that plan is an \$850 deductible. The result -- after
22 DFR reviewed, they said that that was too large of a
23 change to make. And we had to offer a benefit design
24 that's closer to the 2019 plan offering which is going to
25 be a reduction in benefits and therefore corresponding

1 reduction in premium rate.

2 Q. And all that was reflected in that Exhibit 11
3 we looked at a moment ago; correct?

4 A. Yes. That's correct.

5 Q. Was MVP -- the products department at MVP,
6 contacted by DFR on Friday this last week?

7 A. My understanding is that they were.

8 Q. And what did DFR call about?

9 A. After the initial notification from DFR to
10 MVP, MVP modified the plan design to be close to the 2019
11 plan design, but still a slight reduction in deductible
12 and a couple other different changes in benefit.

13 DFR contacted MVP on Friday and let us know
14 that they would like us to offer benefits that's even
15 closer to the 2019 benefit design. So we are still
16 evaluating the impact of those changes and what that exact
17 plan design is going to be.

18 Q. But as you sit here today, do you believe that
19 change that they requested on Friday will impact this .2
20 reduction?

21 A. I do not. I do expect it to impact the Gold
22 Non-standard 2 premium rate, but I don't expect it to
23 impact the overall book of business average rate increase.
24 Because there is not a significant amount of enrollment in
25 that plan design.

1 Q. And we expect to file something later today on
2 that?

3 A. That's my understanding. Correct.

4 Q. So at the bottom of page 15 -- thank you for
5 going through all those with me. At the bottom of page
6 15, that summary sentence indicates 9.4 to 10.5 pursuant
7 to L&E's opinions; correct?

8 A. That's correct.

9 Q. In your opinion are all of these 7
10 recommendations and the overall increase from 9.4 to 10.5,
11 adding the .5 for the recent hospital budget proposals to
12 11 percent, is all that actuarially sound and reasonable?

13 A. Yes. That is all actuarially sound and
14 reasonable.

15 Q. And in your opinion is 11 percent the best
16 number?

17 A. Yes.

18 Q. Thank you. Matt, I wonder if you could tell
19 the board a little bit about MVP's market share and
20 competitive posture.

21 A. Over the last few years, MVP has been able to
22 improve our competitive premium position. And as a
23 result, we have grown from somewhere around 10 percent of
24 the market a few years ago to approximately 40 percent of
25 the market as of today. And we have achieved that, again

1 through trying to manage costs down and offering more
2 affordable premium rate in the QHP market.

3 Q. Thank you. Next Matt, I want to ask you about
4 reserves and solvency. Do you view -- in your opinion --
5 contributions to reserves in isolation for just one year
6 as it relates to solvency?

7 A. We generally view solvency over the long haul.
8 It's a little bit of both. So we want every filing to be
9 self supporting and be able to ensure that we are not
10 running at an operating loss which is going to take down
11 our reserve level. But over the -- we also view it as if
12 there is one year fluctuation, as long as it's not too
13 significant, we can manage within that.

14 We generally don't want to shock the market
15 just to achieve some target reserve level. We generally
16 would rather step into it over a few years.

17 Q. Thank you. Matt, would you go back to Exhibit
18 2, page 32, please.

19 A. Okay.

20 Q. At the top of the page, we touched on this
21 earlier. I want to talk in more detail.

22 Do you see the reference to contribution to
23 reserves at 1.5 percent?

24 A. Yes.

25 Q. And you testified last year MVP sought 2

1 percent.

2 A. That's correct.

3 Q. Okay. So let's go to Exhibit 10. DFR
4 solvency analysis, please. Exhibit 10.

5 You're familiar with this letter dated July
6 10, 2019?

7 A. Yes.

8 Q. And would you please read the sentence under
9 "Summary of Opinion"?

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

14 Q. And do you agree with that statement?

15 A. Yes.

16 Q. And would you go to the second page, please,
17 and read the third bullet point. Second page.

18 A. "Finally, in 2018, all of MVP Holding
19 Company's operations in Vermont accounted for
20 approximately 4.8 percent of its total premiums written.
21 DFR has determined that MVPHP's Vermont operations pose
22 little risk to its solvency. Nonetheless, adequacy of
23 rates and contribution to surplus are necessary for all
24 health insurers to maintain strength of capital that keeps
25 pace with claims trends."

1 Q. Do you agree with those statements next to
2 bullet 3?

3 A. Yes.

4 Q. And under the heading just below there it
5 says, "Impact of the Filing on Solvency."

6 Would you please read those sentences?

7 A. "Based on the entity-wide assessment above and
8 contingent upon GMCB's actuary's finding that the proposed
9 rate is not inadequate, DFR's opinion is that a proposed
10 rate will not have a negative impact on MVPHP's solvency."

11 Q. Do you agree with that?

12 A. Yes.

13 Q. In your opinion would the increase of the
14 original filing of 9.4 percent to 11 percent adversely
15 impact the solvency of MVP Healthcare, Inc.?

16 A. It will not.

17 Q. Although our proposed rate is changed has our
18 CTR remained the same at 1.5 percent?

19 A. Yes.

20 Q. Thank you. Would you please go to Exhibit 9.
21 Page 14.

22 A. Okay.

23 Q. Do you see a heading that says: "15. Changes
24 in Contribution to Reserves"?

25 A. Yes.

1 Q. And this is L&E's amended report; correct?

2 A. Correct.

3 Q. Okay. So go to the second paragraph under
4 that heading.

5 A. Okay.

6 Q. And you'll see there is a reference to a
7 reasonableness -- reasonableness check. And there is a
8 reference to 2019. Do you see that?

9 A. Yes.

10 Q. And the next paragraph do you see the
11 reference to 2018?

12 A. Yes.

13 Q. Okay. Would you tell me what this
14 reasonableness check that L&E talks about, what that's
15 about?

16 A. L&E accessed 1,600, approximately 1,600
17 filings that were submitted in the last two years. And
18 what they identified was that MVP's proposed CTR of 1.5
19 percent is approximately the 20th percentile. Meaning out
20 of the 1,600 filings that L&E reviewed, 80 percent of the
21 filings had a CTR included that was greater than 1.5
22 percent.

23 Q. Okay. And then the fourth paragraph under 15
24 starts: "Based on L&E's evaluation."

25 Do you see that paragraph?

1 A. Yes.

2 Q. Would you please read those two sentences?

3 A. "Based on L&E's evaluation of MVP's CTR
4 compared to the assumed CTR levels underlying every QHP
5 filing submitted in 2018 and 2019, L&E believes that MVP's
6 proposed CTR is reasonable in light of its underlying
7 risks. L&E believes that this allows the company to
8 offset potential adverse events with appropriate
9 consideration given to maintaining the CTR at an adequate
10 long-term level."

11 Q. So I know you -- well let me ask you. Have
12 you seen the underlying data of the reasonableness checks
13 for those two years?

14 A. I have not.

15 Q. But based on this summary, do you agree with
16 the two sentences you just read in paragraph 4 under
17 heading 15?

18 A. Yes.

19 Q. Okay. And if you go down to the 6th
20 paragraph. Just above the number 16.

21 A. Okay.

22 Q. Would you read the first sentence in that
23 paragraph, please?

24 A. "L&E believes the CTR assumption is
25 reasonable, and does not recommend any changes to the CTR.

1 In addition to L&E's review, L&E recommends that any
2 solvency analysis performed by the Department of Financial
3 Regulation be considered."

4 Q. And you agree with both of those statements?

5 A. Yes.

6 Q. And then in the fifth paragraph just above
7 paragraph you just read, there is a reference to bad debt.
8 Do you see that?

9 A. Yes.

10 Q. Now we talked about that before. Right? You
11 explained bad debt?

12 A. Yes.

13 Q. There is a reference here to .4 percent. What
14 is L&E saying about the .4 percent?

15 A. L&E reviewed MVP's historical bad debt
16 percentages, and over the last three years the average
17 amount was .4 percent, which is the amount that we are
18 building into our proposed premium rates for 2020.

19 Q. Thank you. So Matt, I want to pivot now and
20 talk a little bit about lowering costs, promoting quality
21 of care and access and affordability. Staying with
22 Exhibit 9. Would you please go to page 13.

23 A. Okay.

24 Q. And you'll see paragraph numbered 13 on that
25 page called "Changes in Administrative Costs."

1 Do you see that?

2 A. Yes.

3 Q. And there is two paragraphs. Can you read the
4 last sentence in the last paragraph, please?

5 A. "In light of the steps taken by MVP to reduce
6 administrative costs over the recent years, the assumed
7 administrative 2020 costs are reasonable and appropriate."

8 Q. And do you agree with the commentary in the
9 two paragraphs under 13?

10 A. Yes.

11 Q. So let's go to the first paragraph. Read the
12 last two sentences, please.

13 A. "The overall rate impact is a decrease of 1
14 percent. Because the premium is also increasing from
15 the 2019 exchange filing, the administrative expenses as a
16 percentage of premium, are decreasing."

17 So what that means is that even though the
18 PMPM is increasing, it's increasing at a slower rate than
19 the proposed rate increase which is having a dampening
20 effect on the overall rate impact.

21 Q. In the second paragraph in this section L&E
22 talks a bit about the block of members in New York and
23 their relationship with the block of members in Vermont;
24 correct?

25 A. Correct.

1 Q. Can you explain that to the board and how that
2 impacts on these percentages and the increases and
3 decreases?

4 A. Yes. So even though we have experienced a lot
5 of growth in Vermont, that's been more than offset by
6 contraction in our membership in our New York business.
7 And we have fixed costs that are spread across both
8 states. The example I generally go to is a claims
9 operating system. We have one claims operating system that
10 is physically housed in New York, but it's used by members
11 regardless of which state it's in.

12 So the cost of maintaining that claims
13 operating system, and any kind of administrative expenses
14 associated with it, or employees, has to be spread across
15 MVP's entire membership base, and because the overall
16 membership base has decreased by about 5 percent in the
17 last two years, that is increasing the overall per member
18 per month levels.

19 Q. So L&E talks about that a little bit in the
20 second paragraph; correct?

21 A. Correct.

22 Q. So given all of that, did L&E find our changes
23 relating to administrative costs reasonable and
24 appropriate?

25 A. Yes.

1 Q. Matt, first I'm going to start with a general
2 question for you. Has and will MVP take steps to lower
3 costs, promote quality care and access, and establish that
4 its rates proposed are affordable to Vermonters?

5 A. Yes.

6 Q. Would you please go to Exhibit 5.

7 A. Okay.

8 Q. And Matt, this is another MVP response to in
9 this case non-actuarial interrogatories; correct?

10 A. That's correct.

11 Q. That's what it says at the beginning of
12 Exhibit 5. The heading; correct?

13 A. Correct.

14 Q. Would you go to page 2, please.

15 A. Okay.

16 Q. And let me read the question on page 2.
17 "Please describe the evidence you intend to rely on to
18 establish the rates proposed in the filing are affordable
19 to Vermonters."

20 Do you see that?

21 A. Yes.

22 Q. Okay. And then if you start on page 2, do you
23 see there is numbered paragraphs that start at number 1;
24 right?

25 A. Yes.

1 Q. And they go to 44 items. Going to page 6.

2 A. Yes.

3 Q. Okay. So I want to go through these and
4 explain to the board how this all relates to the question
5 of steps MVP has taken to lower costs, promote quality
6 care and access, and establish the rates affordable to
7 Vermonters. Okay?

8 I don't think we have time to go through them
9 in order, 1 through 44. So I'll identify three categories
10 I want to talk about with you.

11 A. Sounds good.

12 Q. Let's start first with managing care and
13 medication. Second, with managing administrative costs
14 and contracts. And then third, we are going to talk about
15 managing the plan and membership.

16 A. Okay.

17 Q. So let's start with the first one. And you're
18 free to reference some of these numbered paragraphs as you
19 talk, and I'll help you through it.

20 So starting with managing care and medication.
21 Let's first talk about primary care, please. Again
22 keeping in mind those statutory issues that I described
23 for you. Can you talk to the board about primary care?

24 A. The MVP is a strong believer that primary care
25 should be center to a patient's medical experience,

1 having a regular contact -- having regular contact with
2 your PCP. Not only does it help establish a relationship
3 where there can be efficiencies created because they know
4 your medical history, but they will also be able to
5 delegate or refer care in the most efficient way possible.

6 So if you have -- if you have a solid
7 relationship with your PCP, there are downstream effects
8 that can help avoid future higher costs because they will
9 be able -- they know your history and will be able to
10 direct you appropriately.

11 We also have a quality program in place for
12 PCPs, so if they meet certain quality criteria, there is
13 financial incentives attached. So we also -- in addition
14 to trying to reduce costs down the road, it's important to
15 us that not only is an affordable product, but it's also a
16 high quality product. So certain metrics such as well
17 screenings and procedures within your well screening visit
18 are followed.

19 Q. Thank you. And looking at item 3, part of
20 which is redacted. Just at a high level, there is a
21 reference to a marketplace primary care improvement
22 program. What's that?

23 A. That's the program I was referencing where if
24 PCPs meet certain quality metrics, there is a financial
25 incentive attached for them.

1 Q. Okay. And item 6 references aligning fees to
2 increase access. Can you describe that, please?

3 A. Yes. So we have taken steps in recent years
4 to ensure that there isn't as large of a spread between
5 hospital-owned physician reimbursement versus community-
6 physician reimbursement. It's important that the
7 physician that's down the road in Montpelier is
8 compensated comparably to the physicians that are employed
9 by hospitals.

10 And what that does is it isn't a strong
11 incentive for physicians to only be employed by larger
12 hospitals, and it will provide hopefully higher care in
13 the community-based physician offices.

14 Q. Thank you. The next item is MVP's hiring and
15 using clinician staff. Could you explain that to the
16 board?

17 A. Yeah. MVP employs a comprehensive staff of
18 clinicians ranging from respiratory therapists and
19 registered nurses all the way through MDs, and we have a
20 number of programs in place to help members when they have
21 a critical point in their life where they need to use
22 medical care.

23 So we have a transplant network in place where
24 you have one-on-one contact with an MVP clinician to help
25 direct you to the appropriate facility. And we only use

1 the highest quality transplant networks, because these are
2 really high-cost, complex -- complex procedures that are
3 performed. And what we want to ensure there aren't
4 downstream impacts. If you go to a lower-quality
5 transplant facility, you may not have the same outcomes.

6 We also have a critical program where --
7 critical program in place where if a member unfortunately
8 receives a negative or unfavorable diagnosis such as
9 intense cancer, then we have a program in place to help
10 contact those members and help guide them through the
11 process. Because we recognize that the healthcare system
12 is complex, and especially when you're dealing with one of
13 these life events that could be life altering, and we want
14 to try to provide the most positive experience possible to
15 our members.

16 And on the front of trying to reduce costs, we
17 also have a program in place where we analyze members that
18 have been accessing the ER in a non-traditional fashion,
19 so members that may have three plus ER visits in 90 days,
20 we reach out to them and try to provide some education
21 materials to let them know that we have other programs in
22 place or -- such as our telemedicine benefit which has
23 been great in recent years. We have seen an uptick in
24 utilization. That's a great program that we will talk
25 about.

1 And additionally, where we can direct them to
2 an urgent care facility which is a lot lower cost,
3 somewhere between, you know, 20 percent less on average
4 for the telemedicine to somewhere between, you know, I'm
5 sorry, I misspoke on those percentages. It's around \$45
6 for the telemedicine visit and can be upwards of a
7 thousand dollars for an ER visit. So we are really trying
8 to promote access and provide some cost relief.

9 MR. ANGOFF: Mr. Hearing Officer, I
10 don't want to interfere while they are putting on
11 their case, but in this case Mr. Lombardo's not
12 testifying as an actuary; right? He's testifying as
13 an executive with knowledge of the company's
14 policies.

15 MR. BARBER: Is that a point of
16 clarification or an objection?

17 MR. ANGOFF: I'm sorry?

18 MR. BARBER: Is that a point of
19 clarification or an objection?

20 MR. ANGOFF: I just -- yeah. I would
21 just like to make it clear, that it appears that Mr.
22 Lombardo is not testifying in his capacity as an
23 actuary. He is testifying as a corporate executive
24 which he's certainly -- a reasonable thing for him to
25 do, but this is not actuarial testimony.

1 MR. BARBER: Okay. Point is taken.

2 MR. KARNEDY: The only thing I would
3 say on that is although Mr. Lombardo is wearing a
4 suit, I don't know if he would take offense of
5 calling him a corporate executive or not. He's a
6 fact witness. He's wearing many hats here today.
7 He's also an expert witness. So you can draw
8 whatever conclusions you like about his testimony.
9 But he's been disclosed as such.

10 BY MR. KARNEDY:

11 Q. So Matt, let's go back. You referenced by way
12 of example some particular care management programs, some
13 specific ones. But there is a number of those that MVP
14 administers. I'm looking at number 10.

15 A. Yes. Yes. So we also have care management
16 programs in place for members that are being discharged
17 from a hospital, from an inpatient setting, trying to
18 guide them through helping them maintain their health
19 after they leave the hospital which will help reduce
20 readmissions and therefore reduce costs down the road.

21 Q. And Matt, you talked about a number of
22 different types of clinicians on staff. Are there nurses
23 available to take calls 24/7? I'm looking at number 8.

24 A. Yes. MVP has a 24/7 nurse help line
25 available. So if something happens in the middle of the

1 night or holiday where offices are closed, we can provide
2 a member with somewhat of a triage to direct them to the
3 appropriate place of what they should actually do.

4 Q. And does MVP also provide healthcare case
5 managers to help folks when they are navigating all this?

6 A. Yeah. As I referenced earlier, we recognize
7 that the healthcare system is complex, and it may not be
8 how your claims are going to be paid, may not be the first
9 thing on your mind if you're facing a crisis. So we have
10 case managers to help intervene and educate and inform
11 members and monitor whether or not members are following
12 up with their physicians and adhering to their
13 prescriptions.

14 Q. And looking at item 14. How is engagement
15 been going with Vermont members?

16 A. It's been successful. There's been 30
17 percent of Vermont members that we specifically contacted
18 have accepted some form of care management, and we are
19 proud of those statistics. To be able to achieve 3 out of
20 10 Vermont members to be willing to accept care management
21 and help understand the healthcare system and stepping
22 through their policies and through their treatment, it's
23 really great.

24 Q. Next, Matt, I would like to again -- managing
25 care and medication. Website online tools. And

1 telemedicine. Can you explain some of those efforts to
2 the board?

3 A. Yeah. I do want to clarify item 22 where we
4 quote that there was 2.1 million sessions in 2018. That
5 figure is from after last year's rate hearing, so that's
6 approximately 6 and-a-half months of data. We did go back
7 and we analyzed August 1st, 2018 through the end of June
8 2019, so 11 months. And there was overall about 3.5
9 million sessions, because there is a lot of really helpful
10 information on MVP's website. Whether or not it's how to
11 go through -- whether or not it's identified where doctors
12 are within your service area or wherever you're located.

13 So the example I was providing earlier where
14 if you're on vacation in Arizona or California, you can
15 still go on MVP's website and find a doctor for any
16 condition that's within a certain radius of the city or
17 zip code where you're located.

18 Additionally, there is a lot of information on
19 the website about health and wellness. And there is also
20 information that leads you to telemedicine. So the
21 telemedicine benefit, as I was mentioning, that provides
22 you -- if you have a cell signal, provides you with the
23 ability to have 24/7, 365-day-a-year urgent care mental
24 health visit with your doctor. And I utilize that, that
25 benefit. And I have had really positive experience. And

1 that's consistent with MVP's members where the vast
2 majority of them gave it a four or five star rating out of
3 five stars.

4 Q. And Matt, would you expand a little bit if you
5 go to item 25, above the online tool, to locate a care
6 provider and explain that a little bit more as it relates
7 to Vermont.

8 A. So in addition to just identifying where
9 providers are located, there is also a cost estimate
10 calculator that's provided. So you can see what the costs
11 are if you're in a product that's driven by a deductible
12 and you know that you're going to have to pay out of
13 pocket expense, the cost treatment calculator will
14 estimate the cost of the procedure for various providers
15 within your given chosen radius of where you're located.

16 Additionally, there is also a pharmacy
17 comparison tool. So you can see again if you're under a
18 deductible or you have a co-insurance benefit, then it's
19 helpful to understand what your out of pocket is expected
20 to be. So you can use a similar tool for prescription
21 drugs that will inform you what the costs of a given drug
22 is at various pharmacies within a given area.

23 Q. Thank you. And there is a -- in 24 there is a
24 reference to welcome packet, so in contrast to the
25 website. How about at the outset as it relates to welcome

1 packets?

2 A. Whenever someone enrolls with MVP, they
3 receive a welcome packet that tries to provide a simple
4 understanding of the benefits that they purchased. And
5 also provides an understanding of some common terms that
6 are used like copay, deductible, co-insurance.

7 There have been some studies that have been
8 performed that show that the average consumer doesn't even
9 understand what those terminologies mean. I think we take
10 it for granted sometimes because we talk this language all
11 the time. And it's important that we can provide some
12 sort of knowledge to our members before they start
13 accessing care so they can have a reference point and
14 understand exactly what they purchased from us.

15 Q. And referencing item 30. Has MVP provided
16 anything for folks who might enroll mid year?

17 A. Yes. We have, you know, the website is
18 designed to help someone that does not enroll during the
19 open enrollment period which ends on December 15. You may
20 have a life event, you may get married or have a child or
21 change employer. And in that case, you need to enroll or
22 you should enroll in your policy off cycle. And MVP
23 provides tools available to members so that they can
24 understand those special enrollment periods.

25 Q. Thank you. And Matt, the last item under this

1 category is item 44. Can you read that, please?

2 A. "MVP continues to negotiate with OneCare."

3 Q. Thank you. And Matt, would you go to please
4 Exhibit 5-A. This is a confidential exhibit. So I don't
5 want you to say anything.

6 A. Okay.

7 Q. And if you turn to page 8 of the exhibit.

8 A. Okay.

9 Q. What I would like you to do is read the
10 question. So read 4. And then pause. Read 4-A and
11 pause. And read 4-B and pause to allow the board time to
12 read the responses on the OneCare issue.

13 A. Okay. Number 4. "Please describe your plans
14 for contracting with OneCare Vermont in the 2020 plan
15 year, if any."

16 4-A. "If you plan to contract with OneCare in
17 the 2020 plan year, do you expect to incorporate capitated
18 payments?"

19 4-B. "If you plan to contract with OneCare in
20 the 2020 plan year, do you expect this partnership to
21 impact rates? If so, when?"

22 Q. Thank you, Matt. So generally now, what has
23 MVP done in terms of its team at the company dealing with
24 value-based risk sharing?

25 A. MVP recognizes that the fee-for-service model

1 has not worked. And in addition to OneCare in Vermont,
2 New York State has rolled out a road map for our Medicaid
3 population where you have to have certain -- a certain
4 number of contracts for percentage of your overall dollars
5 covered by Medicaid in some sort of risk share
6 arrangement.

7 So level 1 risk share arrangements are
8 arrangements where only the carrier is taking risk. Level
9 2 arrangements are where there is shared risk between the
10 carrier and the provider group. And level 3 is capitated
11 -- is a capitated arrangement where only the provider is
12 taking risk.

13 So MVP -- again we recognize that the fee-for-
14 service model has not been working, so we are putting
15 additional staff towards this focus to try to improve on
16 the contracts that we are writing and understand what's
17 driving costs. As of right now, our experience in New
18 York, as you know, we did not participate with OneCare in
19 2019. In New York we have had some experience over a
20 couple of years. The results of value-based contracting
21 have been mixed.

22 The one positive that I would say -- well not
23 the one positive -- but one of the big positives is that
24 we are sharing information with the provider groups to
25 help inform them so they have a better understanding of

1 what are the cost drivers. What are the items that they
2 can try to manage and understand better. And depending on
3 the level of arrangement that you have with MVP, there is
4 additional information that's provided. So certain
5 provider groups are provided with information about
6 providers that may be mis -- having higher utilization
7 than anticipated relative to their peers, or providers
8 that are sharing information that is -- or that are
9 admitting -- referring outside of a smaller network that
10 would help manage costs down.

11 Q. Thank you. Matt, I want to go back to Exhibit
12 5 and list of 44 and talk about the second category which
13 is managing administrative costs and contracts.

14 Would you tell the board about what MVP's
15 doing with contracts, please?

16 A. For third-party vendors that we negotiate or
17 have vendor agreements with, we have policies and
18 procedures in place that -- to ensure that we are getting
19 the best price possible. So you can't just hire any
20 third-party vendor. You have to have an RFP, or Request
21 for Proposal, from at least two different vendors. So we
22 can understand what is the product that they are selling
23 and also what are the costs associated with this product.
24 And then that helps inform our decision making to
25 understand the balance of quality product versus cost.

1 It also helps because when you have 2 or more
2 parties against one another, you can try to leverage them
3 to drive costs down. In the -- contracting with
4 facilities and providers and PBMs, we are going back and
5 forth, and having numerous conversations with them. In
6 New York there isn't a process in place like the Green
7 Mountain Care Board oversight. So it's on the onus of the
8 carriers to go out to providers and facilities and
9 negotiate the best possible contracts possible.

10 Our goal is to deliver an affordable premium
11 rate. So in this filing 89 percent of every premium
12 dollar is going towards either medical or pharmacy
13 expenses, so we recognize how important it is that we try
14 and manage costs down. So we do go through comprehensive
15 back and forth process with our providers and facilities
16 to try to keep costs down to deliver the lowest premium
17 rate possible. And on the PBM side, that's a vendor that
18 -- they are actually a third-party vendor. Every couple
19 of years we bring in numerous PBMs and try to understand
20 what are the -- what is the best -- which PBM can provide
21 us with the best discounts off average wholesale prices
22 and the most rebate.

23 So we are, again, in the effort of trying to
24 keep costs down to make premium rates as affordable as
25 possible. We are going through a negotiation process with

1 our PBMs every couple of years, and then in between those,
2 you know, RFPs, we are actually going back to the PBM we
3 are contracted with and doing a renegotiation to the
4 extent it's needed. The PBM is also providing a lot of
5 value to us in the sense that they are helping us
6 understand as drugs are coming off a form -- as drugs are
7 coming off patent, and we are adjusting our formularies,
8 so just to give a little bit of background. When a drug
9 is approved by the FDA, there is an exclusivity period.
10 During that time period it's deemed as a brand drug, and
11 they are generally more expensive than generic.

12 So after the patent expires, when the generic
13 -- when a generic drug is released, MVP evaluates its
14 formulary and makes a decision on if we need to make an
15 adjustment to the formulary to remove the higher cost
16 brand drug from the actual formulary list.

17 Q. Thank you. And on administrative costs, you
18 testified to that to some degree already. But how does
19 MVP undertake initiatives to address administrative costs?

20 A. Over the last handful of years it's been an
21 MVP corporate-wide initiative to manage our admin costs
22 down. A number of years ago we had identified that our
23 administrative costs were out of line with our peers. So
24 in an effort to improve on that charge, we have managed
25 the costs down significantly over time.

1 Now as inflation has taken place and years
2 have gone by, we do have to put some efforts towards
3 updating technology. Health insurance is a very
4 technologically-based industry. We do have to put some
5 efforts and money towards improving our technology. But
6 otherwise, it is always our focus on trying to keep our
7 costs down to the point where we are maintaining statutory
8 reserves, meeting our statutory reserve requirements. And
9 offering an affordable premium to the extent it's
10 possible.

11 Q. Thank you. And would you explain MVP's use of
12 the nationwide network, how that works?

13 A. Yes. So MVP only operates in New York and
14 Vermont. But we also recognize that people travel all the
15 time, whether it's for work or vacation. And at those
16 times you may need to access a provider. Additionally,
17 there are points where you may not want to go to a
18 provider in upstate New York or Vermont, and you would
19 rather go somewhere like the Mayo Clinic or somewhere
20 outside of the northeast.

21 So MVP contracts with another carrier that's a
22 nationwide carrier to ensure that you can have peace of
23 mind and access to a high-quality provider or facility
24 regardless of where you are in the country.

25 Q. Thank you. And then the last category, Matt,

1 was on managing the plan and membership, which are items
2 34, 35, 39 and 42. Rather than going through each one
3 specifically, could you please describe how MVP's
4 managing the plan membership to keep costs down and
5 address the issues of affordability and other non-
6 actuarial issues?

7 A. Yeah. So we participate -- the Vermont Health
8 Connect is an ACA-compliant, small group, individual
9 product offering. So we are taking advantage of the
10 benefits included with that which includes the advance
11 premium tax subsidy which comes from the federal
12 government, and in the State of Vermont there is an
13 additional one and-a-half percent for lower income
14 individuals. So that's helping set a ceiling on how much
15 a given member can pay out of pocket for premium if they
16 meet certain federal poverty restrictions.

17 We are also offering non-standard plans to
18 members so that we can offer a different benefit design
19 that we think is going to attract them. So not everybody
20 wants to purchase the standard benefit design. It may not
21 be a cost sharing structure that is in their best
22 interest. So we offer non-standard plans to try to fill
23 those gaps for consumers. And also, we are continuing to
24 participate in the CSR program. We aren't being funded
25 for it, by the federal government. We are receiving the

1 Vermont funding.

2 But on top of that we also have the Silver
3 Reflective Plans as a result of the CSR defunding. So
4 that consumers that aren't eligible for APTCs or CSR can
5 purchase a Silver Plan that isn't loaded up for the CSR
6 defunding.

7 Q. And what about drug classes being considered
8 preventative?

9 A. Yeah. Additionally, we are -- we are
10 undertaking initiative this year. There's been a lot of
11 studies that have been performed that's shown that mental
12 health -- there is a lot of overlap with mental health
13 substance abuse disorders with overall health of a member
14 or of a person, I should say. And we are undertaking
15 efforts to try to in-source a lot more mental health and
16 substance abuse work and ensure that we can manage the
17 cost of those members more effectively.

18 Q. Matt, if you would go -- just to wrap up this
19 section. If you go to page 2 of the exhibit of Exhibit 5.

20 A. Okay.

21 Q. Based on all the testimony that you provided
22 on these various other factors in your testimony earlier
23 today, can you explain how all that can be summed up in
24 responding to issues 1 and 2.

25 A. It's important that MVP not only puts forth

1 the most affordable premium rate relative to the benefits
2 being offered, but also high-quality product. So we have
3 a lot of different programs in place that we just
4 discussed to try to ensure that not only is the member
5 receiving an affordable product, but also high quality
6 product that gives them access to providers, facilities
7 and pharmacies around the country.

8 Q. Thank you. Okay. Matt, in your opinion is
9 there a long-term risk in making health insurance
10 affordable for just one year and undercutting price for
11 one year?

12 A. It depends on the magnitude. In one year in
13 isolation if it isn't -- magnitude isn't huge, then it
14 wouldn't impact a well-operating insurer's solvency. But
15 if it continues to happen year over year over year, MVP's
16 current reserve position -- MVP is down south in New York.
17 We don't operate under RBC. I know Vermont is an RBC
18 state, but New York's guidelines are more percentage of
19 premium based. The minimum percentage of premium of
20 reserves available for an insurer is 12 and-a-half
21 percent. Our comfort level is closer to 16 to 20 percent.
22 And right now we are somewhere in the 14 and-a-half to 15
23 percent premium range.

24 As I was mentioning just a moment ago, one
25 given year if the magnitude of the cut isn't too severe,

1 it won't take us from 14 and-a-half percent below our 12
2 and-a-half percent threshold, but over time there is risk
3 that if rate cuts continue, that our reserve position is
4 going to get worse and worse and closer to the 12
5 and-a-half percent minimum.

6 Q. Thank you. Matt, I just want to go through
7 the statutory criteria. As I understand it, we have an
8 amended rate, and the 10.5 increase suggested by L&E with
9 the statutory criteria and we are suggesting an additional
10 .5 percent increase for the hospital budget proposals,
11 that gets you to 11 percent; correct?

12 A. Correct.

13 Q. Based on the rate filing, other evidence and
14 your testimony today, do the MVP rates meet the standard
15 of affordability?

16 A. Yes.

17 Q. Based on the rate filing and other evidence
18 submitted today and your testimony today do the rates
19 promote quality of care and access to healthcare?

20 A. Yes.

21 Q. Based on the rate filing and your testimony
22 and other evidence submitted today, are the rates unjust,
23 unfair, inequitable, misleading, or contrary to law?

24 A. They are not.

25 Q. Is that because the rates are reasonable based

1 on the data that we have?

2 A. Yes.

3 Q. And are the rates actuarially sound and fairly
4 charged premium for services covered?

5 A. With the adjustments. Yes.

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

8 A. No.

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

11 A. Yes.

12 Q. Would you agree that rates may be considered
13 adequate if they provide for payment of claims,
14 administrative expenses, taxes, and regulatory fees, and
15 have a reasonable contingency or profit margins?

16 A. Yes.

17 Q. So the rates here are adequate?

18 A. Yes.

19 Q. 11 percent?

20 A. Yes.

21 Q. Would you agree that rates may be considered
22 excessive if they exceed the rate needed to provide for
23 payments of claims, administrative expenses, taxes,
24 regulatory fees, and reasonable contingency and profit
25 margins?

1 A. Yes.

2 Q. So is the 11 percent excessive in your
3 opinion?

4 A. No. It's not.

5 Q. Would you agree that rates may be considered
6 unfairly discriminatory if the rates result in premium
7 differences among insureds within similar risk categories
8 that one, are not permissible under applicable law, or
9 two, in the absence of applicable law do not reasonably
10 correspond to differences in expected costs? Do you agree
11 with that standard?

12 A. Yes.

13 Q. So is the 11 percent proposed by MVP unfairly
14 discriminatory?

15 A. It is not.

16 Q. Would you agree with me that the statutory
17 criteria we just went through are all interrelated?

18 A. Yes.

19 Q. They are not separately siloed?

20 A. There is interdependence of them. I agree.

21 Q. Any adjustment to a rate increase for whatever
22 reason, plus or minus, all feeds into that final number;
23 correct?

24 A. That's correct.

25 Q. And it's important that that final number is

1 actuarially sound and reasonable; correct? In this case
2 the 11 percent?

3 A. Correct.

4 Q. In contrast, excuse me, and if the board cuts
5 the final number based on a non-actuarial ground could
6 that adequacy of the rate be in jeopardy?

7 A. Yes.

8 Q. And in contrast, based on your testimony and
9 the other evidence that's in evidence, the insurance
10 product is affordable with the 11 percent increase, in
11 your opinion does that strike the right balance under all
12 the statutory criteria?

13 A. It does.

14 Q. And is that the best rate in your view for
15 2020?

16 A. Yes.

17 Q. Thank you very much.

18 MR. BARBER: Are you finished with the
19 questions?

20 MR. KARNEDY: I am.

21 MR. BARBER: Okay. Mr. Angoff, do you
22 have questions for this witness?

23 MR. ANGOFF: Yes, I do.

24 CROSS EXAMINATION

25 BY MR. ANGOFF:

1 Q. Good morning, Mr. Lombardo.

2 A. Good morning, Mr. Angoff. How are you?

3 Q. I would just like to make sure that I
4 understand and make sure the board understands certain
5 concepts. Turn to page -- Exhibit 2 page 23.

6 MR. KARNEDY: Page 23?

7 MR. ANGOFF: Page 3 of the amended rate
8 filing Exhibit 2.

9 THE WITNESS: Title at the top is
10 "Experience Period Claims."

11 BY MR. ANGOFF:

12 Q. Correct. In the last paragraph you talk about
13 IBNR; do you see that?

14 A. Yes.

15 Q. Could you explain to the board what IBNR is?

16 A. IBNR is an estimate of your outstanding
17 liabilities, so if you go to the doctor today, the claim
18 may not be paid for three months or so. And based on
19 statutory guidance -- so you can evaluate an insurer's
20 claim adequacy, and their income statements. You have to
21 hold appropriate reserve levels. Those reserve levels are
22 audited by a third party every year to ensure they are
23 within a range of reasonableness.

24 Q. So is it fair to say then when you include
25 IBNR that is your best estimate of how much you're

1 ultimately going to pay out?

2 A. Yes.

3 Q. You're not including any fudge factor or any
4 variance; that's your best estimate?

5 A. That's our best estimate.

6 Q. Very good. Can you turn to page 7, or page
7 27. Exhibit 2.

8 A. Okay.

9 Q. Okay. And there you discuss the -- what you
10 originally were going to do with AHPs, with respect to
11 AHPs. I'm sorry. There you discuss what you were
12 originally going to do based on what was AHP, what was the
13 law related to AHPs when you filed your rate filing. Just
14 so I make sure that I understand what the ultimate outcome
15 is.

16 Originally is it fair to say you were going to
17 raise your rates by 1 percent because AHPs were going to
18 be allowed in Vermont in 2020?

19 A. That's a true statement.

20 Q. Okay. And based on the -- the DFR guidance
21 and the federal court case striking down the Federal Rule
22 on AHP's it's now the case, isn't it, that in Vermont AHPs
23 will not be allowed to be sold in 2020?

24 A. That's my understanding.

25 Q. And therefore, you no longer include that 1

1 percent that you originally included based on what was
2 then your -- what was then the law with respect to AHPs?

3 A. That's correct.

4 Q. Okay. And let me just make sure I understand
5 the arithmetic. You were going to raise rates by 1
6 percent, and I thought I saw a number in here, or maybe it
7 was in L&E's report, saying that because AHPs are not
8 going to be allowed in 2020, the rate comes down by
9 8/10ths of a percent not one percent.

10 Could you explain the arithmetic there?

11 A. Yeah. This is a claim adjustment. The .8
12 percent is also considering the impact of our
13 administrative loads, and taxes and fees, and CTR.

14 Q. Okay. So administrative load and CTR aside,
15 if you're going to -- put those aside for a second.

16 A. Okay.

17 Q. If you're going to make a change that raises
18 rates by 1 percent, and decide not to make that change,
19 does that mean that that 1 percent proposed increase is no
20 longer applicable?

21 A. It's a 1 percent claim adjustment. So you do
22 have to account for the target loss ratio of approximately
23 89 percent, which is where you arrive at the .8 percent,
24 plus it's the reciprocal, so it's one divided by that
25 number. So the .8 percent is the result of those two

1 different items.

2 Q. I'm sorry. Is the result of what two
3 different items?

4 A. Adjusting for administrative expenses, and
5 taxes and fees, and CTR. As well as the fact that it's
6 just an arithmetic thing, you have to flip the numbers
7 around so 110 divided by 100 is plus 10 percent. 100
8 divided by 110 isn't exactly minus 10 percent.

9 Q. Okay. Did you say earlier that MVP in the
10 past year did not get into the AHP business at all?

11 A. That's correct.

12 Q. And why was that?

13 A. At the time the ruling was passed, after we
14 had the ability to adjust and even contact AHPs and former
15 -- and submit a filing for 2019. Beyond that, I really
16 was not involved in those conversations. So I can't
17 really provide any more input.

18 Q. Okay. And did you make any assumption as to
19 what -- what happened to the people currently in AHPs in
20 2020 in -- putting together your rate filing?

21 A. Yes. Could you clarify exactly?

22 Q. Yeah. So there will be no new people on AHPs
23 in 2020; correct?

24 A. Well my understanding is there will not be new
25 people in AHPs in 2020. There also will not be the

1 existing people that are enrolled in AHPs in 2019. They
2 will have to find insurance through the Vermont Health
3 Connect or another way.

4 Q. Okay. And what did you assume about those
5 people in AHPs in 2020 -- in 2019 who have to find new
6 coverage?

7 A. We assumed that the members that left the
8 Vermont Health Connect market and went to AHPs were
9 materially healthier than the members that stayed in AHPs.
10 We assumed that we would see a similar transition in 2020.
11 So there was a second year adjustment as well.

12 Q. So you assumed that at least some of those
13 people would come back to MVP; correct?

14 A. What's on page 27 of this document is assuming
15 that there is going to be more members leaving the Vermont
16 Health Connect market, because the rates that are offered
17 by AHPs by our competitor are more aligned with MVP's
18 exchange rates. So we were anticipating a similar
19 migration in 2020 away from MVP. Nobody coming back to
20 MVP.

21 Q. You were assuming that no one currently in an
22 AHP would come back to MVP?

23 A. In the submitted rates in the amended filing
24 that we are reviewing?

25 Q. I'm sorry, no. Now. Based on the law today.

1 What, if anything, are you assuming as to the extent to
2 which people then in AHPs would come back to MVP?

3 A. Well we are hoping to attract more than the
4 approximately 1,000 members that we expect that we lost.
5 All that said, the way that premium rates are set it's
6 based on market-wide average risk. So if they come back
7 into the market, once we take our claims from 2018 and
8 adjust for risk adjustment, our rates would not change
9 based on if they came to us or if they went back to Blue
10 Cross.

11 Q. Okay. So those people are healthier than the
12 average in the market; right?

13 A. They are healthier than the members that MVP
14 was insuring.

15 Q. But you're not assuming that -- you're not
16 assuming any rate decrease for the people -- for those
17 people who are healthier who would come back to MVP?

18 A. Again, it's because we are pricing to market-
19 wide average risk. So their lower claim costs would be
20 offset by a payment into risk adjustment which is captured
21 in our 2018 data because AHPs did not exist. Once you
22 account for the fact that we are paying into risk
23 adjustment, then that gets us to the market-wide average
24 risk prior to AHPs existing.

25 Q. So you're not assuming any separate rate

1 reduction because of the people who would come back to
2 MVP, who are now in the AHP market?

3 A. I'm not.

4 Q. I'm sorry?

5 A. We are not.

6 Q. Could you turn to page 6. I'm sorry. Page
7 26. Middle of 6.

8 A. Okay.

9 Q. And in the middle of the page you see there
10 the paragraph beginning: "Line 18 Adjustment for
11 Individual Mandate Penalties Set to Zero"?

12 A. Yes.

13 Q. Okay. Am I correct in understanding the
14 following. That last year MVP assumed that because the
15 individual mandate equalled zero that it was approximately
16 2 percent of -- an approximate 2 percent increase because
17 MVP assumed that the healthiest people would leave because
18 of the zero penalty for the individual mandate; correct?

19 A. I don't recall the exact adjustment, but we
20 did have an upward adjustment for what you described.

21 Q. Okay. And MVP wasn't alone in assuming that;
22 right?

23 A. That's correct.

24 Q. In fact, you relied on a study by L&E that
25 said essentially the same thing; right?

1 A. We did our own study, and they were
2 comparable, and we adopted L&E's analysis.

3 Q. Okay. But, in fact, you found that there was
4 no effect of the zero penalty for the individual mandate;
5 correct?

6 A. In the Vermont Health Connect market we did
7 not see a change in 2019 individual marketplace
8 enrollment.

9 Q. So you just -- so you took out the -- so
10 explain what you did then in this filing with respect to
11 the individual mandate.

12 A. We are not making an adjustment, because we
13 are seeing that the 2019 -- 2019 enrollment is comparable
14 to 2018 enrollment. So an adjustment isn't warranted.

15 Q. So how much does that reduce the rate by?

16 A. I would have to go back to the 2019 filing. I
17 don't know that off the top of my head.

18 Q. Okay. But it's the same amount as was in the
19 2019 filing?

20 A. Yes.

21 Q. You're not assuming that -- strike that.
22 That's fine. Could you turn to page 4, please.

23 A. 24 or 4?

24 Q. Page 24 of Exhibit 2. Page 4 of the rate
25 filing.

1 And do you see on the bottom of that page
2 there is discussion about a pooling charge?

3 A. Yes.

4 Q. Okay. Could you explain to the board what the
5 pooling charge is?

6 A. Yeah. Claims -- high-cost claims are very
7 volatile. So, in general, your claim curve will kind of
8 look similar from year to year, not to get too much into
9 the actuarial mechanics of it, but if you were to really
10 zoom in on just that last 5 percent or so of claimants,
11 the really high-cost claimants, there is a lot of annual
12 volatility from year to year. So we chose a hundred
13 thousand dollars; a hundred thousand dollars. And we
14 analyzed three years of data to understand the historical
15 average of that claim volatility, and the average claims
16 are in excess of \$100,000. We remove claims over \$100,000
17 from the experience period, and then we replace that with
18 the historical three-year average.

19 Q. And so is that the methodology that you
20 followed in past years too that you always use the
21 historical three-year average?

22 A. Yes.

23 Q. Okay. When you say high-cost claims in this
24 case, what you mean by high-cost claims is claims
25 exceeding a hundred thousand dollars; right?

1 A. That's correct.

2 Q. And you see the table on the top of page 25?

3 A. Yes.

4 Q. Okay. And you see there the percentage of
5 high-cost claims has decreased over the last three years;
6 right?

7 A. Yes. Yes. That is the trend that we have
8 seen in recent years.

9 Q. Did you consider the possibility that maybe
10 the trend is downward, and therefore instead of taking a
11 three-year average, you should weigh the most recent year
12 -- either weigh the most recent year the most heavily or
13 even assume that downward trend is going to continue. Did
14 you consider that?

15 A. We had conversations about that. But it truly
16 is incredibly volatile from one year to the next.
17 Additionally, these high-cost claimants, as we have grown
18 our enrollment, L&E even commented in their opinion that
19 we are insuring lower cost, lower benefit members. So you
20 would see a -- potentially a decrease in here which you're
21 paying back in, but again, paying back in through risk
22 adjustment. But there is so much volatility. If you look
23 at the tail of any carriers' claims from year to year, for
24 example, you know there is the national reinsurance pool
25 of one million dollars, the national reinsurance pool that

1 we discussed earlier. And while MVP didn't have any
2 claims exceeding that threshold in Vermont, we did
3 experience some in our New York markets.

4 But then in prior years before that we didn't
5 experience any of those claimants in our New York markets.

6 Q. You're talking now though about claims
7 exceeding one million; right?

8 A. Yes.

9 Q. Okay. So when you say there is a lot of
10 volatility, you were referring initially, weren't you, to
11 the claims above a hundred thousand dollars?

12 A. Yes.

13 Q. Okay. And the chart on the top of page 5
14 shows high-cost claims decreasing from 16.8 to 10.5
15 percent over three years. Do you view that decrease --
16 the difference between the 16.8 and the 10.5 as highly
17 volatile?

18 A. There is significant volatility in claims over
19 a hundred thousand dollars.

20 Q. And so is that 16.5 to -- 16.8 to 10.5, is
21 that the basis for your conclusion that there is
22 significant volatility?

23 A. That's the basis of our 12.5 percent
24 adjustment.

25 Q. Is it the basis for your conclusion that there

1 is significant volatility?

2 A. No. I mean that's just based on a lot of
3 other actuarial studies and data that we have analyzed
4 that there is volatility.

5 Q. Did you happen to recall what the highest
6 percentage high-cost claims was in the years that you have
7 been reviewing these claims in Vermont?

8 A. I do not.

9 Q. Would it be more than 20 percent?

10 A. I do not recall what the overall range was.
11 This is what I have in front of me, and this is what I can
12 speak to right now.

13 Q. Would you be surprised if it were over 20
14 percent?

15 A. I wouldn't be surprised if it were over 20
16 percent. I also wouldn't be surprised if it were less
17 than 10.5.

18 Q. Can you turn please to page 8. I'm sorry.
19 Page 28.

20 A. I was going to Exhibit 8. 28 in Exhibit 2.

21 Q. Page 8 of the exhibit -- page 28 of the
22 Exhibit 2.

23 A. Okay.

24 Q. Okay. And we were just discussing this. This
25 is in the line 21. Do you see that adjustment for

1 national high-cost reinsurance pool?

2 A. Yes.

3 Q. And you said that the .24 by which you're
4 raising rates should not be reduced because you don't
5 anticipate a -- you haven't had and you don't anticipate
6 any claims above one million in Vermont; correct?

7 A. It's not a projection of what we anticipate.
8 It's what happened in the 2018 experience period that we
9 are using to set our rates. If there were a claimant in
10 2018 that were in excess of one million dollars, we would
11 be capturing the impact of the recovery from the CMS
12 national reinsurance pool and the rate development, and
13 then also building in the charge that we would have to pay
14 into the program.

15 Q. You do say, don't you, in that -- in the last
16 paragraph under line 21 that you do not anticipate any
17 claimants for the rating period.

18 A. That is -- yes. That is a statement that is
19 being made.

20 Q. And do you know whether in Vermont there has
21 ever been a claim that MVP has had that has exceeded one
22 million?

23 A. In the ACA-compliant market?

24 Q. Correct.

25 A. I believe we have not.

1 Q. Could you turn, please, to page 5. Or page
2 25.

3 A. Okay.

4 Q. I'm sorry. I keep referring to the number of
5 the rate filing. We understand each other; right? Page 5
6 of the rate filing is page 25.

7 A. For this exhibit. Yes. That's correct.

8 Q. On the bottom of the page there you refer to
9 something you wish -- I don't quite understand -- and that
10 is the second to last paragraph, the last full paragraph
11 you talk about a change in methodology to normalize the
12 date for the historical average policy duration.

13 Could you explain that to a non actuary?

14 A. Yes. So all of the contracts are calendar-
15 year contracts in the Vermont Health Connect market. So
16 they begin when you enroll and they end on 12/31 of the
17 calendar year. And in prior years we were making
18 adjustments for the fact that just because we had someone
19 that enrolled during a special enrollment period or
20 someone that stopped covering -- stopped having -- paying
21 their premiums or having insurance coverage at some point
22 during the year, we were adjusting our claim projection up
23 to a full contract. That also had something to do with
24 the fact that we anticipated there would be changes in the
25 market with the Vermont -- with the individual mandate

1 policy being set to zero.

2 But based on what we actually have experienced
3 in recent years, and the fact that the individual
4 enrollment hasn't changed, even with the individual
5 mandate penalty being set to zero, we are not making that
6 adjustment this year and assuming that our historical data
7 is representative of what will happen in the 2020 year.

8 Q. Had you used the old methodology would the
9 rate recommendation be higher or lower?

10 A. Given that these are calendar-year contracts,
11 it would have been higher.

12 Q. Could you turn, please, to page 11.

13 A. 31 or 11?

14 Q. Page 11 of the rate filing. Page 31 of the
15 exhibit.

16 A. Okay. Thank you.

17 Q. And do you see there down under the last
18 section: "General Administrative Expense Load."

19 A. Yes.

20 Q. Okay. It's true, isn't it, that MVP has been
21 expanding substantially in Vermont?

22 A. Yes.

23 Q. And it's also true, isn't it, that all things
24 equal, as a company acquires more business, administrative
25 expenses should go down?

1 A. Yes. But we are not growing overall as an
2 enterprise. We are contracting, which we addressed
3 earlier.

4 Q. I'm sorry. Could you repeat that?

5 A. We are contracting enterprise wide. So we
6 operate in New York and Vermont. Our New York membership
7 losses are outweighing the membership gains in Vermont.
8 And we have to spread our administrative costs for a
9 number of services over both states.

10 Q. Okay. So administrative services are not
11 applicable then to Vermont and New York. You spread those
12 administrative costs company wide; is that correct?

13 A. We generally manage enterprise wide, but we do
14 analyze state by state. So we did our best to estimate
15 specific costs based on block of business that we are
16 rating.

17 Q. But you're not calculating those
18 administrative costs for Vermont only. You're calculating
19 them, aren't you, based on your company-wide
20 administrative costs?

21 A. Yes. But we are company wide, but there is
22 also a component underlying it which is what is the cost
23 -- the variable expense associated with covering
24 Vermonters versus New York small group or individual
25 members.

1 Q. Well could you explain that? Of your --

2 A. I'm sorry.

3 Q. Your \$42 PMPM assumption on administrative
4 costs, how much of that is based on allocating
5 company-wide costs to Vermonters, and how much is based
6 solely on Vermont?

7 A. I don't have that data available. I don't
8 know that off the top of my head. We do have a team that
9 manages costs, that manages our financial or
10 administrative cost projections. So what is specifically
11 Vermont related versus New York related, I can't speak to
12 that.

13 Q. But Vermont-related costs wouldn't go up,
14 would they?

15 A. Well it depends on what changes are taking
16 place, and you have to balance membership changes versus
17 fixed costs in Vermont versus variable costs in any
18 projects that we are undertaking such as, as I was
19 addressing earlier, updating technology to improve our
20 processing or member experience.

21 Q. And your Vermont business is expanding, has
22 expanded very substantially over the last several years,
23 so you would expect to the extent that you -- that you
24 calculate the administrative expenses based on your
25 Vermont business, administrative costs would go down,

1 wouldn't they?

2 MR. KARNEDY: Objection. Asked and
3 answered.

4 MR. BARBER: I was trying to write.
5 Sorry. So I missed the question. So if you could
6 ask the question.

7 THE WITNESS: Okay. Could you please
8 re-ask the question?

9 MR. ANGOFF: Yeah.

10 BY MR. ANGOFF:

11 Q. We all agree MVP has expanded its business in
12 Vermont. My question is, that based on that expansion
13 looking solely at Vermont business, shouldn't
14 administrative expenses go down?

15 MR. KARNEDY: Same objection.

16 MR. BARBER: I'll allow it. Please
17 answer.

18 THE WITNESS: You have to analyze the
19 overall cost of administrative expenses. As I was
20 referring to our claims operating system earlier,
21 that is physically housed in New York State. But the
22 same operating system is being used by Vermonters and
23 New Yorkers alike, so the cost of those items need to
24 be understood relative to our enterprise-wide
25 membership.

1 There are certain expenses that would
2 be Vermont specific. With expansion that would
3 change and decrease all else equal. But the
4 enterprise-wide membership shift does have an impact
5 on the overall PMPM rate charge to New Yorkers and
6 Vermonters.

7 BY MR. ANGOFF:

8 Q. Okay. And just as administrative costs must
9 be looked at company wide, so must total adjusted capital,
10 musn't it?

11 A. Yes.

12 Q. Okay. And you're familiar with the
13 Commissioner's opinion in Exhibit 10, the solvency
14 opinion; correct?

15 A. Correct.

16 Q. Okay. And you recall on page 2 of that
17 opinion he says that MVP's Vermont business accounts for
18 about 4.8 percent of MVP's total business?

19 A. Yes.

20 Q. So just doing the arithmetic, it's correct,
21 isn't it, that any effect of the CTR in Vermont on MVP's
22 company-wide total adjusted capital is trivial; correct?

23 A. I wouldn't agree with that. We do set our
24 premium rates to be self sustaining and self supporting.
25 Similar to -- similar to Attorney Karnedy's comment

1 earlier about building up stones, if you were to remove
2 that stone and Vermont was running at a significant loss,
3 it could cause the tower to crumble.

4 Q. I appreciate Attorney Karnedy's reference to
5 Zen, and I appreciate your reference to Zen. But the
6 question was, given that Vermont business accounts for
7 less than 5 percent of MVP's business, whether there is a
8 CTR of 1.5 or 1 or .5 or 0 or a couple of points less than
9 zero, is not going to have an effect, a material effect,
10 on MVP's total adjusted capital; correct?

11 A. It would depend on the order of magnitude. We
12 are growing. So 4.8 percent is, I think, more material
13 than kind of the way that's being referenced. And in a
14 given year that wouldn't cause us to have strain, but over
15 the long haul, if we continue to write our business at
16 material losses, that's going to be problematic.

17 As I was referencing earlier, the minimum
18 reserve requirement in New York state is 12 and-a-half
19 percent. We're only at 14.5 right now to 15. Somewhere
20 in that range. So if we were to continue writing losses
21 and we are facing regulatory pressures in both markets,
22 both markets we are facing similar challenges, then there
23 is a significant opportunity or risk that something could
24 happen if we continue to write Vermont business at a loss.

25 We will get closer to that 12 and-a-half

1 percent which would cause challenges for us.

2 Q. Let me understand that 12 and-a-half percent.
3 That's not Vermont law; correct?

4 A. That's correct. That's New York.

5 Q. Okay. And so New York what does that 12
6 percent refer to? New York requires that what be 12
7 and-a-half percent?

8 A. Your capital and surplus is 12 and-a-half
9 percent of the premium.

10 Q. Company wide; correct?

11 A. Enterprise -- well company wide. Yes. Every
12 legal entity.

13 Q. You're not saying then that New York has a
14 specific requirement as to what the contributions to
15 reserves in Vermont should be?

16 A. They do not. They manage MVP solvency based
17 on the legal entity and business in New York and Vermont.

18 Q. And there is no provision of New York law or
19 regulation, is there, that requires MVP to have a certain
20 amount of capital allocated to Vermont?

21 A. There is not that -- I'm not an expert on that
22 law. I don't believe there is. So --

23 Q. I would like you to turn, please, to page 9.

24 A. In which exhibit?

25 Q. Exhibit 2. Page 29 of the -- page 9 of the

1 rate filing. 29 of the exhibit.

2 A. Okay.

3 Q. And do you see under "Prescription Trend
4 Factors" in the fourth paragraph you talk about the
5 allowed prescription trend of 8.2 percent and the paid
6 prescription trend of 9.6 percent; do you see that?

7 A. Yes.

8 Q. Could you explain to the board what the
9 difference between the allowed trend and the paid trend
10 is?

11 A. Yes. Allowed trend is looking at cost
12 inflation or unit cost plus utilization. Paid trend is
13 accounting for fixed cost share leveraging. So an example
14 would be if you have a benefit where there is a \$10 copay,
15 and the cost of a drug is \$20, then that means that a
16 member -- that MVP would pay 20 minus 10 which is \$10.
17 If there is a 10 percent trend, allowed trend, then the
18 \$20 drug becomes 22. But then the \$10 copay is fixed. 22
19 minus 10 is 12 dollars, which 12 over 10 is 20 percent.
20 So that's the impact of the leveraging is going from the
21 10 percent in that example up to 20 percent.

22 Q. Okay. Could you turn, please, to Exhibit 6.

23 A. Okay.

24 Q. And go to the third page of that exhibit, that
25 little chart there. Do you see that?

1 A. Yes.

2 Q. Okay. And if you go down to the fifth row, it
3 says, "Allowed Prescription Trend." Do you see that?

4 A. Yes.

5 Q. Okay. And then under 2017, it shows, doesn't
6 it, the proposed trend of 11.9 and allowed trend of 11.9
7 and then the actual trend of much lower than that; 4.4.
8 Do you see that?

9 A. I see that.

10 Q. Okay. And so does the difference between the
11 11.9 which you all proposed and the 11.9 -- and in
12 fairness the 11.9 to which L&E agreed, does it give you
13 any pause that the -- because the actual was so much less
14 than what you all and L&E had estimated as reasonable,
15 that maybe your proposed for this year is also too high?

16 A. Well there is a risk-adjusted market, so you
17 have to take into account any changes in the population
18 and how the actual pharmacy trend or pharmacy claims would
19 be impacted by risk adjustment. So I always think that in
20 a risk-adjusted market you need to look at trend after
21 accounting for risk adjustment.

22 This is -- the 11.9 versus the 4.4 that's
23 assuming a static population. If we were to enroll a
24 healthier population, then that could go down to represent
25 a lower figure. But then we would potentially pay more

1 into risk adjustment to offset that.

2 Q. Okay. And would risk adjustment though
3 account for that much of a difference? I mean the 11.9 is
4 more than 2 and-a-half times the 4.4. The risk adjustment
5 have that much -- make that much of a difference?

6 A. It could. Yes. It could.

7 Q. Have you ever seen it make that much of a
8 difference with respect to drug trend?

9 A. It's -- the way the risk adjustment system is
10 developed, it's hard it isolate any one component and what
11 the driver is. You have to look at everything in totality
12 in my opinion. Trend -- overall trend adjusted for risk
13 adjustment.

14 Q. Could you turn to, please, to Exhibit 5. And
15 on page 2 of that exhibit you were going through with Mr.
16 Karnedy some of the -- some of 44 things that MVP is
17 doing, many of which are clearly laudable to reduce costs;
18 correct?

19 A. Correct.

20 Q. Of all those 40 -- can you point to any of
21 those 44, which include or refer to any data,
22 demonstrating that Vermonters can afford what MVP is
23 selling?

24 A. What we are presenting is data to show -- to
25 support that we are putting forth a rate that's affordable

1 relative to the benefits being offered, and we are doing
2 our best to manage costs down while also providing access
3 and quality care.

4 Q. No question that these 44 things are, as I
5 said, laudable. You're trying to reduce costs. You're
6 trying to improve quality. Can you point me to any data
7 demonstrating that Vermonters can afford what MVP is
8 selling?

9 A. We do not address affordability of these
10 benefits relative to what a Vermonter can afford. We are
11 also limited in a lot of regards by the federal government
12 APTC and CSR regulation. So for certain policyholders,
13 they are just bound to whatever the APTC amounts are. But
14 outside of that, we aren't addressing anything in terms of
15 if a Vermonter can deem this as an affordable product.

16 Q. You're senior leader of actuarial services;
17 correct?

18 A. That's my title.

19 Q. Are you senior leader of actuarial services
20 for only Vermont or the whole company?

21 A. The whole company.

22 Q. Then you're familiar with MVP's New York rate
23 filing; correct?

24 A. Correct.

25 Q. Okay. How much of an increase did MVP ask for

1 in New York this year?

2 A. I would have to refer back to it. In the --
3 so I would have to refer back to it. Anything would be
4 speculation. But one given rate increase in a market in
5 Vermont versus New York, everything is relative to one
6 another. So to the extent that there is adjustments that
7 are put forth in Vermont, or just the trends that are
8 being proposed are different, that's going to impact the
9 rate increases that we are putting forth.

10 MR. ANGOFF: I have no further
11 questions.

12 MR. BARBER: Okay. So I think time for
13 the board to get an opportunity to ask questions. Do
14 you want to just start down at the end of the table,
15 Robin?

16 MS. LUNGE: Sure. Good morning.

17 THE WITNESS: Good morning. How are
18 you?

19 MS. LUNGE: Good thanks. Could I ask
20 you to please turn to -- I'm just going to use
21 Exhibit 1 because I don't think there is a change
22 between 1 and 2. Page 12 using either numbering
23 system.

24 THE WITNESS: Yeah. Was it page 12?

25 MS. LUNGE: Yes. So you had talked

1 about some enhancements to your current wellness
2 benefit. Could you describe those to us, please?

3 THE WITNESS: Yes. So there is three
4 different components to the wellness benefit. Each
5 of them provides a subscriber with up to \$200 in
6 reimbursement. One of them would be reimbursements
7 for healthy activities like whether it's youth sports
8 activities or a lift ticket at a ski -- at a
9 mountain. That's \$200 that you can receive. Another
10 \$200 is for receiving a personal health assessment
11 and biometric screening. And then if you don't meet
12 the 200 point requirement that's associated with
13 those items, you can take -- there is videos or there
14 is consultation that you can receive to help
15 understand ways to manage your weight, or manage
16 diabetes, or smoking cessation, items like that.

17 And then the last \$200 is attached to
18 members or subscribers that have a wearable device.
19 If you average a certain number of steps per quarter
20 or per day on average, then you can receive \$50 per
21 quarter for meeting that criteria.

22 MS. LUNGE: And so what was the
23 enhancement? Is that a new wellness benefit? How
24 does it change from last year?

25 THE WITNESS: Last year we were only

1 covering gym reimbursement and the activities, and it
2 was at a lower threshold. This year it's -- I
3 believe the adjustment was or the reimbursement was
4 \$50. And this year it's \$600 in total. I would have
5 to double check though the 50, if that's the correct
6 number, but that's what I recall.

7 MS. LUNGE: Okay. Thank you. Could
8 you turn now to Exhibit 5, please.

9 THE WITNESS: Okay.

10 MS. LUNGE: On page 3 using either
11 numbering system.

12 THE WITNESS: Okay.

13 MS. LUNGE: And keeping in mind that
14 part of the answer to number 3 is confidential.
15 Could you talk a little bit about what quality
16 measures you're looking at in your primary care
17 improvement program?

18 THE WITNESS: That's something that I
19 don't know the exact specifics of what we are
20 providing. We can go back -- I can go back and
21 follow up with the team with respect to that program.

22 MS. LUNGE: That would be helpful.
23 Yeah. If you could give us information on the
24 quality measures, that would be helpful.

25 Do you happen to know if those quality

1 measures are aligned with the set of Vermont quality
2 measures that are looked at either in the Vermont
3 all-payer model or the Vermont ACO program?

4 THE WITNESS: I don't specifically -- I
5 wouldn't want to speculate, so I will, you know, if
6 we could, I'll just start to take notes.

7 MS. LUNGE: Great. That sounds
8 perfect.

9 I also wanted to ask you a little bit
10 about your New York experience. So you talked about
11 how New York has a district Medicaid program that has
12 three different levels of payment methodology. Which
13 payment methodology are you participating with in New
14 York?

15 THE WITNESS: Currently we don't have
16 any level 3 full capitation arrangements. We do have
17 a number of level 1 and level 2 arrangements.
18 Generally speaking, when we -- the first year of a
19 contract with a provider group, they generally are
20 only willing to take the level 1 agreement. And then
21 we sign a multi-year contract, and as the contract
22 progresses it may step up from level 1 to level 2.

23 MS. LUNGE: And is the primary purpose
24 of that to allow the provider group time to adjust to
25 the new methodology -- payment methodology?

1 THE WITNESS: The level 1 initial --
2 the outside year, is that what you're speaking to?

3 MS. LUNGE: Yeah.

4 THE WITNESS: Yeah. I think it's to
5 get used to the methodology. It's also -- it's
6 challenging for them to step into an agreement when
7 they don't understand, when they haven't necessarily
8 been managing care in that same way. So they are
9 unwilling -- there's been more challenges getting a
10 provider group to sign contracts in the initial years
11 where they are taking risk. Until they have more
12 data at their fingertips. Again, one of the pros of
13 the value-based arrangements is that more data is
14 being shared between caregivers and providers. So as
15 we -- they accumulate more data, then they can start
16 to be able to manage costs more effectively, and
17 that's when they generally step up from level 1 to
18 level 2 in the contract.

19 MS. LUNGE: Have you changed your care
20 management programs in any way to adjust for that new
21 value-based program?

22 THE WITNESS: That's -- you know,
23 that's another one where I would have to follow up
24 with the team on it. I can make notes.

25 MS. LUNGE: That would be great. And

1 you talked a little bit about in the same exhibit,
2 the care management that you do including a
3 telemedicine program. And my recollection of your
4 testimony was that -- hold on just one second.
5 Actually if we turn to page 5, that's -- 4 to 5 is
6 where you talked earlier -- you described the
7 telemedicine program. So when a Vermonter is using
8 that telemedicine program, they are not reaching
9 their Vermont provider; is that right?

10 THE WITNESS: That's correct.

11 MS. LUNGE: And how does the
12 information from the telemedicine visit get back to
13 the Vermont primary care provider?

14 THE WITNESS: My understanding is that
15 it would be based on the level of consent that's
16 available. Electronic records can be shared if the
17 member consents.

18 Now to the extent that the telemedicine
19 benefit information is transmitted back to the PCP in
20 Vermont, I'm not a hundred percent sure of that.

21 MS. LUNGE: So it's not like the
22 benefit comes with something like the patient
23 technology, for example, that would alert the primary
24 care provider that their patient had received a
25 telemedicine visit from another provider?

1 THE WITNESS: I'm not aware of that.

2 MS. LUNGE: Okay. Thank you. On page
3 6 of the same Exhibit Number, 38. You describe your
4 utilization management program and it's designed to
5 decrease unwarranted variations in care and support
6 appropriate utilization.

7 Do you have any information about
8 trends or specific areas of unwarranted variations
9 that you would -- could speak to in terms of the
10 Vermont population?

11 THE WITNESS: I would have to refer
12 that one back to the medical team as well.

13 MS. LUNGE: Okay. Great. Thank you.
14 On page 7 of that exhibit you describe litigation
15 that you were involved with.

16 Do you have any information since the
17 time of filing to update on this question?

18 THE WITNESS: I'm sorry. What bullet
19 was that?

20 MS. LUNGE: On page 7 you describe
21 litigation that your company is involved in. And it
22 includes the fact that there might be an entry of
23 final judgment in June or July, 2019. I'm wondering
24 if you received that judgment.

25 THE WITNESS: I have not -- no one has

1 transmitted or provided any information to me. I did
2 reach out to our legal team last week. I haven't
3 heard back from them on that.

4 MS. LUNGE: Okay. If you have, could
5 please you let us know?

6 THE WITNESS: Yup.

7 MS. LUNGE: The other question I had
8 was about the new ambulatory surgical center that's
9 opened in Vermont. At the time of filing of the
10 materials, you had not finalized information with
11 that company. I'm wondering if you could give us an
12 update about that.

13 THE WITNESS: We did contact our
14 contracting team to understand -- this was a few
15 weeks ago. So it's not as of today, if the contract
16 has been finalized, and the feedback that we received
17 was it has not yet been finalized.

18 MS. LUNGE: Could you check on that and
19 update that for us?

20 THE WITNESS: Yes.

21 MS. LUNGE: Thank you. That's all my
22 questions for this time.

23 MR. BARBER: Okay. Ms. Holmes? Mr.
24 Pelham. Sorry.

25 MR. PELHAM: Well thank you. So I have

1 -- my first question just has to offer some context
2 here for this discussion. And I refer to Exhibit 11
3 which was the table that you showed the impact on the
4 various plans with the fix that DFR requested for the
5 Gold Plan. And I'm looking at the numbers in terms
6 of the projected 2020 premium versus the current 2019
7 premium. And that's 204.3 million versus 188.6
8 million or .7 million, which is a change of about
9 15.6 million in terms of --

10 THE WITNESS: I'm sorry.

11 MR. BARBER: Which page of the exhibit?

12 MR. PELHAM: Pardon me.

13 MS. HOLMES: Which page are you on?

14 MR. PELHAM: Oh, okay. You're making
15 me work here. It is Exhibit 11.

16 THE WITNESS: Page 6.

17 MR. PELHAM: Page 6. So if you -- I
18 can barely read them with my reading glasses. They
19 are teeny. You're looking at a current 2019 premium
20 at 188.6 million. And a projected 2020 up through
21 this amendment at 204.3 million. And that's a change
22 of 15.6, 15.7 million dollars.

23 THE WITNESS: Okay.

24 MR. PELHAM: So that's the change that
25 we are talking about here in terms of the sense of

1 scale. And I'm -- and we are kind of -- both you and
2 L&E kind of parsed that into 16 different pieces in
3 terms of the moving parts. And, you know, in my
4 experience, which is certainly not in terms of health
5 care projections, but in terms of the state budget,
6 we do the same thing actuarially with economists to
7 try to figure out, you know, where we are going to be
8 down the road.

9 And as one of my fellow board members
10 always tells me, we are never right. You know, there
11 is always a margin of error around it. And so I'm
12 looking at this change in the context of your rapid
13 growth in membership in Vermont. So it's not that
14 there is a stable experience, settled scenario here.
15 You really picked up market share, and you've grown
16 rapidly.

17 So do you think -- and one other
18 context here is that you're looking at MLR in this
19 filing at 90.6, which is an important number to me
20 because it connects the two biggest moving parts
21 which are premiums and claims.

22 So do you sense that that, you know,
23 looking at past filings, going back, I think, to
24 2016, that number has been very volatile. And I'm
25 wondering if you feel that it is kind of settling

1 into a range that you have really solid confidence
2 about.

3 THE WITNESS: The MLR -- so there is
4 items that are outside of our control in some of the
5 MLR items. For example, the ACA insurer tax. The
6 federal government has had a moratorium one or two
7 years, then they have reinstated it. So that's a 1
8 percent charge. That is out of our control. That is
9 going to directly impact the loss ratio from year to
10 year.

11 So the 2019 rates we did not have an
12 ACA charge of 1 percent built in. But this year we
13 have to build that ACA charge back in, so that's
14 going to cause a swing. Additionally, we do have a
15 fixed PMPM administrative load, so depending on how
16 the claim projection is changing relative to our
17 administrative changes from year to year, that's
18 going to have an impact on our loss ratio.

19 So I would say that the MLR -- target
20 MLR there is some items that are outside of our
21 control. So I wouldn't feel confident that what we
22 have today is going to be predictive of what exists
23 in the future. I wouldn't expect significant changes
24 for the items that MVP can control unless there is a
25 dramatic change in claim trend in future years.

1 MR. PELHAM: Well that's helpful. And
2 so I'm wondering if you can do this. I'm looking
3 back at the MLRs that were in the filings in 2016,
4 '17, and '18. And they were 91.3, 91.6, and 89.7
5 according to your supplemental filings with the
6 National Association of Insurance Commissioners. But
7 the actual MLRs on those same documents are at 99.5
8 percent, 77.1 percent, and 91.9 percent respectively.
9 So there is a lot of noise there. And I don't, you
10 know, it would be helpful if you could go back and
11 look at those and kind of connect the dots in terms
12 of what the major moving parts are between what you
13 predicted in your filing or the target in your filing
14 and how things actually unfolded.

15 THE WITNESS: Yeah. I can actually
16 speak to one or two of those items. I know in '18
17 one of the items that's driving the -- first I'll
18 caveat that the NAIC filing is separate. The way
19 that it's measured there is a lot of prior year noise
20 that can be built into it. So, for example, we don't
21 receive our final risk adjustment results -- we
22 didn't receive our 2018 risk adjustment results until
23 June 28 or somewhere around there of 2019. But we
24 have to close our books at the end of December in
25 2018.

1 We make an assumption at that point
2 about what we anticipate our risk adjustment payment
3 to be or receipt, depending on the market. So if you
4 look at the NAIC filing, you know, I'll just say that
5 there is a lot of that noise from year to year that
6 can be influencing our loss ratios.

7 Additionally, what's reflected in the
8 fourth quarter of 2017 and 2018 is the CSR defunding.
9 So there is going to be some variances from
10 expectation because those were liabilities that we
11 didn't collect premium for.

12 MR. PELHAM: Well that would just be
13 helpful to have that.

14 THE WITNESS: Okay.

15 MR. PELHAM: Because it's not clear in
16 the NAIC documents of what that experience in
17 volatility are.

18 My next question is, again, looking at
19 page 6 on Exhibit 11 it profiles the 2019 premiums by
20 plan. And so I'm looking at, for example, those
21 numbers relative to federal poverty levels. And so
22 to me there is a really stark contrast between those
23 plans below 400 percent of poverty or customers below
24 400 percent of poverty and those above 400 percent
25 poverty. And it's a wall. It's not a gradual cliff

1 at all. And by -- over the year we worked with DVHA
2 a bit to kind of figure out what that wall looked
3 like. And if I can tell you what we found we could
4 talk about it --

5 THE WITNESS: Yes.

6 MR. PELHAM: -- a bit. So if you're
7 looking at someone just like 399 percent of poverty
8 for a Bronze Plan for a single, and this is for a
9 Bronze Plan. The single premium was \$426 which
10 you'll find on that exhibit. 8 -- but the -- let me
11 step back.

12 The established premium was \$426 a
13 month. Someone below 400 percent of poverty, just
14 below 400 percent of poverty was paying \$203 or 5.1
15 percent of their income. On the other side of that
16 400 percent, someone that's 401 percent, they were
17 paying the full premium because there is no subsidies
18 at all. And that's 9.36 percent of their income.

19 Similarly, for a couple if you're just
20 below the 400 percent line, you're paying \$150 a
21 month. That's 2.73 percent just for the premium. We
22 have got copays and deductibles outstanding. But
23 someone right across that line is at \$852 or 13.8
24 percent. That pattern continues up through adults
25 and family. And it's just -- it's hard for me to

1 see, you know, a couple in Vermont let's say 65
2 thousand dollars, two people in their 40s and 50s
3 working, concerned about healthcare issues, they are
4 not young enough to say nothing is going to ever
5 happen to me. And to be in a position of having to
6 pay 13.8 percent of their income just for the
7 premium.

8 And I'm wondering if you have any -- if
9 you look at my concurring vote last year on your
10 proposal, I came out of the box with an opinion
11 talking about my real concern about affordability.
12 And I'm just -- and I think I laid out a plan, can be
13 debated or not, a plan to address this. I personally
14 don't think it would cost that much to close that gap
15 between 400 and 450 percent of poverty and 450 to
16 500. Because if you take the federal standard at
17 about 9.8 percent of income as affordable, quote
18 unquote, that wedge closes pretty rapidly.

19 So I'm wondering what thoughts you
20 might have about how we can address that cliff.

21 THE WITNESS: Yeah. That's -- I mean
22 that's all very true, and you know, very real. My
23 general thought is the safeguards that are in place
24 under the federal ACA and also the additional
25 subsidies from Vermont, other than -- I mean as a

1 carrier we are trying our best to put forth the
2 lowest premium possible relative to the benefits we
3 are recovering, which is met with the growth in our
4 market share.

5 But to address what you're referencing,
6 it almost feels like a change in legislation would be
7 needed. If that's something that I don't -- public
8 policy -- I don't really want to wade into those
9 waters. But outside of some sort of public policy
10 change or legislative change, that would be the way
11 that I would think about that initially.

12 MR. PELHAM: Well and I know having
13 spent years at the State House that you do have
14 representation in the State House. And I agree with
15 you that it is a legislative issue. But it rolls
16 back to these premiums. And with the percentage of
17 people's incomes that they are kind of, you know,
18 have to pay if they want insurance at all.

19 My next question is just in terms of
20 moving from the proposed -- from the rear-view mirror
21 of the hospital budgets to the proposed budgets as a
22 standard. What level of detail have you gotten? I
23 mean we haven't even seen those budgets yet, haven't
24 had hearings on them, the 2020 budgets, but yet they
25 are proposed or being used in this process. And I'm

1 just wondering what kind of level of actuarial work
2 that you've done on those 2020 budgets in terms of
3 Medicaid share, Medicare share, commercial share, bad
4 debt, free care, all those moving parts that go into
5 that budget process have not been scrubbed yet.

6 THE WITNESS: Yeah. We are using
7 whatever the net patient revenue changes that the
8 carrier -- that the hospitals are proposing.

9 MR. PELHAM: For all categories of --

10 THE WITNESS: That would be applicable
11 here, so commercial.

12 MR. PELHAM: Right.

13 THE WITNESS: And that's the best
14 estimate of how our actual rate filing and our claim
15 costs would be met.

16 MR. PELHAM: Have you gone back and
17 looked at the history of between what hospitals
18 submit and what the board has approved as a guide?

19 THE WITNESS: Well I know L&E last year
20 used that information to inform their recommendation
21 for the adjustment between the -- what was in our
22 rates versus proposed hospital budgets versus what
23 they ultimately expected to be approved.

24 Now our approach is that we should use
25 the best data available because what has happened in

1 past years may not be indicative of what is going to
2 happen this year. So the best data that we have
3 available to us right now is the proposed hospital
4 budgets.

5 MR. PELHAM: I understand it's a data
6 point, but what's interesting in most of this rate
7 review process, it is a rear-view mirror look whether
8 it's pharmacy, or medical trends, or administrative
9 trends. You know, it's looking in the rear-view
10 mirror and trying to statistically predict forward,
11 walk forward, and here we are taking a data point
12 that's out in the future. It's inconsistent, I
13 think, the current number with the all-payer model of
14 2.5 percent. And, you know, the board hasn't even
15 had time to visit that yet. So it's -- it kind of
16 doesn't fit the scenario of most of the other data
17 that's being used in setting these rates.

18 My next question is having to do with
19 the cost shift in terms of your actuarial work. I
20 went through and looked in your filings for a number
21 for the cost shift because it's certainly something
22 that the commercial carriers have to deal with even
23 though it's kind of a hidden pressure. The board by
24 statute in Vermont has to measure annually what the
25 cost shift is, and for 2019 the estimate is that it's

1 -- it's in the range of 216 million dollars. So it
2 is a big number. And I look at the appropriations in
3 the state budget for 2020 and for the key
4 appropriation that affects Medicaid expenditures
5 which is the Medicaid global commitment line item,
6 for 2018 the total appropriation was 719 million
7 dollars. For 2019 it was 731 million dollars or just
8 a 1.7 percent increase. And for 2020 it was 738
9 million dollars or just a 9/10ths of one percent
10 increase. And that includes the 1.1 million dollar
11 increase for an expanded dental benefit.

12 So these are the numbers that we are
13 looking at relative to a Medicaid program that serves
14 about 22 percent of Vermonters. And here we are with
15 you folks looking at, you know, plus or minus 10
16 percent for a much smaller share. So I'm just
17 wondering what your thoughts are on the cost shift
18 and whether it's just from your perspective just
19 embedded in the trend data and it is what it is, or
20 it's something that needs to be addressed.

21 THE WITNESS: It is -- it is implicitly
22 included in the trend that we have included in the
23 filing, the proposed trend. Now when they are --
24 whether or not that is problematic that's, you know,
25 that's a debate that's outside of the actuarial

1 scope. I agree with you that the fact that Medicaid
2 is not going up at the same rate as what other
3 providers or facilities need to run their business,
4 that is definitely resulting in higher cost trends in
5 the commercial market. But our job is to set forth a
6 rate that is adequate for what's being covered.

7 MR. PELHAM: Inclusive.

8 THE WITNESS: And that cost shift is
9 included in those trends figures.

10 MR. PELHAM: Well maybe we can change
11 that over time a bit. My next question has to do
12 with -- if I can read my own writing here. Is the
13 employer share in the small market.

14 There was a study in 2015 that
15 indicated that in the small employer market that
16 between 66 percent and 75 percent of the premium was
17 supported by the employer. And but that's a 2015
18 number. I'm just wondering if you have any sense as
19 to where that might be now.

20 THE WITNESS: No. That's something
21 that's outside of my scope of knowledge.

22 MR. PELHAM: Okay. And that's it.
23 Thank you.

24 THE WITNESS: Thank you.

25 MR. BARBER: Ms. Holmes.

1 MS. HOLMES: Thank you. Can you just
2 turn to Exhibit 7 page 2. There is a chart on there.

3 THE WITNESS: Okay.

4 MS. HOLMES: I'm just looking at --
5 again this is a similar version of the chart was
6 referenced earlier, but I was struck by the -- in
7 2017 differences between proposed, actual, or allowed
8 and actual. And I'm wondering if you could not only
9 for Rx trend but also for the medical costs and
10 utilization, I am wondering if you can speak a little
11 bit further about some of those differences and also
12 when we might see and when might be available the
13 2018 actuals that would go with that.

14 THE WITNESS: Yeah. 2018 we would --
15 should be able to provide that. We have enough run
16 out at this point where that's something that we
17 should be able to provide.

18 MS. HOLMES: Okay.

19 THE WITNESS: I just want to be sure
20 I'm understanding. This is the filing for '18;
21 correct? In the '18 column, I believe that's the
22 case. So yeah, we would have '18 over '17 at this
23 point. Because we have enough run out.

24 MS. HOLMES: Okay.

25 THE WITNESS: What I guess I'll go back

1 to what I was addressing earlier with differences in
2 allowed -- or proposed and actuals. It's really
3 driven because of our membership changes, it can be
4 driven substantially by how much our membership has
5 been changing.

6 MS. HOLMES: Would it be fair to say
7 the deviation -- the difference between proposed and
8 actual as your market stabilizes would be closer?

9 THE WITNESS: I would assume,
10 especially as our population has gotten larger,
11 because the smaller data set, you know, we had 10,000
12 members in 2017. While that sounds like a big
13 number, it can take a few costs or a few high-cost
14 claimants can really drive that actual trend figure
15 to be much higher than we would expect. So there is
16 a lot more volatility.

17 As you collect more data and you have
18 more stable population then you shouldn't see as many
19 changes as long as the benefits being covered are
20 comparable. That said, we did an interesting review
21 of our claim cost distribution. And it was really
22 telling to us that 50 percent of the lowest 50
23 percent costs or lowest utilizers of members only
24 accounted for somewhere in the 4 to 5 percent range
25 of overall cost for the commercial book of business.

1 And then the highest 5 percent cost members accounted
2 for 50 percent.

3 So they are kind of flipped around.
4 The curve is very -- rises very steeply; right? So
5 to the extent that in that tail where it's so
6 volatile from one year to the next just changes by
7 one to two members or one really high-cost member
8 maybe only had -- I know we used \$100,000 as our
9 pulling point. But suppose that the average cost
10 over a hundred thousand dollars in one year is only
11 105,000, and then the next year we have the same
12 number of people over a hundred thousand, but it's an
13 average cost of 125,000. That can have a really
14 substantial impact on your overall claim trend.

15 So yeah. Those changes -- there is a
16 lot that can go into an actual trend figure that you
17 really have to kind of peel back the onion to get at
18 the understanding of it.

19 MS. HOLMES: Thank you. And so you'll
20 follow up with the 2018 as you can?

21 THE WITNESS: Yeah.

22 MS. HOLMES: So actually my second
23 question, and we have talked about this market share
24 that MVP has gained in the last few years from 10
25 percent of the market, the QHP market in 2016, to 40

1 percent now. And clearly when you submitted the rate
2 filing you did not know the competitors', you know,
3 rate filing at that point in time.

4 THE WITNESS: Yup.

5 MS. HOLMES: So I'm wondering what are
6 you assuming now given that you have a better idea of
7 the landscape for 2020? What is the expected growth
8 in market share that you might anticipate?

9 THE WITNESS: You know, it really
10 depends on what the ultimate approved rate increase
11 is.

12 MS. HOLMES: Sure.

13 THE WITNESS: As it currently stands --
14 based on L&E's recommendations we expect our relative
15 position to be comparable to where we were in 2019.
16 I think it's going to be a little bit different. So
17 we are around 11. I don't recall Blue Cross's exact
18 recommendation, but I think it was somewhere in that
19 11 range. So largely we expect our position to be
20 unchanged. But given the spread that we are seeing
21 right now, we are optimistic that we can continue to
22 grow market share.

23 What is our kind of -- I don't know
24 what the maximum level would be. I think that's
25 really contingent on the ultimate approved rate

1 increase and just continuing to market to our
2 consumers and make people in Vermont -- make
3 Vermonters more aware of MVP's products.

4 MS. HOLMES: Well I guess in part my
5 question was driven by if more people migrate to MVP,
6 would, for example, your estimate of the per member
7 per month administrative costs of \$42 be correct? Or
8 if more people migrate, then you're spreading those
9 fixed costs, more individuals, would you have to make
10 an adjustment to that estimate?

11 THE WITNESS: It's a matter of
12 understanding our fixed costs broken out by Vermont
13 versus enterprise wide. That would be the level of
14 detail that we would have to understand before we
15 would be comfortable -- I would be comfortable making
16 a definitive statement about that.

17 MS. HOLMES: Okay. I noticed that you
18 adjusted the premiums up slightly for leap year.
19 There is going to be an extra year. Does that mean
20 next year we will have an adjustment down because
21 there will be one less year in your --

22 THE WITNESS: Yeah. When we are using
23 2020 data, we will definitely back out -- we will do
24 365 over 366. I believe we did that in the 2018
25 filing where we used 2016 data.

1 MS. HOLMES: Okay. Just to make sure
2 it goes back in the other direction. So I think I
3 was struck by some of the differences in unit cost
4 increases for providers that were regulated by the
5 Green Mountain Care Board and providers that are
6 outside of the regulatory authority of the Green
7 Mountain Care Board. In fact, the unit cost increase
8 was twice as much for those outside of what the Green
9 Mountain Care Board regulates, and that second
10 category was quite substantial.

11 I recognize there was an adjustment,
12 but even 40 percent of the spend is happening outside
13 of what the Green Mountain Care Board regulates. My
14 understanding is that it's growing. Right? That
15 portion of the spend that's happening outside what
16 the Green Mountain Care Board regulates is growing.

17 Can you just speak a little bit to
18 what's happening outside where there is growth for
19 those providers, whether that be in New York, New
20 Hampshire, Massachusetts, Florida. Where that's
21 happening and why it's growing, and what we can
22 foresee about expenditure growth if that's the
23 pattern.

24 THE WITNESS: Yeah. So I would -- in
25 New York, we are doing our best to try to manage

1 costs down. It's generally when we -- at the outset
2 of negotiations with a provider facility there is
3 usually a pretty big spread. We generally come out
4 with a number. That's probably around zero or close
5 to zero, and then they come out with a much larger
6 number. And we have to always balance the importance
7 of having an adequate network with access for our
8 members versus costs.

9 So there is a lot of -- there are a
10 number of facilities where if you were to remove that
11 facility from our network, then the product itself
12 would then become unappealing and would not be a
13 marketable figure. So it's kind of a negotiation of
14 how much leverage -- how much negotiating power do we
15 actually have. That's the one item.

16 In terms of members traveling or going
17 outside of our jurisdiction, or outside of where we
18 manage costs in New York, and Vermont, we do rely on
19 a third party. We do update our contract terms with
20 them. But we are generally receiving whatever their
21 discounts are at given facilities. So we aren't --
22 my understanding is that there isn't some sort of
23 secondary fee schedule that we are paying that's
24 impacting us. But we do feel that being able to
25 provide members with access to a facility like

1 Dartmouth Hitchcock, we negotiate with, or Mass.
2 General in Boston who we rely on our third-party
3 vendor, or Sloan Kettering in New York City. Those
4 are all -- it's important to have that access because
5 not only costs may be more expensive in those
6 facilities, but it's also those are also centers of
7 excellence where there could be downstream impacts
8 that are actually reducing costs. So you may pay
9 more up front and then have fewer costs down the
10 road.

11 MS. HOLMES: Why are you seeing more
12 migration to those facilities outside of the Green
13 Mountain Care Board territory? It sounded like there
14 was more migration out there. Do you know what's
15 driving that?

16 THE WITNESS: I -- off the top of my
17 head, I couldn't speak to that. It may just be the
18 conditions or the location of our members.

19 MS. HOLMES: Okay. Thank you. So
20 another question related to that. Was -- when you're
21 selecting your network, how much weight do you place
22 on the price that you can negotiate versus the
23 quality of the provider? And how do you even assess
24 quality of providers when you're thinking about your
25 network?

1 THE WITNESS: Yeah. We have -- so we
2 have accreditation that we -- that providers are --
3 credentialing that providers have to go through to
4 actually be part of the network. So there is at
5 least a minimum floor of quality that you have to
6 meet.

7 We are currently undertaking an
8 analysis of cost efficiency which is balanced with --
9 which is balanced with quality. So we are trying to
10 identify who are the bad actors, I suppose you could
11 say, on both fronts. If -- and determine who those
12 that are that have low quality and higher than
13 average cost, and then also balance that with high
14 quality and high cost.

15 So the line, I guess, is our
16 credentialing. Now above and beyond that, we are
17 undertaking that project right now. It's a really --
18 so it's been just introduced, this project. It's
19 really complicated at this point, because to
20 understand cost, you have to try to capture all the
21 -- so you're trying to isolate the cost for the
22 provider, but you have to also isolate the referral
23 patterns, and you have to get apples-to-apples
24 comparisons for like procedures. So you don't want
25 to compare a provider that's doing a lot of routine

1 services against a similar provider in the same
2 specialty that's doing more high-intensity
3 procedures. So you have to really isolate those
4 metrics.

5 So we are undertaking that initiative.
6 It's proving to be a very challenging initiative, but
7 more to be determined.

8 MS. HOLMES: Well I would say I would
9 add on to that we would be very interested in hearing
10 about that and what the potential impact on rates, if
11 you can, you know, identify providers who are low-
12 value, high-cost providers and not potentially be
13 paying for those services, I would imagine that would
14 help consumers.

15 But like Robin, I think I'm interested
16 in your work in the follow up on the unwarranted
17 variation in medical care in the Vermont population,
18 understanding more about what you're doing to think
19 about that. And I'm also just -- I'm wondering in
20 particular if -- does MVP ever drop providers who,
21 for example, have, as you described, the bad actors
22 or those providers who have, you know, high frequency
23 readmissions or surgery do-overs, or other kinds of
24 metrics by which you can really say this is probably
25 poor quality care. We don't want to pay for it.

1 Does MVP drop providers like that? I see you give
2 carrots for high performing -- performance. Do you
3 give sticks for poor performance?

4 THE WITNESS: If those metrics then
5 lead to those poor quality measures, then we do, you
6 know, not meeting credentialing standards or a
7 certain -- if we want to go forth once we have our
8 analysis completed, if we identify who these
9 providers are, the goal would be to remove them from
10 the benefit designs, a subset of benefits.

11 I would highlight that we did offer for
12 -- a couple years ago we offered -- for about three
13 years we offered a limited network product in our New
14 York population, which had a price decrement of
15 approximately 10 percent. That was somewhere in the
16 9 to 10 percent range. And we actually stopped
17 offering it because when we contacted consumers and
18 asked why, they said well, and this was a robust
19 hospital system down in the Hudson Valley, New York.
20 Near New York City. Consumers said we wanted more
21 access to providers.

22 So we are trying to understand what
23 that right balance is between quality, cost and
24 basically what is attractive to the market. It's
25 something that we are undertaking. I can tell you

1 that.

2 MS. HOLMES: Well welcome to the triple
3 A; right? Cost, quality and access. We are all
4 trying to figure that balance out.

5 THE WITNESS: Exactly.

6 MS. HOLMES: My last question actually
7 related to how many QHP members do you know are using
8 that online tool? The online tool came on for cost
9 and quality, mostly cost comparison tool. In the
10 first couple years there was not a lot of traffic to
11 that website. Has the traffic grown at all based on
12 the population here in Vermont?

13 THE WITNESS: I would have to contact
14 our marketing team for that data.

15 MS. HOLMES: Okay. I'm wondering has
16 that had any impact -- has it had any impact on
17 changing traffic patterns of where people seek care
18 if they know the actual cost of the care?

19 THE WITNESS: That would be something I
20 would have to contact the marketing department for.

21 MS. HOLMES: Great. Those are my
22 questions. Thank you, Matt.

23 THE WITNESS: You're welcome. Thank
24 you.

25 MS. USIFER: Thank you. I'm going to

1 piggyback on some of the questions that were
2 previously asked. But if we look at the high-cost
3 claim, I was also struck by how it was going down
4 year over year, the 16.8, 13.6, 10.5 to get to the
5 12.5. And I believe you stated or in the
6 documentation there was an increase to premiums that
7 that was causing of .26 percent?

8 THE WITNESS: That sounds reasonable.
9 I believe that the experience period claims were less
10 than the pooling charge, so the amount we removed was
11 less than what was added back in for the three-year
12 average.

13 MS. USIFER: So it was going up my
14 point is. Just to go on some of the prior
15 questioning, I mean the trend -- it doesn't seem like
16 it's erratic. It's been doing down 16.8, 13.6, 10.5.
17 So to go to the 12.5, if we had gone with a lower
18 number like the 10.5 that certainly would have been a
19 lower increase to premiums; correct?

20 THE WITNESS: Yes. If that number was
21 lower, it would have been a lower increase in
22 premiums; correct.

23 MS. USIFER: Okay. Admin costs. One
24 of my favorites; right? I also looked at, I think,
25 one of the things that has been happening over the

1 year is you do keep increasing obviously in Vermont
2 and, you know, it's based on assumptions that you put
3 in. And I appreciate that you have been declining in
4 New York as well. And, you know, I did look back to
5 see what you have said in the past. And you've said
6 it was about 50/50, 60/40, between fixed and variable
7 costs.

8 And so, you know, because each year you
9 come in and you base the year on the current year's
10 membership, you know, I went back and looked at, you
11 know, for '19 you based it on 25,000. It came in at
12 30,000. And if I just use 50/50 and said 50
13 variable, 50 fixed, what that would have done to the
14 \$40 or roughly \$40. It would have brought it down by
15 about \$3.30.

16 And if I then carried forward and look
17 at where you currently are for 2020, that's 30,887.
18 And if you did get an increase of 3,000, that would
19 be a reduction from 42 down to 40.14. If you got
20 6,000, you know, it would reduce by almost \$4. So,
21 you know, the tough part is, I get that you're having
22 less in New York, but part of Vermont's is a variable
23 piece.

24 And so as we have more membership, and
25 you have more -- you're collecting those -- the \$42

1 across all those members, and the member increases,
2 you not only contribute more to cover the fixed, you
3 have -- you don't need as much on the variable piece
4 because -- or you can have a piece of the variable
5 that's -- you don't need as much on the fixed. So
6 I'm just trying to say how do we come to terms with
7 the fact that we keep increasing, and we are not
8 really getting those benefits? Because of some of
9 the assumptions you have in for what membership would
10 be.

11 THE WITNESS: Yeah. So I guess I would
12 think -- well the variable is generally the same on a
13 per member per month basis. I think there is a fixed
14 -- there is two levels of the fixed. There is the
15 enterprise-wide fixed versus potentially like an MVP-
16 Vermont specific fixed. So we have an office in
17 Vermont that would be a fixed expense. Obviously
18 that as we grow more Vermont membership, that should
19 go down over time. But the enterprise-wide fixed
20 expense is something that I would have to ask the
21 financial team to be able to break that out at that
22 level of detail. But I think that's the way I would
23 think about it.

24 To the extent that we are growing our
25 membership in Vermont, the Vermont fixed piece, I

1 agree would go down. But the variable, I think in my
2 opinion, would stay flat, and then the fixed
3 enterprise wide is something -- is another one that
4 is dependent on our overall enterprise-wide
5 membership.

6 MS. USIFER: It's just a challenge
7 because we keep running into, you know, we are going
8 up in membership and basing it on a number.

9 THE WITNESS: I completely understand.

10 MS. USIFER: The question on page 66.
11 So you look at the pricing assumptions.

12 MR. BARBER: Where are you?

13 MS. USIFER: Tab 1. Page 66. And when
14 you look at the leveraging impact, and we look at,
15 you know, the allowances and then how copays and
16 deductibles end up reducing that amount; right? To
17 come up to what you get -- what you would get paid.
18 When we looked at the deductible piece in 2020 you're
19 looking at \$60.21. And last year it was 56.27. So
20 about a \$4 difference or per year about \$48.

21 And how does that then correspond to if
22 I look at the change year over year for deductibles
23 and maximum out of pocket. So for Silver, for
24 instance, the deductible is going up by 400. The max
25 out of pocket is 200. Bronze it's 300/300. Gold is

1 50/300. And Platinum is pretty low. And yet the
2 reduction is only, you know, \$48.

3 So it just seems, you know, consumers
4 are paying a lot more out of pocket or for their
5 deductibles or maximum out of pocket, right? And yet
6 when it translates back it's only a \$4 offset. So I
7 mean how do we look at that relationship? Because in
8 each year this creeps up slowly, and that's one of
9 the big things we will hear from consumers about how
10 much more they are paying.

11 THE WITNESS: Yeah. I'm not sure I
12 fully understand the question. But let me just try
13 to answer the way I interpret it. This -- I believe
14 what you're asking is about how our benefits are
15 changing year over year and the deductibles may be
16 increasing or decreasing. The adjustment in the
17 deductible column on page 66 that you're
18 referencing --

19 MS. USIFER: Yeah.

20 THE WITNESS: -- that is reflective of
21 2018 services. When we develop our plan level
22 premium rates, those actuarial values, the pricing
23 actuarial values that we develop capture the impact
24 of deductibles and out-of-pocket impact. So this
25 figure right here is based purely on what happened in

1 the 2018 experience period projected forward. And
2 that said, we are enrolling members in leaner
3 benefits. So as that -- as we are enrolling members
4 in leaner benefits, those are generally plans that
5 have higher deductibles.

6 So to look at last year's figure, and
7 identify what the changes from last year to this
8 year, I think they should also be measured against a
9 change in the average deductible that members are
10 seeking.

11 MS. USIFER: That's what I was trying
12 to say. This change was \$50 roughly; right? So
13 basically you're saying that it's a \$50 impact year
14 over year, but the deductibles are going up by three
15 to four hundred dollars, two hundred. So it's just
16 -- it seems like more of that shift is shifting to
17 the consumer. You're not offsetting all of that
18 here.

19 And I understand it wouldn't be a one
20 for one because everybody doesn't use that. But just
21 wanted to correlate, you know, that \$50 versus --

22 THE WITNESS: Well if a benefit is
23 changing, say there was a \$1,500 deductible in 2019,
24 and then in 2020 there is a \$2,000 deductible, the
25 value of that \$500 increase in deductible is being

1 passed on in the rate increases that we have in the
2 premiums that we are offering. So if we were to go
3 to -- I believe it's page 73. The long table of all
4 the premiums. There is a column that says "Benefit
5 Actuarial Value." It is 7 columns in.

6 That benefit actuarial value is
7 capturing the impact of any benefit changes that are
8 taking place. So there is a premium offset that is
9 implicitly included in here to address the fact that
10 a member would have to pay more out of pocket.

11 MS. USIFER: Yup. When we talk about
12 bad debt and the .4, that's quite a bit higher than,
13 you know, what's being looked for by your other major
14 competitor in the marketplace. And, you know, I mean
15 it's double. So looking at a .4 percent, a couple
16 things. One is you're talking specifically about
17 consumers who didn't pay their premiums and then had
18 claims against those.

19 Is there any way for you to marry those
20 up in some fashion? So if I'm not paying my premium
21 and then I'm getting -- I'm able to collect claims,
22 and have claims paid, you know, it seems like you
23 would be able to leverage that against that consumer,
24 you know.

25 THE WITNESS: I'm not an expert on the

1 policy. But there is a grace period that exists
2 where even if a member doesn't pay their premium, we
3 do have to cover their claims. And there is -- to
4 the best of my knowledge -- there isn't any recourse
5 that we can take.

6 To the extent that a member has
7 exceeded the grace period and isn't paying their
8 premiums, then that's where we will intervene and do
9 a review to ensure that we are not driving up costs
10 for -- unnecessarily for members that are actually
11 paying their premiums. So within the grace period
12 there isn't any recourse that MVP can take for those
13 members.

14 MS. USIFER: Okay. For fraud and
15 waste, you know, how much do you actually collect on
16 fraud and waste? And do you guys have an estimate of
17 what you think is out there for fraud and waste?

18 THE WITNESS: I haven't ever gotten an
19 exact figure for that. I did have a conversation
20 with our SIU lead last week just discussing some of
21 the programs that they have put in place. They are
22 doing -- they improve the staff. They have increased
23 the staffing, and they have actually, through that,
24 done a lot more analytics and data mining.

25 So they are trying to identify the

1 regular practice patterns or what fraud or waste may
2 exist in the system. To put an actual number on what
3 they estimate as a percentage or total dollar amount,
4 that wasn't something that we discussed. But I do
5 know that we are increasing our efforts to try to
6 proactively identify what are some of the items that
7 we can address before it actually gets into a
8 litigation case or having to address it after the
9 fact, so we can set up our system to automatically
10 identify some of these regular patterns and be more
11 proactive about it.

12 MS. USIFER: But you don't have a
13 percentage of what you guys estimate might be the
14 amount of fraud and waste out there?

15 THE WITNESS: I do not.

16 MS. USIFER: You talked about the cost
17 savings. And going to be specific examples with
18 telemedicine, things like that.

19 How much do you think these have
20 benefited year over year, like what the change is?

21 THE WITNESS: Are you speaking to like
22 the cost impact? So while utilization is increasing
23 substantially, when you look at telemedicine in
24 isolation, it's a very small percent of our overall
25 utilization. To the extent that there is growth, we

1 will capture that in our rate filings in the
2 telemedicine benefits. But it isn't enough to really
3 move the needle at this point.

4 I would just -- I advocate for it. I
5 think it's a really effective tool to utilize. But I
6 think there is a lot of education that goes along
7 with that. We have identified -- we have analyzed
8 segments of our population and who is actually
9 utilizing the telemedicine benefit the most. And
10 what we have identified is that self-insured clients
11 that we have are utilizing telemedicine more than
12 large employers, but they are utilizing it more than
13 the small groups and the individual employers.

14 And the reason why we think ASO clients
15 or self-insured clients are the clients that are
16 utilizing those benefits is because there is a direct
17 cost that the client is experiencing. They recognize
18 that there is a savings opportunity that exists. And
19 they are putting a lot more marketing materials
20 forth, a lot more member education or employee
21 education to utilize those benefits.

22 We do try to educate members on that
23 benefit through our member welcome packet or on our
24 website. But there isn't a way for us to just kind
25 of pick up the phone and call people directly and

1 tell them you should utilize the telemedicine benefit
2 in this instance, outside of potentially when we have
3 those programs in place like the ER, the high
4 utilizer of the ER program. Program.

5 MS. USIFER: Okay. But do you embed
6 anything within the premium rates right now for cost
7 savings that you'll be getting whether that is moving
8 people, you know, out of ER into primary care
9 specialists?

10 THE WITNESS: What we are capturing
11 right now is the experience that we had in 2018. Our
12 utilization trends were volatile, so we don't have
13 any utilization trend, and we are not building in
14 anything for additional utilization of something like
15 telemedicine or reduction in ER.

16 MS. USIFER: Okay. And then looking
17 at, you know, the L&E recommendations. You know,
18 several of them were because there was new
19 information, you know, that we have, the risk
20 adjustment, things like that. But on the medical
21 utilization which the proposal is to increase 5.15
22 percent the rate, is what would have happened if L&E
23 didn't find that?

24 THE WITNESS: We would have continued
25 with operating under the assumption that we didn't

1 have enough data to quantify what we -- utilization
2 trend of anything other than zero percent.

3 Now because utilization trend is
4 skinning the entire market and practice patterns, it
5 is helpful for L&E to have the entire market scan and
6 actually be able to analyze both competitors' data to
7 provide an estimate, because we do think that is a
8 more appropriate approach to quantify utilization
9 trend.

10 MS. USIFER: Okay. And I do have one
11 question on confidential information. So how do you
12 want to handle that?

13 MR. BARBER: So this is a public
14 meeting. We would have to go into executive session.

15 MS. USIFER: Can I refer to it and not
16 say the numbers or --

17 MR. BARBER: Well if the question calls
18 for an answer that discloses the numbers -- which
19 document are we talking about?

20 MS. USIFER: I'm talking about tab 3,
21 Appendix A, page 5.

22 MR. BARBER: Yeah. We would have to go
23 into executive session.

24 MS. USIFER: How do we do that? Later
25 or --

1 MR. BARBER: We can do it after the
2 Chair finishes his questions before we take -- do
3 redirect and then take a break.

4 MS. USIFER: Okay.

5 (A discussion was held off the record.)

6 MR. BARBER: Take a break now and
7 continue with the questioning after that. I have to
8 take a break. Convene back in 10 minutes.

9 (Recess was taken.)

10 CHAIRMAN MULLER: Could we get the door
11 closed, please?

12 MR. BARBER: Back on the record after a
13 brief break. I think the plan is the board will --
14 so Chairman Mullin will be doing the questioning, and
15 then we will take up member Usifer's questioning on
16 the confidential document. We will discuss going
17 into executive session to take questions on that. So
18 Mr. Chairman.

19 CHAIRMAN MULLIN: And then we will go
20 to lunch.

21 MR. BARBER: Then we will do redirect
22 and then lunch.

23 CHAIRMAN MULLIN: Okay.

24 MS. HOLMES: It's all about lunch.

25 CHAIRMAN MULLIN: So Mr. Lombardo, you

1 talked about risk adjustment and how it negates some
2 possible consequences. What percentage of actual
3 costs are mitigated through the risk adjustment
4 process that's in place?

5 THE WITNESS: Are you speaking to the
6 CMS risk adjustment program? Or are you talking
7 about -- can you clarify?

8 CHAIRMAN MULLIN: So under the
9 Affordable Care Act, you -- because you have
10 healthier members, have been cutting -- been
11 basically paying money in, but your competitor is
12 receiving money back --

13 THE WITNESS: Yup.

14 CHAIRMAN MULLIN: -- through that risk
15 adjustment. So what percentage of actual variation
16 due to the health status of your members actually
17 gets taken care of through that risk adjustment
18 process?

19 THE WITNESS: Our assumption is that
20 the risk adjustment program is solving for any of
21 those inequities in the market between MVP and our
22 competitor. I will point to we do have an exhibit in
23 our rate filing where we quantify what the percentage
24 actually is that we are paying into risk adjustment
25 as a percent of our projected claim costs. It's on

1 Exhibit 3, which may take me a minute to find.

2 Sorry. It's on Exhibit 2 of the binder. Page 138.

3 We are projecting a risk adjustment
4 program payment of \$60 that's prior to --

5 MR. KARNEDY: Let him get there first.

6 THE WITNESS: Okay.

7 CHAIRMAN MULLIN: Okay.

8 THE WITNESS: So prior to any L&E
9 recommendations, we are projecting a \$60.53 PMPM
10 payment into the risk adjustment program compared to
11 the index rate prior to risk adjustment in line 30 of
12 \$414. The adjustment is somewhere just south of 15
13 percent. With the recommendation of L&E we would add
14 another one and-a-half percent to that.

15 CHAIRMAN MULLIN: You talked about 40
16 percent of the hospital business being done at
17 hospitals that aren't under the regulatory authority
18 of the Green Mountain Care Board. Of that 40 percent
19 what percentage would be Vermont hospitals?
20 Specifically Brattleboro Retreat, and the state
21 hospital that we do not have that regulatory
22 authority?

23 THE WITNESS: That's actually included
24 in the confidential information, I believe. Which
25 exhibit was that? 3-A was the one board member

1 Usifer was referencing. It's not a huge impact.
2 Those two facilities in Vermont aren't driving a lot
3 of the impact of our trend differences.

4 I would like to make one clarifying
5 point though. The 40 percent of business that is not
6 governed by the board is hospital plus physician
7 costs, so also included in that figure is any of our
8 community physicians that we contract with directly
9 in the State of Vermont. So that's not -- I just
10 want to make it clear that's not 40 percent of the
11 business is just leaving Vermont. It's a number
12 that's smaller than that, if we account for
13 physicians that are not governed by the board.

14 CHAIRMAN MULLIN: When you look at that
15 trend, the 5.5 percent, do you see any co-relation
16 between the regulation in a state on those entities
17 versus the non regulation?

18 THE WITNESS: Can you clarify exactly
19 what you're looking for? I'm sorry.

20 CHAIRMAN MULLIN: So if Vermont is
21 growing at half that, do you think that has anything
22 to do with the oversight of those hospitals, or do
23 you think that it has more to do with what's
24 happening in that particular geographic region?

25 THE WITNESS: We see direct impact of

1 the Green Mountain Care Board being able to match the
2 facility trends. We actually put an exhibit together
3 which showed how our premiums have changed since the
4 inception of the ACA over time in a couple of our New
5 York markets relative to Vermont. And what we have
6 seen is that the Vermont premium rate increases and
7 just the level has actually dipped below the New York
8 premium levels. And they weren't always at that
9 level.

10 And we do attribute a large portion of
11 that to the fact that our trends are lower which is
12 because of managing the actual facility trends and
13 the facility-owned physician trends by the board.

14 CHAIRMAN MULLIN: So you mentioned that
15 you negotiated directly with Dartmouth Hitchcock.

16 THE WITNESS: Yes.

17 CHAIRMAN MULLIN: As part of that,
18 knowing that 40 percent of the volume done at the
19 Lebanon campus is Vermonters, do you try to tie any
20 potential increases to rates that you're seeing in
21 Vermont?

22 THE WITNESS: That would be a question
23 I would have to follow up with our contracting team.
24 We do -- no surprise, that is the one facility that
25 has the most utilization for our members because, you

1 know, a lot of southern Vermonters go over the border
2 and access care. We do our best to actually keep the
3 costs down. It's just always challenging to come up
4 with the figures where the board is holding
5 facilities to around 3 and-a-half percent.

6 CHAIRMAN MULLIN: In what states do you
7 negotiate for your own versus using your national
8 carrier? Your national contractor?

9 THE WITNESS: It's New York, upstate
10 New York, for the most part, and then just Dartmouth
11 Hitchcock. There may be one or two other facilities
12 I'm not recalling that are on the border of New York
13 or Vermont, but primarily it's Dartmouth Hitchcock,
14 and then it's New York.

15 CHAIRMAN MULLIN: So obviously your
16 national carrier would have negotiations in both
17 those markets as well.

18 Have you concluded that because MVP is
19 negotiating directly with Dartmouth Hitchcock that
20 you're getting a better rate, and therefore that's
21 why you do it that way? Or what is the historical
22 decision point that you negotiate with Dartmouth
23 Hitchcock versus using your national carrier?

24 THE WITNESS: That would be something I
25 would have to follow up the specifics with the

1 contracting team. We did, MVP being we, did operate
2 in the state of New Hampshire in the past. We
3 withdrew from that market due to challenges with
4 keeping costs down, offering a competitive premium
5 rate. A number of years back we never offered an
6 ACA-compliant product, so I believe the exit was
7 around the time of the inception of the ACA in 2014.
8 It was around that time.

9 But obviously we are still in Vermont,
10 and we recognize how much Vermonters and also New
11 Yorkers for that matter access Dartmouth Hitchcock,
12 which is my understanding of why we need to negotiate
13 with Dartmouth Hitchcock.

14 CHAIRMAN MULLIN: Okay. You mentioned
15 in your testimony that you believe that you got the
16 same percentage off that your national contract
17 carrier receives. Obviously there is no such thing
18 as a free lunch so how are they compensated for doing
19 the work for you? Is it on a percentage basis, a
20 fixed fee or what?

21 THE WITNESS: The national carrier
22 doesn't have a robust network in upstate New York.
23 So they actually leveraged our contracts for their
24 members that want to access care in upstate New York.
25 And then obviously -- and then we leverage their

1 network outside of where we contract. So it is a
2 two-way relationship between the two carriers.

3 The actual terms of the contract, that
4 would be something that I'm not privy to, but someone
5 at MVP is privy to that information and could provide
6 it.

7 CHAIRMAN MULLIN: Are there multiple
8 options for a national contract?

9 THE WITNESS: In terms of could we use
10 another carrier? So there are other national
11 carriers. I don't know if there is another one that
12 has gaps in their network in upstate New York where
13 it would make as much sense, but that would be
14 something that I would have to talk to our
15 contracting team about.

16 CHAIRMAN MULLIN: Would you assume that
17 your contract team is comparing what the percentages
18 are on the contracts with the different options?

19 THE WITNESS: So I'm not sure if that
20 information is readily available. I mean that's one
21 -- that's the carriers -- generally one of their most
22 confidential pieces of information. So I'm not sure
23 how well we have the ability to understand the cost
24 of the national carrier that we leverage versus
25 another carrier at specific facilities.

1 CHAIRMAN MULLIN: Okay. You talked
2 about this board doing an evil thing and making a
3 couple of adjustments mid year. And I'm just curious
4 because we have this year's filings. And one of
5 those adjustments was for a hospital that did not ask
6 for an increase in charges or rates this coming year
7 because a number of carriers had told them that they
8 could not implement the mid-year adjustment until
9 October 1.

10 Do you know how MVP treated those two
11 mid-year adjustments?

12 THE WITNESS: I'm not aware of that.
13 My understanding is that it was effective on the
14 date, but I don't know if there are actual claims
15 that are processed reflecting those adjustments.

16 CHAIRMAN MULLIN: And did you do any
17 analysis of what percentage of MVP's overall business
18 was affected by those two?

19 THE WITNESS: We do have the exhibit in
20 our filing that includes -- it's a confidential
21 exhibit that displays utilization of MVP services by
22 facility in Vermont versus Dartmouth Hitchcock, New
23 York participating hospitals, and our rental network.
24 So that's something that I can either point you to or
25 we can address during the executive session.

1 CHAIRMAN MULLIN: Is it safe to assume
2 that the percentages in that chart though could just
3 be applied to those rate increases that were done mid
4 year?

5 THE WITNESS: Yes.

6 CHAIRMAN MULLIN: Okay. Thank you.
7 You talked about there were 44 different ways that
8 MVP is trying to keep costs down while at the same
9 time guaranteeing quality for your subscribers. And
10 I'm curious if the designation of a particular
11 procedure comes into that discussion, and let me give
12 you an example.

13 You've probably seen a number of ads on
14 TV for a product called Cologuard. And Cologuard is,
15 I think, 90 to 92 percent effective. Colonoscopy is
16 97 percent effective. If you talk to primary care
17 physicians a number of them will tell you that even
18 though because there is no family history in the
19 health status of a patient that is seeing them, they
20 still may not recommend that lower-cost alternative
21 because of the way it's treated in its
22 classification. So, for example, a colonoscopy is a
23 screening measure, and it's protected under Vermont
24 statute, and you have to treat it one way. And what
25 I'm told is that patients have gone for the lower-

1 cost option which is the Cologuard because they don't
2 have to take a day off from work and do everything
3 for the prep and everything else.

4 But if it comes back that there is
5 something that's found, the second colonoscopy that
6 is then necessary gets treated as diagnostic rather
7 than screening. And so it's a huge out-of-pocket
8 cost to the Vermont patient. And so that primary
9 care doctors are reluctant to go to the step of going
10 for the least-cost alternative in the beginning,
11 because they know that in a small percentage of cases
12 it could be very expensive to their patient in the
13 long run.

14 So I'm wondering if you have those
15 discussions.

16 THE WITNESS: That would be something
17 that's discussed by our clinical team, and any of
18 those kinds of discussions -- I mean I'm happy to
19 provide follow up if I can go back to the clinical
20 team and understand if those conversations are taking
21 place and what those conversations are.

22 CHAIRMAN MULLIN: That would be very
23 helpful. You talked about New York State not using
24 RBC but using reserves to premiums, and you talked
25 about the 12 and-a-half percent in New York. You're

1 currently at 14 and-a-half.

2 How does New York treat TPA or ASO
3 arrangements?

4 THE WITNESS: In terms of measuring
5 their -- how they account for the 12 and-a-half
6 percent? Well ASO and self insured generally falls
7 under a different legal entity. And how their
8 premiums or their -- so basically the ASO client is
9 only paying us administrative fees. How that is
10 actually coming into the calculation, or if it's part
11 of the calculation, I would have to follow up with a
12 New York regulator to understand exactly what they
13 are measuring.

14 So to the extent that they are only
15 pulling in our fully-insured business, the way that
16 MVP team has communicated back to me is the 12
17 and-a-half percent are fully insured premiums. Now I
18 don't know if they have taken that for granted or
19 with a grain of salt. The implication has been that
20 ASO is not included in that figure, but I would have
21 to confirm with either our financial team or New York
22 State to be a hundred percent confident.

23 CHAIRMAN MULLIN: Okay. Thank you.
24 You said a couple different times that New York book
25 of business is in decline. Vermont is increasing.

1 But it's a small percentage of your overall business.
2 If there was similarly a Vermont decline but a large
3 increase in New York business, would you come in with
4 a reduced administrative cost in that scenario?

5 THE WITNESS: What we do is we make a
6 projection of a total dollar projection. What it's
7 going to cost to run our business in the upcoming
8 year. I'm really over simplifying it, but that's
9 generally what we are doing. And then we are looking
10 at it relative to our overall membership, you know,
11 with some -- obviously look at how are we operating,
12 what are we actually spending in Vermont versus New
13 York, et cetera.

14 In the extreme scenario if we assume
15 that our membership doubled, which -- enterprise wide
16 which won't happen, but just for scenario sake, you
17 would have a membership -- you would be taking the
18 same total dollar figure or proportional increase for
19 variable cost divided by a much larger base. I would
20 anticipate in that instance we would have a reduction
21 in the PMPM admin costs.

22 If it's small, we still have to account
23 for projects that we are undertaking like updating
24 technology and just other adjustments that we have to
25 pay.

1 CHAIRMAN MULLIN: There were some
2 questions earlier about the Ambulatory Surgery
3 Center. Are you aware that the Green Mountain Care
4 Board is in receipt of a letter from MVP stating that
5 the reimbursement for procedures being done there for
6 MVP subscribers is going to be below that of
7 hospitals?

8 THE WITNESS: I'm not aware of that.

9 CHAIRMAN MULLIN: Okay. Are you aware
10 that the estimated cost savings to the system is \$3
11 million in the opening of the Surgery Center?

12 THE WITNESS: I'm not.

13 CHAIRMAN MULLIN: So if those two
14 things I said were accurate, and that is the case,
15 would -- should there be a small reduction in your
16 filing to indicate those cost savings?

17 THE WITNESS: If the contracted rates
18 that we are able to negotiate are lower than
19 outpatient -- outpatient hospital setting, and we can
20 drive utilization there, then I would agree that we
21 would have an adjustment to our filing if that
22 information was known.

23 CHAIRMAN MULLIN: Okay. I think that's
24 all I have at this time.

25 MR. BARBER: Okay. So just in terms of

1 scheduling, I think realizing now what you said, I
2 think we will do the questioning on the confidential
3 document. We will come back out of executive
4 session. We will have a lunch break. And then we
5 will reconvene, I'm thinking around 1, for any
6 redirect and cross on redirect. Does that make
7 sense?

8 MR. KARNEDY: That's fine. I'm happy
9 to take a short break. Whatever the board would like
10 to do.

11 CHAIRMAN MULLIN: Why don't we make
12 that decision after we finish with the executive
13 session, how long the break is.

14 MR. BARBER: Okay. I'm just trying for
15 people who want to leave and not have to come stand
16 outside the room for the executive session.

17 I would say we will reconvene at 1 for
18 finishing the questioning of this witness. Member
19 Usifer has some questions about -- I believe it was
20 Exhibit 3-A -- which the board has granted
21 confidentiality for. Under the board's rate review
22 rules, we have an obligation to omit references to
23 these materials in the record and in public
24 deliberations and take other appropriate measures to
25 ensure confidentiality.

1 Since this is a public meeting, we
2 would go into executive session to discuss this. The
3 applicable statute 1 V.S.A. 313(a) allows the board
4 to go into executive session to discuss records that
5 are exempt from public inspection and copying under
6 the Public Records Act. Procedurally the board would
7 make a motion -- a motion would need to be made to go
8 into executive session indicating specifically what
9 the purpose is, and questioning would be limited to
10 this document and not go outside of that. So --

11 MS. USIFER: Can I add one more
12 document?

13 MR. BARBER: Yes.

14 MS. USIFER: It's going to be page --
15 under 5 page 8.

16 MR. BARBER: Okay. So two documents.
17 Exhibit 3-A and Exhibit 5.

18 MS. USIFER: Yeah. Tab 5. Page 8.

19 MR. BARBER: Page 8. Which is not
20 actually confidential.

21 MS. USIFER: It's not confidential?
22 That was one where they -- before they just referred
23 to -- I thought that was confidential.

24 MR. KARNEDY: Can I speak to that?

25 MR. BARBER: Sure.

1 MR. KARNEDY: It appears that the
2 exhibit, there is an Exhibit 5, and there is an
3 Exhibit 5-A. And I was being careful.

4 As you'll recall last time we met to
5 make sure that we did not speak to question 4 because
6 it has confidential information in it. For whatever
7 reason, I believe I made a mistake, and Exhibit 5 has
8 that information in it. And I would like to move to
9 strike that response because that should have been
10 confidential, and it was an error on my part. And I
11 apologize for it. That's the confusion that you're
12 expressing.

13 MR. BARBER: So you're claiming that
14 Exhibit 5 response to question 4 is confidential?
15 Because I believe we granted confidentiality for a
16 portion of the top of page 3. Redaction.

17 MR. KARNEDY: Can I confer with the
18 client for a second?

19 MR. BARBER: Sure.

20 MR. KARNEDY: Right. I just wanted to
21 confirm with Matt. So there was an error on my part.
22 I apologize for that. The Q and A on number 4 should
23 have been marked confidential.

24 MR. BARBER: Should have been marked
25 confidential.

1 MR. KARNEDY: Should have been marked
2 confidential.

3 MR. BARBER: All right. So questioning
4 on document 3-A and questioning on Exhibit 5. So
5 there will need to be a motion and 2/3 vote from the
6 board to go into executive session to discuss those
7 exhibits or portions thereof.

8 MS. LUNGE: I can do the motion. I
9 move that we go into executive session to discuss
10 Exhibits 3-A and Exhibit 5, specifically the
11 confidential information contained therein for the
12 reason that we have a duty under the statute to
13 provide confidentiality for those items.

14 MR. BARBER: Is there a second?

15 MS. HOLMES: Second.

16 CHAIRMAN MULLIN: All in favor signify
17 by saying aye.

18 ALL BOARD MEMBERS: Aye.

19 MR. BARBER: Opposed?

20 (No response).

21 MR. BARBER: Okay. So the board has
22 decided to go into executive session. We would need
23 in the room, I believe, obviously Health Care
24 Advocate and their attorneys, our staff, L&E. I
25 don't believe anyone else is necessary, so if

1 everyone else could please leave the room. Sorry.
2 If you could shut off the recording. We are going to
3 continue our recording and continue the
4 transcription. We will come out. We will take a
5 break for lunch and reconvene at 1.

6 (An executive session was held. The
7 testimony continues in a confidential transcript).

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1 (Public Transcript).

2 MR. BARBER: Okay. So I think at this
3 point we are going to break for lunch. Be back at 1
4 with any redirect.

5 (Recess was taken.)

6 MR. BARBER: Call this meeting to
7 order. We are back on the record in the case of
8 GMCB-005-19-rr in re: MVP Healthcare 2020 Vermont
9 Health Plan Rate Filing.

10 I was asked to just remind folks that
11 we have a sign-in sheet outside the door for people
12 for attendance as well as a sign-up sheet if anyone
13 would like to make public comments.

14 We had just finished board questions
15 for MVP's witness, Matthew Lombardo. And Mr.
16 Karnedy, did you have any redirect for this witness?

17 MR. KARNEDY: No redirect.

18 MR. BARBER: Okay. You can be excused.
19 I think that's the procedure -- that's typically what
20 we have done; right?

21 MR. KARNEDY: That's fine. I just
22 wanted Matt to be nervous all through lunch.

23 MR. BARBER: So next we are going to
24 hear from Department of Financial Regulation. Jesse
25 Lussier is here. Also like to recognize Gavin

1 Boyles, Department of Financial Regulation's General
2 Counsel.

3 Jesse, I don't think you were here at
4 the beginning. Could you stand and raise your right
5 hand?

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1 JESSE LUSSIER

2 Having been duly sworn, testified
3 as follows:

4 MR. BARBER: Okay. Thank you. So
5 whenever you're ready.

6 THE WITNESS: Good morning. My name is
7 Jesse Lussier. I'm an examiner and analyst --

8 CHAIRMAN MULLIN: I guess you have to
9 speak really, really loud.

10 THE WITNESS: I can do that.

11 MR. BARBER: I think we can just
12 proceed.

13 THE WITNESS: Good morning everyone.

14 CHAIRMAN MULLIN: Afternoon.

15 THE WITNESS: Afternoon. It is. My
16 name is Jesse Lussier. I work for the Department of
17 Financial Regulation. I'm an examiner and analyst
18 for the department. I have been there for a little
19 over eight years now.

20 We have reviewed the department's role
21 in solvency in the past, so I just want to give a
22 very high level update. But if you have any more
23 specifics, you can let me know. For the analysis
24 piece we reviewed financial statements on a quarterly
25 basis, and we also receive a more robust financial

1 package at year end, and that's on a routine basis.

2 For the examination side, it's more
3 robust in nature. It's more akin to a financial
4 audit, and it happens every three to five years.

5 As we have also noted from the past,
6 insurance regulation is state based, so that every
7 state is responsible for those companies that are
8 domiciled within that state. In MVP's case their
9 lead regulator is New York. So New York will perform
10 substantially similar examination and analysis
11 procedures as Vermont or any other states. And like
12 all state regulation we will rely on New York for
13 those companies, in this case we will rely on New
14 York for MVP's analysis.

15 With respect to this year's solvency
16 it's relatively similar to the prior year, and we
17 have read some of this already. But I'll just read
18 the final paragraph: Based on the entity-wide
19 assessment above, and contingent upon GMCB's
20 actuary's findings that the proposed rate is not
21 inadequate, DFR's opinion is that the proposed rate
22 will not have a negative impact on MVPHP's solvency.

23 There are a couple reasons why that is
24 similar to previous years. One, is just the overall
25 footprint of MVP's business in Vermont relative to

1 its full book of business. Like discussed previously
2 it's around 5 percent which is relatively small.

3 And also, we have not received any
4 solvency-related concerns or communications thereof
5 from the New York department. That's what I have so
6 far. Trying to keep it short. I know we are going
7 to be short on time. Does anybody have any
8 questions?

9 MR. BARBER: So Mr. Karnedy, did you
10 have questions for this witness?

11 MR. KARNEDY: I do. Thank you very
12 much.

13 CROSS EXAMINATION

14 BY MR. KARNEDY:

15 Q. So Mr. Lussier, you're an insurance examiner
16 and analyst for the department; correct?

17 A. Yes.

18 Q. Do you have your CPA?

19 A. I do.

20 Q. And you would -- I think you have in front of
21 you Exhibit 10 which is the letter from DFR; correct?

22 A. Yup.

23 Q. And you're adopting that letter as your
24 testimony on behalf of DFR; correct?

25 A. Correct.

1 Q. Would you please read on the first page of
2 that exhibit the sentence under "Summary of Opinion"
3 please?

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

8 Q. You stand by that opinion; correct?

9 A. Correct.

10 Q. Okay. Would you please read on page two,
11 there is a heading "MVPHP Solvency Opinion." And then
12 there is three bullets. Do you see that?

13 A. Yes.

14 Q. Would you please read the three bullets?

15 A. "DFR has been in communication with MVPHP's
16 primary solvency regulator, the New York Department of
17 Financial Service and has not learned of any solvency
18 concerns. Further, MVPHP currently meets Vermont's
19 foreign insurer licensing requirements. Finally, in 2018,
20 all of MVP Holding Company's operations in Vermont account
21 for approximately 4.8 percent of its total premiums
22 written. DFR has determined that MVPHP's operations pose
23 little risk to its solvency. Nonetheless, adequacy of
24 rates and contribution to surplus are necessary for all
25 health insurers to maintain strength of capital that keeps

1 pace with claims trends."

2 Q. Thank you. I want to focus on the notion in
3 that last sentence, I think in the third bullet. In the
4 sentence before you indicate that MVP -- only about 4.8
5 percent of its premium is written in Vermont; right?

6 A. Correct.

7 Q. Yet the adequacy of those rates and
8 contributions to surplus are important when you look at
9 Vermont. Said another way, even though Vermont is a small
10 percentage of MVP total premium, would you agree you still
11 look at the Vermont premium and this rate to determine
12 whether it's adequate?

13 A. Yes. I would say that's correct.

14 Q. And you read in your opening the sentences, or
15 sentence I should say, under impact of the filing of
16 solvency, you stand by that as your testimony; right?

17 A. Yes.

18 Q. And this letter, Exhibit 10, was based on
19 DFR's review of the original MVP filing; correct?

20 A. Correct.

21 Q. And in that filing MVP saw a 1.5 percent
22 contribution to reserves; correct?

23 A. Correct.

24 Q. You heard testimony here, I saw you today,
25 heard testimony of Mr. Lombardo?

1 A. Yes.

2 Q. And you also heard testimony about L&E's
3 recommendations; correct?

4 A. Yes.

5 Q. So based on L&E's recommendations, your
6 testimony that MVP has increased its proposal from 9.4 to
7 approximately 10.5 on based on L&E's recommendations and
8 then another .5 due to hospital budget proposals for a
9 total of 11 percent. You heard that testimony, right?

10 A. Yes.

11 Q. Do you have an opinion that this increase to
12 the 11 percent will likely have the impact of sustaining
13 MVPHP's current level of solvency?

14 A. That is correct. It wouldn't change our
15 opinion.

16 Q. It would not change your opinion?

17 A. Correct.

18 Q. And when it comes to solvency, would you agree
19 with me it's not a good idea to kick the can down to later
20 years and perhaps have a lower contribution in one year,
21 say 1 percent, figuring you'll just make up for it down
22 the road with a 3 percent increase in the next year?

23 A. From a solvency perspective, I would agree
24 with that, yes.

25 Q. Are you familiar with statistics on proposed

1 CTR filings for single risk-pool filings across the
2 company -- excuse me -- across the country over the last
3 two years?

4 A. Am I familiar with them?

5 Q. Yes.

6 A. No, other than what I read in the L&E memo.

7 Q. Okay. Let's go to that Exhibit 9, please. If
8 you go to page 14. And you heard Mr. Lombardo's testimony
9 today about the two paragraphs under section 15 about
10 reasonableness checks. Correct?

11 A. Yes.

12 Q. And you've read these paragraphs before?

13 A. I did. Yeah.

14 Q. And this is L&E comparing CTRs nationally;
15 isn't it?

16 A. Yeah.

17 Q. Would you agree with me that based on a
18 comparison to these filings nationally, their
19 reasonableness check, that MVP's CTR is reasonable in
20 light of the underlying risks?

21 A. The memo appears reasonable, but I'm not an
22 actuary, so I can't opine on them.

23 Q. Would you agree with me this appears to show
24 that a contribution below 1.5 percent would appear to be
25 an outlier. That less than 20 percent of the proposed

1 CTRs would fall in that category; is that right?

2 A. I would agree on that based on the numbers we
3 have here. Yeah.

4 Q. I believe you testified last year that the DFR
5 review of solvency doesn't end with RBC. It reviews a
6 large amount of data, is that fair?

7 A. That is fair, yes.

8 Q. Recognizing you're relying on the New York
9 regulators; correct?

10 A. Correct.

11 Q. And if you go to page 1 of your report,
12 please. Exhibit 10. Under "Background."

13 Would you read the second and third sentences,
14 first paragraph -- paragraph under background?

15 A. Starting with "Whether an insurer"?

16 Q. Sure. Exhibit 10 under the heading
17 "Background."

18 A. Yeah.

19 Q. There is a paragraph that starts "DFR." And
20 that has three sentences. I would ask you to read the
21 second and third sentences, please.

22 A. "Whether an insurer is solvent is more complex
23 than simply determining whether at any given moment the
24 insurer has more assets than liabilities. Rather, it is
25 an intricate analysis of many factors to discern how close

1 or far away from insolvency the insurer is and in what
2 direction it will move in the future."

3 Q. And that's what DFR did this year, reviewing
4 it, recognizing you're relying on the New York regulators
5 as well?

6 A. Yes.

7 MR. KARNEDY: Thank you very much.

8 MR. BARBER: Okay. Questions for this
9 witness?

10 MR. ANGOFF: Yeah.

11 CROSS EXAMINATION

12 BY MR. ANGOFF:

13 Q. Does DFR do any independent analysis of MVP's
14 solvency?

15 A. We receive the financial statements, so I
16 review those at a high level.

17 Q. You review their annual statements.

18 A. At a high level. Yeah.

19 Q. But you or DFR staff people don't do any
20 independent analysis; correct?

21 A. We don't do a full-blown analysis. The New
22 York Department does that.

23 Q. And you don't go behind the annual statement?

24 A. Pardon?

25 Q. You don't -- you review the annual statement.

1 You don't go behind the annual statement.

2 A. I might look at the basic financials and then
3 I would most likely look at the supplemental healthcare
4 exhibit, and the NLR calculations, just to see if those
5 would affect Vermonters. If there would be a regional
6 effect.

7 Q. You review what's filed with New York and
8 filed with HHS and filed with the NAIC.

9 A. Yes.

10 Q. Did you do any type of analysis where you
11 attribute a certain amount of MVP's capital to Vermont?

12 A. No.

13 Q. And you say in your solvency opinion in the
14 first bullet on page 2 that you have been in touch with
15 the primary regulator in New York, and they didn't have
16 any solvency concerns; right?

17 A. Correct.

18 Q. Did they tell you that if this rate increase
19 was not approved in full, that they would have solvency
20 concerns?

21 A. They did not say that.

22 Q. Did they tell you if no rate increase is
23 approved that they would have solvency concerns?

24 A. No.

25 Q. Did they tell you that if a decrease was

1 approved they would have no solvency concerns?

2 A. No, they did not say that.

3 MR. BARBER: Does the board have
4 questions for Jesse?

5 MS. LUNGE: I have one question which,
6 Jesse, you may not be able to answer so feel free to
7 tell me -- to just say that. Do you know the status
8 of MVP's form filing, specifically the Gold Plan
9 that's being revised?

10 THE WITNESS: No. That would be rates
11 and forms section, so I'm not involved in that.

12 MS. LUNGE: Okay. Thank you.

13 THE WITNESS: Would you like us to get
14 back?

15 MS. LUNGE: Yes. It would be great if
16 we could get an update on the form filing when it's
17 approved. I don't have anything else.

18 CHAIRMAN MULLIN: Tom?

19 MR. PELHAM: Hi. A quick one here. So
20 I'm looking at the sentence in the commissioner's
21 letter that says: "Nonetheless adequacy of rates and
22 contribution to surplus are necessary for all health
23 insurers to maintain strength of capital that keeps
24 pace with claims trends."

25 But my thought would be anyhow is that

1 it's not just rates and surplus. There are -- rates
2 are certainly important, but it could also be a tax
3 credit that could be admitted, it could be bad
4 management that could be starving the bottom line.
5 There is a whole bunch of factors that at the end of
6 every year result in what falls to the bottom line
7 for surplus. Is that a fair assumption?

8 THE WITNESS: Yeah. I think we would
9 say there is quantitative and qualitative factors
10 that go into any company, and so those certainly get
11 taken into account. For instance, if the entire
12 executive team quit at once from a company, that
13 would be certainly very risky, and we would wonder
14 why.

15 So it's not necessarily a numerical
16 item that we would be looking at. Does that answer
17 your question?

18 MR. PELHAM: I think so. I mean you
19 could have, for example, a technological investment
20 that went sour, and all of a sudden it starts
21 bleeding. It has happened in state government from
22 time to time. Bleeding the organization of capital
23 that therefore cannot fall to the bottom line as
24 surplus.

25 So there is a whole bunch of moving

1 parts here that you have to take into consideration
2 at a certain point in time.

3 THE WITNESS: Yeah. I would say that's
4 fair.

5 CHAIRMAN MULLIN: Ms. Holmes.

6 MS. HOLMES: Just one question. I
7 think you said that there is -- every three to four
8 years there is a deeper dive, more like an audit, of
9 the insurer.

10 THE WITNESS: Yeah.

11 MS. HOLMES: When was the last time or
12 when is the next time that's going to be done?

13 THE WITNESS: For MVP?

14 MS. HOLMES: Yeah.

15 THE WITNESS: I would have to double
16 check that. It's the -- statutorily it's every three
17 to five years. I could get back to you. I'm not
18 exactly sure when -- New York would have done that.
19 And I don't think -- Vermont would not have been
20 involved.

21 MS. HOLMES: Okay. Well if you can get
22 back to me, that would be great.

23 THE WITNESS: Sure.

24 MS. HOLMES: Thank you.

25 MR. BARBER: Ms. Usifer, do you have

1 any questions?

2 MS. USIFER: No.

3 CHAIRMAN MULLIN: No.

4 MR. BARBER: Okay. Thanks for your
5 testimony.

6 THE WITNESS: Thank you.

7 MR. BARBER: So the next witness we
8 have on deck is Jacqueline Lee from Lewis & Ellis to
9 be directed by Associate General Counsel Aborjaily.
10 Whenever you're ready.

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1 JACQUELINE B. LEE

2 Having been previously duly sworn,
3 testified as follows:

4 DIRECT EXAMINATION

5 BY MS. ABORJAILY:

6 Q. Thank you. Good afternoon.

7 A. Good afternoon.

8 Q. Would you please state your name for the
9 record and tell us where you're employed?

10 A. Yes. Jacqueline Lee. I'm employed at Lewis &
11 Ellis.

12 Q. And what does Lewis & Ellis do?

13 A. We are an actuarial consulting firm. We are
14 in the Dallas office that's represented by the Green
15 Mountain Care Board. And we consult insurance companies,
16 state regulators, on actuarial issues.

17 Q. And what is your educational background?

18 A. I received a Bachelor of Science in math from
19 Texas Lutheran University. After college I became a
20 credentialed actuary, so I'm a fellow in the Society of
21 Actuaries and a member of the American Academy of
22 Actuaries.

23 Q. So about how long have you been practicing as
24 an actuary?

25 A. I have been an actuary for 15 years.

1 Q. And how long have you been retained by the
2 board to provide actuarial services to the State of
3 Vermont?

4 A. We have been employed by the board since 2014.

5 Q. Since 2014. In that time how many Vermont
6 health insurance rate filings have you worked on?

7 A. We have worked on about 65 filings in Vermont.

8 Q. And in what market segments have those filings
9 been in?

10 A. The market segments that we have worked in
11 have been the merged individual and small group filings,
12 and then we also have reviewed large group and association
13 compliance.

14 Q. So given that experience, how familiar are you
15 with the Vermont health insurance marketplace?

16 A. We are very familiar with the Vermont health
17 insurance marketplace now.

18 Q. And how about other states? How many rate
19 filings have L&E worked on?

20 A. We have worked on countless rate filings. We
21 have assisted about over 20 states since the inception of
22 the Affordable Care Act working specifically on issues
23 with the Affordable Care Act.

24 This year we are working with nine states to
25 -- similar to here -- where we are reviewing rate filings.

1 Some of the times we are -- have that same type of
2 purview. Others we are more in a guidance role. But in
3 either case we are involved in all the filing process.

4 Q. So given that you've done this work with other
5 states, what kind of comparative look would you say you
6 have at the nationwide health insurance marketplace?

7 A. Given that we have worked in a lot of the
8 states, it's helped us to better understand what the
9 variables are between the various states. It also helps
10 us get a handle on what's changing from a market-wide
11 perspective, but also how different states are handling
12 some of their regulatory environment changes. And we keep
13 up with that through just our contacts, but also just
14 through keeping up to speed on, you know, news and new
15 changes in regulations.

16 Q. So moving to reviewing a health insurance rate
17 filing. How do you go about doing the review in general
18 terms?

19 A. Generally speaking, we have three actuaries
20 that touch a filing in Vermont. The first level for this
21 particular filing was Josh Hammerquist. He does a deep
22 dive. He has the most correspondence with the carriers
23 reviewing the initial filing that they have provided
24 through SERFF. And then I work as a peer reviewer. I do
25 a fairly deep review alongside of him talking through key

1 issues, making sure that he's caught all of the questions
2 that we need ask.

3 And then Dave Dillon also helps out because he
4 has a similar role in the Blue Cross filing that I do, but
5 we talk about them in great detail to make sure that we
6 are consistent between the two filings as well as making
7 sure we are accounting for all the market-wide changes
8 that happen.

9 Q. You mentioned the term is SERFF. Could you
10 explain a little bit what SERFF is?

11 A. SERFF is the NAIC's platform for the
12 submission of rate filings, and it's the way we
13 communicate with the carriers to ensure that all of it is
14 available via public record so there is transparency to
15 the process.

16 Q. And when you are reviewing a health insurance
17 filing and you are assisting the board, what is it that
18 you are assisting the board with in terms of evaluation?

19 A. So our charge to the -- is to help the board
20 determine if the rates that have been submitted are
21 reasonable. And how we go about that is look at all of
22 the underlying assumptions to build up to the rate as well
23 as the starting point, and make sure that it's properly
24 supported, that the support appears to be reasonable. And
25 that they have accounted for all of the pieces that they

1 need to within the rate.

2 Q. And when you're making your determination
3 about whether you believe rates to be reasonable, are
4 there certain criteria that are defined in professional
5 guidelines or in state statutes that you're looking at?

6 A. Yes. We have a lot of guidance regarding
7 rates. Some are at the federal level. Some are at the
8 state level. And we have to abide by those.

9 We also -- from the actuarial profession we
10 have standards of practice that we call actuarial
11 standards of practice or ASOP that we have to follow as
12 well. Those provide us guidance that is a little bit more
13 specific to our role to make sure that we are accounting
14 for all the pieces that we need to do so.

15 Q. And so after a company's filing their
16 information into SERFF, how do you go about getting more
17 information should you need it during the review?

18 A. Typically it begins with an inquiry letter
19 that we send through SERFF to each of the carriers. We
20 give them a defined time frame to respond so we can get
21 our responses back. We have that back and forth several
22 times through the process.

23 Q. And that was true with this filing as well?

24 A. Yes, it was.

25 Q. And how long do you have to review a filing

1 from the time it's submitted to the board?

2 A. We have 60 days.

3 Q. And what happens at the conclusion of the 60
4 days?

5 A. We have to submit a final report that becomes
6 publicly available to all the parties.

7 Q. And is it your understanding that the 60 days
8 is a statutory deadline?

9 A. Yes.

10 Q. So talking about today's rate filing, what was
11 your role in L&E's review of this?

12 A. My role was a peer reviewer of the filing
13 itself. So I took a deep dive alongside Josh Hammerquist
14 to make sure that we understood all of the underlying
15 reasons for the rate increase, and asked sufficient
16 questions to make sure that we were in agreement, or if
17 there were disagreements, where we differed.

18 Q. And were you involved in writing the actuarial
19 report with respect to the findings?

20 A. Yes.

21 Q. And is that Exhibit 9, I believe?

22 A. Yes. It is.

23 Q. Now on page 2 of Exhibit 9 you'll see that
24 there is a paragraph labeled "Standard of Review." Is
25 this your standard of review, or is this the board's

1 standard of review?

2 A. This is the board's standard of review.

3 Q. And the standard of review is from the
4 statute?

5 A. Yes, it is.

6 Q. And what is L&E's standard of review?

7 A. Our standard of review incorporates some of
8 the portions of the board's standard of review. Ours is
9 defined through ASOP 8 where we are evaluating whether the
10 rates are excessive, inadequate or unfairly
11 discriminatory.

12 Q. Have you defined ASOP for everyone?

13 A. Yes. Actuarial standard of practice.

14 Q. Thank you. I might have missed that. And how
15 do you determine whether a rate is excessive according to
16 the actuarial standard of practice?

17 A. The actuarial standard defines excessive as
18 having rates that are charged that exceed the amount that
19 are needed to pay for claims, admin, taxes, fees and a
20 reasonable contribution to reserves or profit.

21 Q. And how is adequate defined?

22 A. Adequate is very similar, except it kind of
23 takes the opposing view where we are assessing whether the
24 rates are sufficient to cover the claims, admin expenses,
25 taxes, regulatory fees and a reasonable profit.

1 Q. And how is the term unfairly discriminatory
2 defined?

3 A. Unfairly discriminatory is defined as charging
4 rates to a specific cohort of individuals that is not
5 supported by their respective costs or not supported by
6 federal or other regulatory guidance.

7 Q. And earlier this morning we heard some
8 testimony briefly from MVP about affordability. Just to
9 be clear, did L&E review this filing for affordability?

10 A. We did not.

11 Q. And are there actuarially defined standards
12 for affordability?

13 A. There is not.

14 Q. So moving to the language in your memo. At
15 various points throughout this you said that the
16 carrier's assumption is reasonable and appropriate. Could
17 you give a little explanation of what you mean when you
18 say it's reasonable and appropriate?

19 A. Sure. We use that term to basically state
20 it's not excessive, not inadequate, and not unfairly
21 discriminatory. When we make a recommendation it is
22 typically because it has violated one of those.

23 Q. Moving to your recommendations which I believe
24 are listed back on page 15.

25 A. Yes.

1 Q. Could you give a brief overview of -- before
2 we go into each specific one, could you just sort of skip
3 to the end and just tell us what the ultimate projected
4 rate increase would be if all of your recommendations were
5 implemented?

6 A. Yes. MVP's initial rate increase was 9.4
7 percent. If all of our recommendations were taken into
8 account, then the rate increase changes to 10.5 percent.

9 Q. Okay. And just to be clear, we heard some
10 testimony this morning about budget submission
11 information, updated information, and hospitals submitted
12 their budgets. Is there any recommendation as to that
13 included within the recommendation of 10.5?

14 A. There is not.

15 Q. And we can circle back to that in just a bit.
16 I'm going to walk through the rest of these, but I'll
17 start from the top.

18 So what is the medical trend MVP originally
19 filed as described on page 5?

20 A. Medical trend as filed -- the allowed medical
21 trend is 4.2 percent.

22 Q. And what is the basis of the unit cost trend
23 assumption for this filing?

24 A. The unit cost trend assumption is, in fact,
25 the 4.2 percent. It is accounting for the changes in the

1 hospital contracts between the two years.

2 Q. Okay. And earlier this morning there was some
3 testimony about an error that was discovered as part of
4 this during the review. Could you explain a little bit
5 more about your questions to MVP and what the result of
6 those conversations were?

7 A. Sure. As part of our review we want to ensure
8 that the unit cost assumed within the filing are matching
9 hospital budget process since it is well defined within
10 the Green Mountain Care Board's hospital budget process.
11 So we always ask them to itemize that by facility. In
12 performing that, they recognize that they, meaning the
13 carrier, recognized that they had accidentally used the
14 initial submission of trends rather than the final,
15 approved and ordered unit cost trends.

16 Q. So turning back to page 15, that would be the
17 first bullet point?

18 A. Yes. We recommend that they do, in fact,
19 reflect the order unit cost increases which reduces the
20 premiums by about .9 percent.

21 Q. And do you have any other recommendations
22 regarding the cost trend?

23 A. Yes. As we have discussed earlier today, some
24 updated information regarding the hospital budget process
25 since it has begun has been published in the form of

1 narratives. That typically happens every year, so we were
2 anticipating that happening again.

3 Our recommendation is -- to the board is that
4 the most up-to-date information be used with finalizing
5 and producing the work.

6 Q. And have you had an opportunity to review
7 submissions for this year?

8 A. Yes.

9 Q. Have you had an opportunity -- well it sounds
10 like you had an opportunity then to review hospital budget
11 submissions and draft orders for past years as well; is
12 that right?

13 A. Yes. That's correct.

14 Q. And let's say just for the last three years,
15 what's been the relationship between the budget submission
16 and the rates as they are proposed and then the final
17 budget order from the board?

18 A. The final budget order from the board is
19 typically lower than the original submissions for the
20 hospitals.

21 Q. And you heard some testimony this morning from
22 MVP about what their assumption is based on the budget
23 submissions as they are now. And do you have an opinion
24 on MVP's assumptions?

25 A. I do not have a formal opinion because we have

1 not seen the breakdown. However, we did an independent
2 calculation as well, and our figure closely matches the .5
3 percent that Mr. Lombardo quoted earlier. We would like
4 to see the backup of that.

5 So we do agree that if the proposed trends
6 were incorporated, that would be the rate change.

7 Q. You mentioned independent calculation. And I
8 realize we didn't cover something earlier, but when you
9 were reviewing the filing, do you do independent
10 calculations on everything that's submitted, or are there
11 some instances when you are simply checking the
12 calculations that the carrier has done?

13 A. We typically do a mixture of both. The bigger
14 an assumption is, the greater impact is, we will typically
15 review what the carrier has submitted but also perform our
16 own independent analysis to ensure that either using a
17 different methodology or using different backup data that
18 we come to a similar conclusion.

19 Q. So turning to the other portion of the medical
20 trend. What is the basis of the utilization trend in this
21 filing?

22 A. The initial utilization trend filed by MVP was
23 zero percent. They had performed an analysis where they
24 looked at a closed cohort due to their very recent, large
25 increase in membership. They didn't want to include the

1 newer members because they didn't have as much history of
2 data on those individuals. This proved to be very
3 volatile in its -- in its results. And so they determined
4 it was inconclusive and filed a zero percent which is what
5 they have done since 2014.

6 Q. And do you agree with that assumption?

7 A. We do not agree with that assumption.

8 Q. Could you expand upon that?

9 A. We performed -- given the results of their
10 analysis and the credibility issues that they were
11 experiencing, we determined that a market-wide study would
12 be helpful. So we gathered confidential data from both
13 carriers in the market to do a market-wide scan of the
14 utilization.

15 We came up with some results that can be seen
16 on page 7 of Exhibit 9 of our report. These were all
17 showing non-zero positive trends. So we felt like that it
18 was appropriate to make an adjustment.

19 Our recommended range for the market is having
20 a utilization trend between 1 and 4. For MVP we have
21 recommended a 1 percent utilization trend, and that was
22 based on all of the data we were reviewing, not just the
23 market. We recognize that there is a difference between
24 the populations covered between MVP and Blue Cross, and
25 that MVP's specific data has shown some downward trend in

1 their past, but in 2018 both carriers did experience an
2 increase which we felt should be reflected but maybe not
3 to the same extent as the high end of the ratio which was
4 4.

5 Q. Thank you. Move back to page 15 again.
6 Looking at the next bullet point we were talking about AHP
7 morbidity impacts. Can you explain a little bit about the
8 Association Health Plans, we heard a bit about this
9 morning. So just a brief overview.

10 A. Yes. Mr. Lombardo's summary was quite good.
11 He outlined that in the last year AHPs have been allowable
12 again, which allows small groups to band together to
13 create a larger group called Association Health Plan and
14 to seek coverage. There's been a lot of changes over the
15 last six months and even last month on this issue with
16 DFR's bulletin saying that in 2020 these plans will not be
17 allowed to renew. So given that information, MVP said
18 that they are no longer requesting the rate increase of .8
19 percent for this particular issue.

20 Q. And what is your recommendation regarding --

21 A. Our recommendation is to remove the AHP
22 morbidity load on claims which would reduce the projected
23 premiums about .8 percent.

24 Q. Moving on to a discussion about risk
25 adjustment. Could you briefly explain what makes the risk

1 adjustment calculation so challenging?

2 A. The risk adjustment calculation is challenging
3 from a carrier perspective because it requires them to
4 have knowledge of the other carriers in the market that is
5 confidential such as their risk scores and risk profiles
6 of their populations. Therefore, they aren't very easily
7 able to understand their position in that particular
8 calculation.

9 Additionally, for the 2020 calendar year CMS
10 is making changes to the risk adjustment formula. So
11 there were changes in coefficients or weightings for some
12 of the particular diagnoses, and that was also producing
13 some question marks for each of the carriers as well.

14 Q. And in terms of the timing of the CMS the CMS
15 risk adjustment calculation, could you explain a little
16 bit more about when the information comes in, and at what
17 point you're sure they know what they are looking at?

18 A. Yes. During -- the filing here in Vermont was
19 due roughly around May 11. And the risk adjustment
20 calculation payment transfer information comes out at the
21 end of June. So it's kind of right in the middle of our
22 review period, which proves challenging because that's not
23 too far away from the 60-day deadline that we discussed
24 earlier, and it makes it challenging to have a quick
25 turnaround on that type of information.

1 So to mitigate that, over the past couple of
2 years, we have requested the information that they provide
3 to CMS individually so that we can provide a preliminary
4 calculation earlier in the process, typically provide that
5 to them sometime in May. So that they can provide us with
6 an assessment of how they are going to change their rates
7 and what rate impact that would have earlier in the
8 process.

9 Q. And after having done that work, does L&E have
10 a recommendation regarding risk adjustment?

11 A. Yes. So after performing that work we also
12 did perform an analysis on what the 2020 coefficient
13 change would be. And if you combine those two
14 adjustments, we recommended these rates will increase by
15 1.5 percent.

16 Q. And moving on to our last bullet point for
17 recommendations on page 15 "Changes to Actuarial Value."
18 As we discussed briefly a bit earlier in this morning's
19 testimony there is an outstanding issue of one of MVP's
20 Non-standard Gold Plans.

21 Could you explain where things stand now from
22 your perspective in your recommendation?

23 A. Our recommendation was based on correspondence
24 of a few weeks ago. It's my understanding there is still
25 some loose ends to be tied up here in the next week or so.

1 I don't know that that will have a material change, but we
2 do have an estimate as of a couple of weeks ago, that
3 those changes to the plan will reduce the overall
4 projected premiums by about .2 percent.

5 Q. The recommendations that we have gone through
6 so far have been recommendations involving a change to --
7 that would have a rate impact, and I just wanted to touch
8 on one more recommendation that we have listed here. And
9 that's the new high-cost member program.

10 A. Yes.

11 Q. Could you tell us about your recommendation
12 with regard to that?

13 A. Yes. Mr. Lombardo testified already to what
14 the new high-cost program is. And we just recommended to
15 be compliant with instructions that the -- that assumption
16 be included under the net reinsurance section rather than
17 the risk adjustment section they put it under in the
18 original filing.

19 Q. And to be clear, will that have an impact on
20 rates?

21 A. No, it will not.

22 Q. So let's just briefly turn to contribution to
23 reserves. In your analysis for your report do you review
24 for solvency and contribution to reserves?

25 A. Yes, we do.

1 Q. Is it your understanding that DFR is the --
2 has the primary responsibility for reviewing for solvency?

3 A. They do.

4 Q. And did you prepare any confidential
5 information reviewing for company solvency?

6 A. We did.

7 Q. Do you find the company's assumption of a 1.5
8 percent contribution to reserve to be reasonable and
9 appropriate?

10 A. Yes, we do.

11 Q. So with the recommendation that you have
12 outlined in this report, do you find the filing excessive?

13 A. I do not.

14 Q. Is it inadequate?

15 A. It is not.

16 Q. And is it unfairly discriminatory?

17 A. It is not.

18 MS. ABORJAILY: I have no further
19 questions.

20 MR. BARBER: Okay. Do you have
21 questions for Ms. Lee?

22 MR. KARNEDY: I do.

23 CROSS EXAMINATION

24 BY MR. KARNEDY:

25 Q. Good afternoon, Ms. Lee. How are you?

1 A. I'm good. How are you?

2 Q. I'm well. It sounds like you've got your
3 report in front of you which is Exhibit 9. This is your
4 actuarial opinion; correct?

5 A. Yes, it is.

6 Q. If you go to page 2, I think you were asked
7 about this. I just want to read, understand or review
8 where it starts. "This letter is to assist the board in
9 determining whether the requested rate is affordable, most
10 quality care, most access to healthcare, protects insurer
11 solvency, is not unjust, unfair, inequitable, misleading
12 or contrary to the law, and is not excessive, inadequate
13 or unfairly discriminatory."

14 Did I read that correctly?

15 A. Yes, you did.

16 Q. Okay. Is that a correct statement of the
17 tasks?

18 A. Yes.

19 Q. And the board should consider this report in
20 drawing its conclusions in this year's rate filing;
21 correct?

22 A. Yes, they should.

23 Q. Okay. Let's go to page 17, please. Let me
24 know when you're there.

25 A. I am there.

- 1 Q. Is that your signature in the middle?
- 2 A. Yes, it is.
- 3 Q. Okay. So you're signing off on this report;
- 4 right?
- 5 A. Yes, I am.
- 6 Q. And what do those letters after your name
- 7 mean?
- 8 A. FSA means Fellow in the Society of Actuaries.
- 9 Q. Yeah.
- 10 A. And MAAA means Member in the American Academy
- 11 of Actuaries.
- 12 Q. And there is a signature above of Josh
- 13 Hammerquist; correct?
- 14 A. Yes.
- 15 Q. So Josh signed off on this as well?
- 16 A. Yes, he did.
- 17 Q. And he's an actuary?
- 18 A. He is a fellow.
- 19 Q. And he has those same letters after his name;
- 20 right?
- 21 A. Yes, he does.
- 22 Q. Okay. There is a signature below by Mr.
- 23 Dillon who I think is here today. Correct?
- 24 A. Yes.
- 25 Q. And he has those same letters after his name;

1 right?

2 A. Yes.

3 Q. And he's a principal at Lewis & Ellis?

4 A. Yes.

5 Q. So three actuaries have signed off on this
6 report; correct?

7 A. Yes.

8 Q. And I think you said you've done 65 filings in
9 Vermont alone; is that right?

10 A. That's correct.

11 Q. And in other states, you've done filings in
12 more than 20 states or around 20 states?

13 A. Yes.

14 Q. And this year you've got at least nine states
15 you're working in?

16 A. That's correct.

17 Q. Okay. Page -- go to page 18, please. There
18 is a Disclosures in Actuarial Reports." Do you see
19 that --

20 A. Yes.

21 Q. -- as a heading? Would you read the fourth
22 bullet?

23 A. "The responsible actuaries"?

24 Q. Please.

25 A. "The responsible actuaries identified above

1 are qualified as specified in the qualification standards
2 of the American Academy of Actuaries."

3 Q. Thank you. And would you read the second
4 bullet, please?

5 A. "Lewis & Ellis is financially and
6 organizationally independent from the health insurance
7 issuers whose rate filings were reviewed. There is
8 nothing that would impair or seem to impair the
9 objectivity of the work."

10 Q. So is it fair to say that L&E is not beholden
11 to MVP; is it?

12 A. That's fair.

13 Q. And your opinions are governed by a Code of
14 Professional Conduct; correct?

15 A. That's correct.

16 Q. And the ASOPs?

17 A. And the ASOPs. Yes.

18 Q. And the third bullet, would you read that,
19 please?

20 A. "The purpose of this report is to assist the
21 board in assessing whether to approve, modify, or
22 disapprove the rate filing."

23 Q. And my presumption is that you're not told in
24 advance by the board some preordained number for a rate
25 increase that they might like you to find. You're

1 providing an independent objective opinion; correct?

2 A. That is correct.

3 Q. And would you agree with me that such
4 independence and objectivity add significant credibility
5 to your actuarial opinions?

6 A. It does.

7 Q. As an actuary you aren't influenced by public
8 opinion. That doesn't enter in your calculus; does it?

9 A. No, it does not.

10 Q. And that objectivity is illustrated in Exhibit
11 9. If your opinion is that MVP's approach on a particular
12 issue is reasonable and appropriate, you've said so;
13 haven't you?

14 A. That's correct.

15 Q. And that's indicated in the exhibit; correct?

16 A. Yes.

17 Q. And if you don't agree with MVP, you say so.
18 Correct?

19 A. That's correct.

20 Q. And you recommend a change?

21 A. We quantify the change. Yes.

22 Q. Okay. Even if your recommendation results in
23 a higher rate than even MVP's requesting in any given
24 year; correct?

25 A. That's correct.

1 Q. Like an umpire in a baseball game, you call
2 them as you see them; don't you?

3 A. That's correct.

4 Q. And the percentage rate increase that you're
5 recommending this year, the 10.5, is what you believe the
6 board should adopt; correct?

7 A. I think the board should adopt 10.5, but there
8 are a few items that are still outstanding.

9 Q. Fair enough. Fair enough. You heard Matt's
10 -- Mr. Lombardo's testimony regarding a .5 percent
11 increase relating to the July 16 completed, proposed
12 budgets of the hospitals?

13 A. That's correct.

14 Q. And that's the most recent data we have as we
15 sit here today; correct?

16 A. That is correct.

17 Q. And it sounds like you concur with the
18 calculus where they came to a .5 percent change, but you
19 want to confirm and see their backup; is that right?

20 A. That's correct.

21 Q. Last year when this issue came up, not saying
22 numbers line up, but just coincidentally, MVP -- similar
23 situation on hospital budgets. They came up with a .5,
24 and you reduced that to .2 relying on historical data. Do
25 you recall that?

1 A. Yes.

2 Q. Have you done that this year?

3 A. I have not had an opportunity to do that this
4 year.

5 Q. Based on your experience do you expect that if
6 you do that, there will be a difference of opinion? It
7 won't be .5?

8 A. I do expect there to be a difference of
9 opinion.

10 Q. Do you expect it will be in the range of .2,
11 or do you know?

12 A. I would say .2 to .3.

13 Q. Thank you very much. Now last year when you
14 and Mr. Lombardo had a respectful disagreement about how
15 to approach that, you didn't have the benefit of knowing
16 that the board in really 2019 made a change to some
17 hospital amounts that they can charge; correct? That
18 hadn't occurred; right?

19 A. Correct.

20 Q. But you're familiar with that occurring this
21 year?

22 A. Yes.

23 Q. So do you believe you can predict with a
24 hundred percent certainty that the board is going to
25 reduce -- reduce from the proposed budgets?

1 A. No.

2 Q. And this year you're recommending an increase
3 above what MVP has originally filed; correct?

4 A. Yes.

5 Q. So with all the numbers, the variables and
6 issues that are in MVP's report, and in your good report,
7 they are at 11 percent, and you're at maybe it's 10.7 or
8 10.8, we're not sure, but close; correct?

9 A. That's correct.

10 Q. And that was the only issue of disagreement
11 this year, the hospital budget issue; right?

12 A. Yes.

13 Q. And you heard Mr. Lombardo's testimony this
14 morning?

15 A. I did.

16 Q. I don't believe he testified this afternoon.
17 And MVP agreed with all of your recommendations on page 15
18 of your report. Correct? All the bullets?

19 A. Yes.

20 Q. And you heard that Mr. Lombardo -- he's also a
21 member of the American Academy; right?

22 A. Yes.

23 Q. And you know that Eric Bachner who works with
24 Mr. Lombardo also signed the amended filing; correct?

25 A. Yes.

1 Q. If I count that up right, that's five
2 actuaries; is that correct?

3 A. That's correct.

4 Q. Three from L&E, two from MVP recommended a
5 10.5 percent increase with a caveat that MVP would say go
6 to 11 percent, and L&E would say maybe go to 10.7, 10.8
7 percent. We're not sure yet.

8 Is that a fair summary?

9 A. That is correct.

10 Q. But they all agree on the increase over the
11 9.4; correct?

12 A. Yes.

13 Q. Would you agree with me that five heads are
14 better than one?

15 A. Yes.

16 Q. And that multiple, very smart people, have all
17 agreed with the proposed rate increase with this caveat of
18 about 10.7 or 10.8 versus 11; correct?

19 A. Yes.

20 Q. I want to ask you a little bit about
21 administrative costs.

22 Would you please go to page 13. Page 13 of
23 the exhibit.

24 A. I'm there.

25 Q. And there is a number 13, "Changes in

1 Administrative Costs." Do you see that?

2 A. Yes.

3 Q. The first paragraph -- read the third
4 sentence, please.

5 A. "Because the premium is also increasing from
6 the 2019 exchange filing."

7 Q. I think I might be on the wrong page. Bear
8 with me a second. Oh, I'm sorry. I said the third
9 sentence. I think you're reading the fourth sentence. I
10 tricked you. So could you please read the third sentence?

11 A. "The overall rate impact is a decrease of 1
12 percent."

13 Q. And you reference the 42 PMPM in the first
14 sentence; do you see that?

15 A. Yes.

16 Q. And then in the next paragraph the second
17 sentence you said: "These costs have fallen substantially
18 since 2013 when they were 46.57 PMPM." Do you see that?

19 A. Yes.

20 Q. Do you stand by that statement?

21 A. Yes.

22 Q. And then the second paragraph, would you read
23 the last sentence, please?

24 A. "In light of the steps taken by MVP to reduce
25 administrative costs over the recent years, the assumed

1 administrative 2020 costs are reasonable and appropriate."

2 Q. So it's your opinion as an actuary for Green
3 Mountain Care Board that MVP has substantially reduced
4 administrative costs over recent years; correct?

5 A. Correct.

6 Q. Okay. Let's go to unit trend on page 5. Unit
7 cost trend. I asked Matt about it this morning. Just
8 cleaning up a typo, and I just want to make sure it didn't
9 change your opinions in anyway.

10 That last bullet on page 5 it says:
11 "Approximately 40 percent," and goes on from there. Did
12 you see that?

13 A. Yes.

14 Q. That number in the original L&E filing was 55
15 percent. And that was a mistake. It was changed to 40;
16 correct?

17 A. That's correct.

18 Q. That doesn't change your opinions in anyway?

19 A. It does not.

20 Q. Okay. On "Contributions to Reserves." Let's
21 go to page 14, please. Would you read -- there is one
22 paragraph -- the last paragraph of 15. Would you read the
23 first sentence in that last paragraph starting "L&E
24 believes."

25 A. "L&E believes the CTR assumption is reasonable

1 and does not recommend any changes to the CTR."

2 Q. And would this be true if you increased to the
3 11 percent suggested by MVP or the 10.7/10.8 percent that
4 may be suggested by L&E?

5 A. Yes.

6 Q. And then I wanted to clean up another typo
7 just so the record's clear. Not trying to point anything
8 out. If you look at the very first paragraph in 15,
9 "Changes in Contributions to Reserves." I think there is
10 a typo in there. So let me first ask you the question.

11 Do you recall last year MVP requested 2
12 percent and the board approved 1.5 percent?

13 A. I will trust your statement.

14 Q. Okay. So it looks like the inference could be
15 drawn that the board only approved a .5 percent last year.
16 Would that be an error? It was actually 1.5 percent?

17 A. I believe so.

18 Q. All right. Point is, in this paragraph MVP's
19 requesting a lower CTR than it did last year; right? It
20 requested 2 percent last year and 1.5 percent this year?

21 A. That's correct.

22 Q. Okay. And we reviewed with interest your
23 reasonableness checks which are referenced in the second
24 and third paragraphs under section 15 on page 14. Do you
25 see that?

1 A. Yes.

2 Q. Would you explain what you did there, please?

3 A. Yes. We utilized the publicly-available data
4 from the URRTs to assess where the contribution to reserve
5 figure landed relative to the other filings for the prior
6 two years.

7 Q. And what did you find?

8 A. We found that the average submitted CTR was
9 2.95 percent, and the median was 3.15 percent. And that
10 MVP's assumption of 1.5 percent would rank as 629 out of
11 the 777 filings.

12 Q. So for -- it's the first year. For 2019, 82
13 percent of the filings were higher than the 1.5 percent;
14 is that right?

15 A. Yes. That's correct.

16 Q. And for 2018, in that next paragraph, 79
17 percent of the filings were higher than 1.5 percent;
18 right?

19 A. That's correct.

20 Q. Do you know on that -- I'm visualizing a
21 curve. What percentage was at 1 percent or less?

22 A. I do not know that.

23 Q. As an actuary you want to be conservative in
24 considering CTR, so you've set aside sufficient monies;
25 correct?

1 A. Agreed.

2 Q. As an actuary you don't want to set aside too
3 much or too little; correct?

4 A. That's correct.

5 Q. And you don't want to be an outlier on that
6 bell curve; do you?

7 A. You do not.

8 Q. I want to -- you were asked about medical
9 utilization trend. I just want to go to that briefly.

10 If you go to page 15, just for point of
11 reference. Bullet 3. That's the medical utilization
12 trend conclusion which would increase the rates by
13 approximately 1.5 percent; correct?

14 A. Correct.

15 Q. And you heard more questions about this
16 medical utilization trend just before the lunch break;
17 correct?

18 A. Correct.

19 Q. Okay. If you go to the bottom of page 6 of
20 your report, please. And there is a sentence that starts
21 "Because." Could you read that sentence, please?

22 A. "Because of the atypical results produced by
23 MVP's analysis using their own data, L&E analyzed
24 utilization trends by using market-wide utilization data,
25 i.e., a combination of utilization data from both QHP

1 carriers."

2 Q. So L&E used more data; correct?

3 A. Correct.

4 Q. And that was appropriate in your opinion;
5 correct?

6 A. Yes.

7 Q. And you stand by this conclusion; don't you?

8 A. Yes.

9 Q. If you go back to page 15, please. L&E makes
10 a recommendation on a variety of issues to modify MVP's
11 proposal; correct?

12 A. Correct.

13 Q. And would you agree with me that all these
14 issues are interrelated? They all impact the final
15 number?

16 A. Yes. They are all interrelated.

17 Q. There's some pluses, there's some minuses, but
18 they all impact that final number; correct?

19 A. Correct.

20 Q. Thank you very much.

21 MR. BARBER: Mr. Angoff.

22 CROSS EXAMINATION

23 BY MR. ANGOFF:

24 Q. Good afternoon, Ms. Lee.

25 A. Good afternoon.

1 Q. You found that a 10.5 percent increase would
2 produce rates that are not excessive, inadequate or
3 unfairly discriminatory; correct?

4 A. Correct.

5 Q. You didn't find anything with respect to
6 whether or not that 10.5 percent rate increase would be
7 affordable?

8 A. Yes. I did not.

9 Q. And that's not your job; right?

10 A. That is not.

11 Q. Similarly you didn't find that the 10.5
12 percent increase would promote quality care?

13 A. Did not.

14 Q. And you didn't find that it would promote
15 access to healthcare?

16 A. We did not.

17 Q. Okay. This might be just be a quibble, but on
18 page two you say: Under "Standard of Review," you say
19 that, "The purpose of this letter is to assist the board
20 in determining whether the requested rate is affordable
21 and contains" -- and then you go on to repeat all the
22 standards in the statute.

23 That's an overstatement; isn't it? Your
24 purpose is to assist the board in determining whether or
25 not the rate is excessive, inadequate and unfairly

1 discriminatory; correct?

2 A. We are assisting the board by providing the
3 information regarding the filing. They make the
4 determinations on all of those pieces, but we do provide
5 that information.

6 Q. They make the determination on all those
7 pieces?

8 A. Right.

9 Q. But your expertise is limited to whether or
10 not the rate is excessive, inadequate or unfairly
11 discriminatory; correct?

12 A. That's correct.

13 Q. I take it that you found the 9.4 percent
14 increase proposed by MVP would produce inadequate rates?

15 A. That's correct.

16 Q. Okay. You know Mr. Lombardo; right?

17 A. Yes.

18 Q. Mr. Lombardo's an actuary; correct?

19 A. Yes.

20 Q. A credentialed actuary?

21 A. That's correct.

22 Q. Why would MVP submit an increase -- submit a
23 proposed rate that produces inadequate rates?

24 A. We had more information than he did. Based on
25 his knowledge he did submit a rate that was adequate. But

1 based on more information, we determined that it was
2 potentially inadequate.

3 Q. I'm sorry. You determined that what?

4 A. It was potentially inadequate because we had
5 more information.

6 Q. Potentially inadequate. Could you please turn
7 to page 2? I'm sorry. Page 4 in the L&E report Exhibit
8 9. And you see paragraph 1 there under the chart where
9 you say that URRT shows that the 2018 allowed claim
10 experience was 1.4 percent lower than projected?

11 A. Yes.

12 Q. Okay. And so what does that mean?

13 A. That means that the experience came in
14 favorably for that in that time frame.

15 Q. I'm sorry. I didn't catch the last part of
16 it.

17 A. In that time frame.

18 Q. I'm sorry. I'm hard of hearing. Could you
19 get closer to the mic and speak louder?

20 A. I don't think the mic's working.

21 Q. That would explain it.

22 A. I think I said that that means that they had
23 unfavorable claim experience during that time frame.

24 Q. Okay. And so they paid out less than they
25 projected they were to pay?

1 A. That's correct.

2 Q. And less than you projected that they would
3 pay out; correct?

4 A. That's correct.

5 Q. Could you turn, please, to page 6. And under
6 "Utilization Trend and Intensity." You see that -- you
7 note that MVP assumed a zero percent trend?

8 A. Yes. That's correct.

9 Q. Okay. And were they using the same
10 methodology they used in the past?

11 A. I believe the last two years they have
12 performed an analysis, but I would have to go back and
13 review my notes. In some of the years they felt their
14 data was not credible enough, and so they didn't provide
15 us with a lot of information. But I do believe the last
16 two years they performed a similar closed-court analysis.

17 Q. As you say in the middle of page 7, "There is
18 a wide range of results when different analyses --
19 analysis methods are used;" right?

20 A. That's correct.

21 Q. Okay. So was your conclusion that their
22 method of analysis, based on which they came up with the
23 zero percent utilization trend, was defective?

24 A. No. They had a disadvantage. On page 6 I
25 state that, "Since 2017 MVP has approximately tripled its

1 membership."

2 That's great from the perspective of gaining
3 market share, but it is not great for being able to
4 predict what that population is going to do in the future.
5 They haven't been around long enough.

6 Q. So you have another method which you think is
7 superior?

8 A. Correct.

9 Q. But that -- does that mean that you reject
10 their method? Does that mean that you think their method
11 is unacceptable? Actuarially unacceptable?

12 A. No. We utilize their information as well.

13 Q. Say that again.

14 A. We utilize their information as well alone.
15 No.

16 Q. Let me ask it this way. Do you believe that
17 the methodology they used that produced the zero percent
18 trend was actuarially unacceptable?

19 A. Based on the information that they had, no.

20 Q. So you chose a 1 percent trend rather than the
21 zero percent trend; correct?

22 A. Correct.

23 Q. Can you show me where that is in your chart on
24 page 16?

25 A. On page 16 the second chart, there is a line

1 number three, trend from 2019 to 2020. They originally
2 had 4.8. Now it's 5.1. That change is embedded in there
3 as well as -- I'm sorry. The one prior to it as well. 2.
4 Difference in trend between '18 and '19. A combination of
5 those two has it included.

6 Q. Okay. So I'm not going find the 1 percent
7 directly reflected, but it's embedded in two of the lines,
8 2 and 3?

9 A. Correct. And unfortunately this is based on
10 the URRT, and the URRT splits that over two years which
11 makes it challenging to directly see it.

12 Q. What did you find was a reasonable
13 prescription trend?

14 A. You mean prescription drugs?

15 Q. Yes.

16 A. 8.2 percent as filed by the carrier.

17 Q. And could you go to Exhibit 6, page 3, please.

18 A. Okay. I'm there.

19 Q. And does the fact in 2017, the latest year for
20 which data is available, that the drug trend was -- the
21 actual drug trend was so much lower than what was proposed
22 by either MVP or L&E, does that give you any pause about
23 assuming the trend you are assuming this year?

24 A. It does not because I -- because I don't
25 think that -- it does not tell the whole story in that

1 MVP's book of business is healthier on average and there
2 is a risk adjustment per component that makes it
3 challenging to look at claims information in isolation of
4 that very large trigger.

5 Q. Can risk adjustment account for a difference
6 that is that great?

7 A. Yes.

8 Q. Have you seen it account for a difference that
9 great?

10 A. MVP's payable's quite large. And even on a
11 PMPM basis it's quite large.

12 Q. I'm sorry. I missed the last statement.

13 A. Even on a PMPM basis it is quite large.

14 Q. What is quite large?

15 A. The risk adjustment payable.

16 Q. Is it large enough to make up the difference
17 between the 4.4 and the 11.1?

18 A. I have not done that calculation because you
19 can't break that out as easily, but I can see that being
20 the case. Yes.

21 Q. Last year MVP assumed that because of the zero
22 penalty for the individual mandate that healthy people
23 would leave the company; correct?

24 A. Yes.

25 Q. And you all assumed the same thing; correct?

1 A. Yes.

2 Q. And that didn't prove to be true; did it?

3 A. No.

4 Q. And MVP accounts for that in the filing;
5 correct? MVP accounts for the fact that its assumption
6 about people leaving because of the zero individual
7 mandate penalty proved to be incorrect. They account for
8 that in the filing.

9 A. Yes. They do.

10 Q. Can you explain how MVP handles pooling claims
11 above 100,000?

12 A. Yes. I'll turn to their exhibit or their
13 memo. They remove claims over a hundred thousand dollars
14 to ensure that they are not overreacting to large claims
15 and to single out their experience period data so that
16 it's not impacted by large claims.

17 Q. Do you know is that methodology typical among
18 companies?

19 A. Yes.

20 Q. Any companies use the actual rather than the
21 expected?

22 A. Very rarely. I wouldn't recommend it because
23 then in some years you could have a great increase due to
24 one claimant that may or may not be around in the next
25 time period.

1 Q. Sure. But you haven't seen that. Have you
2 seen that type of increase here?

3 A. Can you rephrase? What is your question,
4 please?

5 Q. Have you seen a huge increase with an MVP
6 claim that would make it improper to do the analysis based
7 on the actual rather than the expected?

8 A. They have always performed this calculation to
9 smooth out the data.

10 Q. They have also done the expected?

11 A. Correct.

12 Q. Can you turn to the top of page 10.

13 A. Of Exhibit 9?

14 Q. Yes, please.

15 A. I'm there.

16 Q. And that chart there shows five years of an
17 average age factor; correct?

18 A. That's correct.

19 Q. Okay. And what is the average age factor
20 measure?

21 A. The average age factor generally measures the
22 average age of the population, and that's associated with
23 a rate impact for that age.

24 Q. Okay. Does that mean as the average age
25 factor goes down, that the average age goes down?

1 A. Right.

2 Q. And all things equal, the claims will go down?

3 A. Yes.

4 Q. And you see that -- you see, in fact, the
5 average impact, it does go down, right?

6 A. Yes. On that chart.

7 Q. But MVP has used the same age factor despite
8 the fact that the average age factor hasn't been going
9 down; correct?

10 A. That's correct.

11 Q. At the bottom of page 10 there is a discussion
12 of how the rate would be affected by the change in AHP
13 law. Do you see that?

14 A. Yes.

15 Q. And L&E agrees, doesn't it, that because AHPs
16 are not permitted in Vermont in 2020, that the original
17 assumed increase based on prior AHP law should be backed
18 out; correct?

19 A. Yes.

20 Q. Would it be reasonable for AHP to also reduce
21 the rate because some people who are in AHPs in 2019 would
22 be coming back into the exchange market?

23 A. The experience period is 2018, and AHPs were
24 not allowable in 2018.

25 Q. But would it be reasonable to assume that some

1 people who are now in AHPs, or AHPs in 2019, would it be
2 reasonable to assume that some of those people will be
3 coming back to the private market, whether Blue Cross or
4 MVP?

5 A. Yes.

6 Q. Could you turn to page 11, please. Number 9:
7 "Changes Due to Reinsurance." You assumed that MVP should
8 pay -- you concluded that MVP should pay the additional --
9 should increase the rate by the additional .24 because it
10 does not anticipate any claims over a million dollars in
11 2020; correct?

12 A. That's correct.

13 Q. Okay. Do you know whether MVP has ever had
14 claims over a million dollars?

15 A. I do not, no.

16 Q. You don't know?

17 A. No.

18 Q. Could you turn to the next page, page 12.
19 Could you explain the risk adjustment methodology that MVP
20 employed in its original filing?

21 A. In its original filing it made an estimate
22 based on the most recent data they had available which was
23 the interim report, which was what they included as their
24 assumption.

25 Q. And is that the same methodology that they

1 used in past years?

2 A. Yes.

3 Q. And there are places in this filing, aren't
4 there, where you conclude that because the company used
5 this certain methodology in past years, it's reasonable
6 and appropriate for it to use the same methodology this
7 year; correct?

8 A. For other assumptions, yes.

9 Q. So, for example, on the top of page 9, read
10 the last sentence in the first paragraph which is an
11 incomplete paragraph.

12 A. "As this methodology is consistent with MVP's
13 other filings, L&E does not propose any change at this
14 time."

15 Q. So why not just accept the methodology that
16 MVP was using for risk adjustment, that it had used in
17 past years?

18 A. Because there was no new information since the
19 filing of their -- the submission of their filing, there
20 were changes to the risk adjustment formula as well that
21 -- and it is a different population.

22 Q. And whether it's MVP assumptions regarding
23 risk adjustment or L&E's assumptions regarding risk
24 adjustment, they are all estimates; correct?

25 A. No. The first set of that is no longer an

1 estimate.

2 Q. I'm sorry. First what?

3 A. The first figure, the first recommendation, is
4 a final figure.

5 Q. You mean you don't -- the amount that you --
6 that you in your report say that MVP will have to pay
7 under the risk adjustment?

8 A. For the 2018 figure, yes.

9 Q. For 2018.

10 A. That's correct. That's what we are
11 recommending.

12 Q. Okay. What about 2019?

13 A. 2019, that's irrelevant to this filing.

14 Q. Say that again.

15 A. That is irrelevant to this filing.

16 Q. So you're saying the 2018 risk adjustment
17 number's a hard number?

18 A. Yes.

19 Q. You're certain that that will be the amount?

20 A. Yes.

21 Q. Okay. I guess we will see next year.

22 Did you consider in this filing whether MVP
23 could or should be a tougher negotiator with healthcare
24 providers?

25 A. Will you ask the question part again, please?

1 Q. Yes. Did you consider whether or not MVP
2 should be a tougher negotiator with healthcare providers?

3 A. No.

4 Q. Do you know that MVP asked New York for a 6.5
5 percent rate increase?

6 A. I did not know that.

7 Q. Would that trouble you at all?

8 A. No.

9 Q. Why not? With the fact that MVP asked for a
10 6.5 percent increase in New York but 11 percent -- you
11 recommended between the 10.5 and 11 percent increase in
12 Vermont, why would that difference not bother you at all?

13 A. It's a different population they are assessing
14 and determining the rate increase on.

15 Q. Does L&E advise any insurers in connection
16 with their exchange rates this year?

17 A. Not that I'm aware of.

18 Q. L&E is not advising any insurers this year
19 regarding the individual rates on the exchange?

20 A. Not that I'm aware of. No.

21 Q. Does MVP do any work for individual market
22 insurers this year?

23 A. I don't work for MVP. I don't know.

24 Q. I'm sorry. I didn't hear you.

25 A. I don't work for MVP. I don't know.

1 Q. My mistake. Does L&E do any work for
2 individual market insurers in 2019?

3 A. Not that I'm aware of.

4 Q. Did it last year?

5 A. Not that I'm aware of. I do not believe we
6 have any clients that participate in the individual and
7 small group markets.

8 Q. Does MVP do any work -- pardon me again. Does
9 L&E do any work in any state that has a statutory standard
10 governing the lawfulness of the rate like Vermont's?

11 A. A lot of the states have increased their
12 oversight. I still believe that Vermont is one of the
13 toughest though.

14 Q. Do you know of any other state that has the
15 same standard that Vermont does?

16 A. Exactly, no.

17 Q. And in fact you don't know of any state that
18 requires the regulator to consider affordability; do you?

19 A. No.

20 MR. ANGOFF: I have no further
21 questions.

22 MR. BARBER: Board members. Starting
23 with Ms. Lunge.

24 MS. LUNGE: Should I attempt to use the
25 mic or should I just yell?

1 MR. BARGER: Just yell.

2 MS. LUNGE: Jackie, I just had a couple
3 of questions. Are you familiar with the board's
4 hospital budget guidance for 2020? In general?

5 THE WITNESS: The general process?

6 MS. LUNGE: Or the actual guidance that
7 we issued.

8 THE WITNESS: No.

9 MS. LUNGE: Okay. Thank you. When you
10 are reviewing rates in other states, as part of that
11 are you generally familiar with the Affordable Care
12 Act standards for effective rate review program?

13 THE WITNESS: Yes.

14 MS. LUNGE: Am I correct that that
15 standard requires that states review filings in
16 excess of 10 percent at minimum?

17 THE WITNESS: Yes.

18 MS. LUNGE: But not all states review
19 filings under 10 percent; is that right?

20 THE WITNESS: That's correct. Not all
21 states do. The states we work with do, but that's
22 not a requirement.

23 MS. LUNGE: Okay. And when you did
24 your reasonableness check and pulled the 777 filings,
25 did you exclude states that did not review filings

1 under 10 percent?

2 THE WITNESS: I would have to defer
3 that question to Dave, but I don't think we did. We
4 used all the data that we had available to us.

5 MS. LUNGE: Thank you. No further
6 questions.

7 MR. BARBER: Mr. Pelham.

8 MR. PELHAM: Hi. So I'm looking at
9 page 3 of your report. And the second paragraph down
10 where it says: Exhibit 3 shows the index rate
11 development starting from MVP's experience period
12 claims, encompassing about 320,000 total member
13 months, from ACA-compliant individuals, small group
14 employers as well as grandfathered small groups that
15 will be migrating to this block by 2020."

16 How many of those 320 member months are
17 Medicare? Insured by Medicare?

18 THE WITNESS: I would say zero
19 percent.

20 MR. PELHAM: Right answer I think. I
21 ask that because we are looking at hospital budgets
22 where a third of the population -- a third of the
23 cash flow is from Medicare, and in the last three
24 years that's run at a very high rate.

25 So I was, again, concerned about a

1 switching from a process where we have been looking,
2 you know, in the rear-view mirror to kind of try to
3 figure out where we are going to go, to riding on an
4 important process that hasn't even begun to unfold.
5 We have had no hearings, we have had no deep analysis
6 of these hospital budgets.

7 As I just said, the trend from '16, '17
8 and '18 has been the proportion of hospital budgets
9 from Medicare is growing, yet this population is not
10 a Medicare population. So I worry that the analysis
11 hasn't been done to try to even filter that out of
12 the analysis to -- if it can be filtered out.

13 THE WITNESS: Are you referring to the
14 rate -- the increases that they are doing for the
15 unit cost increases?

16 MR. PELHAM: The rate I'm -- is the
17 actual revenue to Vermont hospitals from Medicare. I
18 can give us the numbers if you want.

19 THE WITNESS: The reason I ask is I did
20 believe that UVMMC does provide a break out for
21 commercial alone and its subsidiaries. So that we
22 do have broken out versus Medicare.

23 MR. PELHAM: The Green Mountain Care
24 Board data, we have commercial data, we have Medicare
25 data, and we have --

1 THE WITNESS: Right.

2 MR. PELHAM: -- Medicaid data. And it
3 all rolls up to the entire amount of NPR, you know,
4 in the hospitals' budgets.

5 THE WITNESS: Right. I just think they
6 break it out. The only reason that that's helpful --

7 MR. PELHAM: They break it out by
8 hospital.

9 THE WITNESS: I think they are the only
10 facilities that don't. Well, right. It's broken out
11 by hospital, and they have their facility, and they
12 do break out what commercial is versus the other
13 pieces. The others, from what I understand, don't.
14 But they actually did, and since they are such a
15 large percentage, that does give a little bit of
16 weight in what the numbers that they are using. If
17 that answers your question.

18 MR. PELHAM: Well I don't know if it
19 answers it. It just means to me there is some noise
20 in that comparison.

21 THE WITNESS: That's true. Yes.

22 MR. BARBER: Member Holmes.

23 MS. HOLMES: Yeah. Thank you, Jackie.
24 One quick question. Two questions actually.

25 Given the submissions of both carriers,

1 I'm wondering if you've done any kind of assessment
2 of what you expect the market share to look like, you
3 know, given the rate differential and expected growth
4 in MPV's enrollments.

5 THE WITNESS: Definitely over the last
6 several years we have noted that MVP's seen
7 significant enrollment shifts, and that was highly
8 due to the fact that their rates dipped below the
9 Blue Cross's rates several years ago. That has
10 persisted, and even at substantial -- some
11 substantial margins.

12 So I suspect that MVP will continue to
13 gain more market share in the coming years if the --
14 as modified by our recommendations, if those are
15 ordered, then that same differential would be there.
16 So I think it would still continue to grow.

17 MS. HOLMES: And does that have any
18 impact on things like administrative costs per member
19 per month or other types of, you know, aspects of the
20 rate filing, the rate request, if the market share
21 grows?

22 THE WITNESS: Correct. Yes. It will
23 have impacts on several pieces. Right now MVP has a
24 lot of healthy members because those are the ones
25 that are typically the most price sensitive that will

1 jump sooner than others. So I would suspect that
2 their healthy population will start to deteriorate,
3 because now you're going to get members who do
4 utilize but that are going to switch over. So that's
5 going to stabilize a little bit. So it also means
6 that the risk adjustment environment might change.

7 From an administrative cost
8 perspective, it really depends on how an organization
9 determines their administrative costs. I know MVP
10 has had to talk a lot about that today. My reaction
11 to that is I think the way that MVP has done it to
12 include New York is not beneficial for the current
13 situation, but when the situation was reversed and
14 they didn't have a large market share, we didn't see
15 a lot of movement here on the MVP side. We actually
16 -- or on the Vermont side. We actually did see a
17 decrease because of all their initiatives but not due
18 to a substantial increase and/or decrease of their
19 block.

20 So while I understand it's not
21 assisting this Vermont filing which is unfortunate, I
22 do wonder about if the roles start to change we also
23 don't want administrative costs to start to skyrocket
24 if they start to lose that membership. But I do
25 think there is some correlation depending on how the

1 organization determines their administrative costs.

2 MS. HOLMES: And my second question
3 that actually relates to something you just talked
4 about. On page two of your report. You have an
5 initial distribution by metal level based on the
6 submitted rate request. And then on page 16 with the
7 revision of the L&E recommendation, you have a new
8 distribution by metal level.

9 So if you compare the table on page 2
10 to the table on page 16, you see some movement within
11 metal categories of membership. And I'm wondering if
12 you can talk a little bit about how you came up with
13 that change in that distribution and, in particular,
14 how that relates to how we think about risk
15 adjustment in the sense that the impact of the risk
16 adjustment payment depends a little bit, it seems to
17 me from what I've read on the metal distribution, the
18 higher the impact on low-risk Bronze members, you
19 know, that impact is higher than they are on high
20 risk.

21 THE WITNESS: Yeah, that's correct.

22 MS. HOLMES: How does that all play
23 out?

24 THE WITNESS: Right. So in a perfect
25 world, risk adjustment would match up one for one

1 from a claims cost perspective. But it's not. And
2 so CMS recognized that, and that's why they have
3 changes for the 2020 to better align. It had its
4 greatest impact on those low claimants who were
5 healthier, which obviously impacted MVP the most,
6 because that was -- as you can see, that's where
7 their groupings are.

8 And how we can handle that is we looked
9 at what the -- what the changes where to that risk
10 adjustment so that we could better assess that from a
11 global perspective, and we're hopeful going forward
12 that's going to start to match up one to one. And
13 then this distribution will change primarily just due
14 to premium differences between the two carriers.

15 Again, low-cost members tend to be more
16 price sensitive because they are not, you know,
17 really working with a doctor very closely on a
18 particular diagnosis that they have so they are
19 willing to change PCPs versus somebody who's had a
20 long-term illness that they have been working with
21 the same doctor that maybe isn't covered under both,
22 or it makes them nervous to switch because they don't
23 know how that will impact their out-of-pocket costs
24 due to the, you know, the complexity of health
25 insurance.

1 So to see the shift really is going to
2 be due to premium changes most likely. And as those
3 grow, people will likely shift more.

4 MS. HOLMES: So I understood that.
5 Thank you, I think. One of the things -- so this,
6 you know, in the page 16, this distribution that you
7 predicted of percent of membership that obviously has
8 changed from page 2 to page 16. So the factors that
9 go into that prediction are not only the rate changes
10 within MVP but also the relative comparison to Blue
11 Cross Blue Shield and how competitive each metal
12 level is. Both of those factors weigh into your
13 distribution calculations.

14 THE WITNESS: Yes. And I want to look
15 into that figure here, because oh, so the numbers in
16 the -- on page 16 match the numbers that are here on
17 page 2. They are just in the second chart. So it's
18 the 2019 changes. So those are based on 2019
19 membership. They match.

20 And then I'm going to have to look --
21 that's different up here. Maybe this is 2018 and
22 this is 2019. This is not a prediction. These are
23 actual figures.

24 MS. HOLMES: Okay. I thought --

25 CHAIRMAN MULLIN: We used to have a

1 footnote.

2 MS. HOLMES: Okay. I thought this was
3 based on the L&E recommended overall change, this is
4 what you would expect in the percent membership.

5 THE WITNESS: No. That is to help us
6 calculate the overall number.

7 MS. HOLMES: Okay. Do you do an
8 analysis that predicts the distribution of metal
9 count based on --

10 THE WITNESS: We have done that for
11 you. But we have not published that in our report.
12 No.

13 MS. HOLMES: Okay.

14 THE WITNESS: Sorry for the confusion.

15 MS. HOLMES: No problem. Thank you.

16 THE WITNESS: But I will clarify that
17 for you.

18 MS. HOLMES: Thank you.

19 MS. USIFER: Just a couple questions.

20 THE WITNESS: Yes.

21 MS. USIFER: On page 16. On the chart
22 there. Can you say where the negative .9 percent for
23 the budget projection changes from hospitals, is that
24 in line 3?

25 THE WITNESS: So the .9.

1 MS. USIFER: MVP resubmitted.

2 THE WITNESS: Correct.

3 MS. USIFER: And they put like 8.4. I
4 look at it as we are going from 8.4 to the 10.5 --

5 THE WITNESS: Correct. That would be
6 in lines 2 and -- well no. I would say primarily
7 line 3 because it's for 2019 figures.

8 MS. USIFER: Okay. That's what I
9 assumed.

10 THE WITNESS: Yes.

11 MS. USIFER: And then just talking
12 about risk adjustment where we have had a lot of
13 discussion on risk adjustment. And because we are
14 really, you know, two primary insurers in the state,
15 do you really look at that as flipping between one to
16 the other? So where we are seeing a one and-a-half
17 percent increase on top of their 4.4. So when I look
18 at MVP's rate change 5.9 percent is due to risk
19 adjustment.

20 THE WITNESS: That's correct.

21 MS. USIFER: And I'll come back to that
22 part in a second, the 5.9. But the change you're
23 putting in of the 1.5, you're then offsetting that in
24 Blue Cross's submission so that the numbers tie out;
25 is that correct?

1 THE WITNESS: We are not recommending
2 such that when you add them up they are zero. That's
3 really complicated. Because they have two separate
4 projections for membership, and that's -- the figure
5 is highly tied to how much membership that they have.
6 And so we haven't done that direct comparison to make
7 sure when you multiply out their projected membership
8 by the PMPM, and that it actually matches up with
9 zero.

10 We have projected what we think or
11 recommended that we think is the most appropriate
12 figure for both of those, and that it will be close
13 enough on a PMPM.

14 MS. USIFER: The intent is that it
15 pretty much balances.

16 THE WITNESS: Correct.

17 MS. USIFER: And then if MVP grows, if
18 they do get more people coming in to their -- buying
19 insurance, and there is such a large risk adjustment
20 on a PMPM, has that been correct -- assuming then
21 they can't keep getting just the healthier people.
22 It has to kind of balance out; right?

23 THE WITNESS: Right.

24 MS. USIFER: So how does that work?
25 Because we are calculating on a PMPM. It's a pretty

1 significant PMPM number that are in the rates.

2 THE WITNESS: Correct.

3 MS. USIFER: As they get more people,
4 that number would go down, and we just correct that
5 next year?

6 THE WITNESS: Yes. As they get more
7 people, that number will go down. When you go to
8 review the Blue Cross filing, you can see too that
9 their number has kind of done the opposite and gone
10 up. It's highly correlated, and that's why even a
11 couple of years ago when MVP had a really large
12 amount of payable, but not many members, PMPM was
13 really high for them. That number is going to
14 continue to drop if membership continues to go up.

15 I also think, as we discussed earlier,
16 that they can't continue to just get healthy members
17 only. So that's also going to stabilize, which might
18 bring -- that will just hopefully take it down across
19 the board since they are related to one another such
20 that MVP is not making such a big payment into the
21 pool as well.

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

24 THE WITNESS: You're welcome.

25 MR. BARBER: Okay. Any redirect?

1 MS. ABORJAILY: I just had one
2 question, I think.

3 REDIRECT EXAMINATION

4 BY MS. ABORJAILY:

5 Q. The HCA brought up the people who are
6 currently enrolled in the 2019 AHPs, and I was wondering
7 whether in your report you address if there is any
8 calculation done to address the people who are possibly
9 returning to the marketplace from the 2019 AHPs.

10 A. No.

11 Q. And would you explain why that is?

12 A. Right. So the 2018 is the experience period
13 that is being utilized here. And there were not AHPs
14 present during that time, so we are not anticipating
15 anybody coming back on, because they were included in our
16 experience period. The only thing that happened was they
17 were removed from the rate which is a 2019 rate, the
18 impact of thinking that those individuals would be
19 leaving.

20 MS. ABORJAILY: Thank you.

21 MR. BARBER: Anyone else?

22 MR. KARNEDY: No, thank you.

23 MR. BARBER: Anything else? Thank you,
24 Ms. Lee.

25 THE WITNESS: Thank you.

1 MR. BARBER: So that we are done with
2 testimony, right? I'm losing my mind. I don't think
3 we have any more witnesses.

4 So would the parties like to -- sorry.
5 I am losing my mind. Sorry. Mike Fisher.

6 MR. FISHER: Good afternoon.

7 MR. BARBER: Are you leading Mr. Fisher
8 questioning?

9 MR. ANGOFF: I'm sorry?

10 MR. BARBER: Are you going to be
11 leading his testimony?

12 MR. ANGOFF: I was assuming like the
13 Commissioner last year, we would just be presenting.

14 MR. KARNEDY: Can I speak to that?
15 Last year that is how it worked. I did at the outset
16 say I might have to be politely rude and object if
17 he's saying something I would object to. It didn't
18 happen last year, but I just wanted to set a table.

19 MR. FISHER: I won't take offense.
20 I'm Mike Fisher, and I'm the chief --

21 MR. BARBER: He was sworn in.

22 MS. HOLMES: Sorry. Yeah.

23 MR. FISHER: I was sworn in this
24 morning.

25

1 MIKE FISHER

2 Having been previously duly sworn,
3 testified as follows:

4 MR. FISHER: I'm Mike Fisher. I'm the
5 Chief Health Care Advocate, and thank you for the
6 opportunity to speak for a few moments.

7 I come from a bit of a different
8 perspective than you've heard all day. And speaking
9 of all day, it's been a long day. We are all tired.
10 I am tired. I think I can be pretty brief. And I
11 want to recognize that I don't have anything to say
12 today that isn't broadly understood by most
13 Vermonters.

14 Healthcare, the cost of buying coverage
15 and getting care, is a barrier that prevents some
16 people, some Vermonters, from getting the care they
17 need. It's important, though, even though this is
18 broadly known, to take a few moments here to make
19 sure that at least it's said out loud in these
20 proceedings, to focus on and consider the consumers'
21 perspective.

22 The stress that Vermonters experience
23 when they need care and don't know how they are going
24 to get it, and how they are going to pay for it, is
25 real. Affordability is a consideration of the

1 consumers' ability to pay for coverage and care.
2 Simply put, can Vermonters -- can Vermont families
3 reasonably get the care they need or the care their
4 providers recommend and do things like put food on
5 the table or heat their homes. And can Vermont's
6 small businesses provide a meaningful healthcare
7 benefit to their employees and survive given the
8 margins of their business.

9 We recognize -- I recognize -- that the
10 board can't achieve full affordability in this rate
11 filing. Zero percent rate increase wouldn't achieve
12 this. This means the question before us today is not
13 if health insurance will be affordable to all
14 Vermonters. The question is how many more Vermonters
15 will be priced out of the ability to get the care
16 they need. The push and pull of the financial
17 well-being of Vermonters and the financial well-being
18 of MVP Healthcare in this case are competing
19 pressures.

20 The board has a tremendously difficult
21 task in front of you in considering these competing
22 interests. I appreciate that. I recognize it.
23 There is no easy answer here. Yes, we need healthy
24 carriers. And yes, we need rates that consumers can
25 buy plans that they can afford to use. It's been

1 interesting for me to listen today about -- to all
2 the actuarial considerations without any
3 consideration of the consumer.

4 I think we need consumers in this in
5 order for this to work. The ability of Vermonters to
6 afford coverage is key to the success of healthcare
7 financing. It's not a nice afterthought after the
8 experts have set the rates. To give an extreme
9 example, none of us would celebrate a rate that was
10 as actuarially sound as possible if only Warren
11 Buffett and Bill Gates could afford it. It wouldn't
12 work.

13 According to the 2018 Household Health
14 Insurance Survey, I believe that's Exhibit 17 in your
15 book today, 40 percent of us are -- under the age of
16 65 in the commercial marketplace are under insured.
17 40 percent. That number, by the way, four years
18 earlier in 2014 was 27 percent. So it's climbing. I
19 know these proceedings are not about plan designs,
20 but when premiums rise, more and more Vermonters are
21 forced into paying higher and higher out-of-pocket
22 costs. Some of the people in that 40 percent
23 category live day-to-day with the reality of what a
24 15 thousand dollar deductible means when they have
25 loved ones who need care. Others may not be worried

1 about out-of-pocket costs because they are healthy at
2 this moment. But we all know what that gamble means.

3 At the Healthcare Advocates' help line
4 we get calls most days, every day, from Vermonters
5 with affordability concerns, but today I'm going to
6 focus my comments on the comments that were submitted
7 to the board in the last few days and weeks. It's an
8 interesting list of comments that have come in. To
9 break them into a few themes, many people said,
10 "These rates are unaffordable. These rates will
11 force us to drop coverage. Deductibles are also
12 unaffordable. I don't go to the doctor because my
13 fear -- because of my fear of the bill. Health
14 insurance is our biggest household expense. This
15 rate will hurt my business." This said by employers
16 and employees by the way. "Health insurance costs
17 keep me from being able to put money into savings,
18 retirement, college funds. Health insurance
19 increases are far out pacing wage increases in
20 Vermont. This is unsustainable."

21 I'm going to quote from just two and be
22 very brief. Comment number 38. A woman who
23 identified herself as Amy said, "Monthly premiums
24 plus high and ever-increasing deductibles are already
25 a huge financial burden at 20 percent of my gross

1 income. Another increase without anticipated
2 increase in income only makes it worse. I'm also a
3 healthcare provider who accepts insurance and have
4 not seen reimbursement increases across the board
5 making a premium increase request even more
6 frustrating."

7 Another commenter recognized herself as
8 a small business owner who owns a -- runs a
9 developmental care home. She said: "Our family of
10 four has no options for health insurance but
11 privately paying for it at about 16 hundred dollars
12 per month. Yes. \$20,000 a year. We would like to
13 save for college. We would like to take a family
14 vacation before our kids leave us. We would like to
15 pay our mortgage and save a bit for retirement. We
16 fear going without insurance desperately trying to
17 keep our family safe. How can anyone afford this?"

18 Another point of information that I
19 found interesting and that is that this year Rutland
20 Regional Medical Center in its hospital budget
21 submission is requesting a 2.65 percent rate increase
22 effective October 1. They indicated that this
23 increase is -- this rate increase directly relates to
24 the increase in their free-care program. Their need
25 to provide free care has increased by 2.5 million

1 dollars from budget to budget. They report that they
2 have not changed the eligibility of free care, rather
3 this is a result of an increase in patients who have
4 insurance but can't afford deductibles and copays.
5 Nearly 48 percent of their free care is provided to
6 patients who have some level of insurance.

7 I know you've heard me say something
8 very similar to this before, and I'm sure you've
9 heard many others say very similar concerns. There
10 is a risk that we become desensitized and distance
11 ourselves from these expressions of fear and
12 frustration. Let me put it another way. While there
13 have been times in my life where my family had less
14 income, I've never had to face the fear of being
15 scared to death of what it would mean if I had a
16 family member that needed care, and I had no idea how
17 I would pay for it. I know about the pressures of
18 affordability in my job, but only from a more distant
19 perspective. For me, it was a really powerful
20 experience.

21 I don't know if you have had the
22 opportunity to do it yet, but I'm sure you will, but
23 it's a powerful experience to take the time to read
24 the comments that came to you in the last couple of
25 days. Yeah, some of them were shaky. Some of them

1 were not completely on target. But many of them were
2 from regular Vermonters, Vermont families doing their
3 best, desperately wanting and doing their best and
4 desperately wanting the rules of the game to give
5 them a fighting change.

6 Thank you for your work on this, and
7 thank you for your consideration.

8 MR. BARBER: Mr. Karnedy, do you have
9 any questions?

10 MR. KARNEDY: I do.

11 MR. BARBER: Sure.

12 CROSS EXAMINATION

13 BY MR. KARNEDY:

14 Q. Good afternoon, Mr. Fisher.

15 A. Good afternoon.

16 Q. You're not an actuary; are you?

17 A. I am not an actuary.

18 Q. That's all I have.

19 A. I should have said that at the very beginning.

20 MR. BARBER: Board members, do you have
21 any questions of Mr. Fisher?

22 CHAIRMAN MULLIN: I do.

23 MR. BARBER: All right.

24 CHAIRMAN MULLIN: So Mike, you're a
25 close follower of everything that happens in the

1 healthcare world, and you've seen a period where
2 there have been very, very small increases in
3 Medicaid especially and Medicare.

4 So would you agree that when a rate
5 filing comes in that's higher than the medical
6 inflationary rate, that government needs to take some
7 responsibility?

8 THE WITNESS: Absolutely.

9 CHAIRMAN MULLIN: Thank you.

10 MR. BARBER: Okay. I think you're
11 done. Thank you.

12 THE WITNESS: Thank you.

13 MS. HOLMES: Actually I just want to
14 make one comment which is just to your point about me
15 becoming desensitized. I want to assure you and
16 everybody that you work with and speak with that at
17 least I can say to you that I'm not desensitized. I
18 hear it. I hear it all the time when I'm out.
19 People hear I'm on the Green Mountain Care Board, you
20 can imagine what the next conversation is.

21 I just want to assure you and everybody
22 else I know, we read all the public comments, and we
23 have a special forum tomorrow night, and we welcome
24 those comments. I want to make -- assure you that we
25 are not desensitized, and we are listening.

1 THE WITNESS: Thank you.

2 MR. PELHAM: If I could make a comment.
3 So you wrote an Op Ed a little while ago, and in it
4 you said: "But when a sizeable portion of Vermonters
5 can't afford to get their care they need, those same
6 neighbors and policy makers to see the crisis."

7 And then it went on to say -- well I
8 assumed I was one of those regulators. And I took a
9 little bit of offense to it. Because, you know, that
10 -- in my concurring opinion last year on this rate
11 filing, the first sentence in that opinion was: "I
12 write separately, however, to discuss my deep concern
13 with the evidence presented as to the affordability
14 of the proposed rates." And I went on and had a
15 fairly lengthy proposal that as a former finance
16 committee I think is a very -- finance commissioner,
17 I think is a credible proposal.

18 So but in order to move forward on
19 that, we need some help from the state entity to give
20 us a number to work toward. So when these plans were
21 presented last February, I asked the folks from DVHA
22 could they give us a number. And they said they
23 would. And then when -- on June 7 it was another
24 meeting and I asked again for the update. And I
25 still haven't received it. And for me, until I know

1 what the price tag is on something, it's hard to
2 advocate for it except conceptually.

3 So I'm just going to ask you will you
4 help get that number from DVHA to understand so we
5 can have a measurement of what a subsidy is above 400
6 percent of poverty to 500 percent of poverty below
7 the 9.86 percent threshold. There is a number there.
8 And if we knew it outside of this process, but if we
9 knew it, we might be able to work collectively to
10 solve some of these problems.

11 THE WITNESS: I'm happy to engage in
12 trying to get that number. It's a number
13 understanding sort of what it would cost to finance a
14 reasonable slope, the way I would put a reasonable
15 slope to 4 and 500 percent of poverty is a great
16 activity, a worthy activity, and I will engage in
17 that.

18 And I do want to say, I put that
19 desensitization or that recognition in my own terms.
20 I didn't -- I don't intend in any way to call any out
21 as being insensitive or not recognizing the needs of
22 Vermonters. I don't have the experience of knowing
23 that fear and desperation, that panic.

24 One commenter said something very good.
25 He said stress -- the financial stress of figuring

1 out how to pay for healthcare isn't conducive to
2 anybody's health. So I recognize the tremendous work
3 and the tremendously impossible box that you are all
4 in. I think the main task I'm here to say is this is
5 a balancing act. I don't know whether the right -- I
6 like the metaphor of the stone pile that you can't
7 upset. I don't know whether the base of that stone
8 pile is appropriately the consumer or the actuarial
9 analysis. I think it depends on your perspective a
10 little bit. But we need to have a balance. Thank
11 you.

12 MR. BARBER: Thank you, Mr. Fisher.
13 Mr. Karnedy, do you have any rebuttal witnesses?

14 MR. KARNEDY: I do not.

15 MR. BARBER: Okay. And the parties
16 wish to make closing arguments?

17 MR. KARNEDY: Briefly, if that's
18 appropriate.

19 MR. BARBER: Okay. You can begin.

20 MR. KARNEDY: So MVP has proposed 11
21 percent increase. L&E and MVP agree on 10.5. And
22 the delta between those is a .5 percent that we
23 provided evidence on.

24 L&E testified today they need to check
25 the numbers themselves, but it's going to be roughly

1 2.7 or 2.8. It depends. You'll see that before you
2 make a final decision, I presume.

3 So after a multitude of factors, and
4 considering all the statutory criteria, the actuaries
5 are virtually identical and in agreement. Got two
6 MVP actuaries, got three L&E actuaries, they all
7 agree. There is no contrary expert evidence
8 supporting a different number.

9 In considering a final number, we would
10 respectfully request that the board consider the rate
11 within what is actuarially sound and reasonable and
12 statutorily adequate.

13 I did mention the stack of stones this
14 morning, and how the actuaries have found just the
15 right balance to meet all the statutory criteria.
16 You have information to consider all the statutory
17 criteria. We would just ask that the board not pull
18 a large non-actuarial stone from the middle of that
19 stack and cause the rate to be inadequate and all
20 those stones to come tumbling down. Thank you very
21 much.

22 MR. BARBER: Mr. Angoff.

23 MR. ANGOFF: Thank you, Mr. Hearing
24 Officer. Mr. Chair, Members of the Board, four quick
25 points.

1 Number one, looking just at the
2 actuarial analysis, they are all kind of different
3 methodologies, different types of analyses in
4 connection with which the board has discretion and
5 connection with which both the carriers and L&E were
6 wrong last year. They were both wrong in raising the
7 rate substantially because they assumed that zeroing
8 -- having zero penalty for an individual mandate
9 would make a difference.

10 They were both wrong about morbidity.
11 There are many provisions in the analyses where
12 judgment or lots of judgment is allowed. So for
13 example, they may choose -- an actuary may choose to
14 use a straight average where the trend is down, and
15 it would make just as much sense to follow the
16 downward trend and to weigh the most recent data more
17 heavily. So on those issues the board has
18 discretion, and I think should err on the side of
19 trying to promote affordability to the maximum extent
20 possible.

21 On the other hand, if there really is a
22 hard number, for example, if Ms. Lee is right about
23 risk adjustment, their risk adjustment methodology
24 using hard numbers, objectively, verifiable numbers
25 that's different. Then I would agree with L&E that

1 if it's a hard number, that is something that the
2 board would be hard pressed not to adopt. But the
3 only hard number in the analysis, if Ms. Lee is
4 right, is the risk adjustment number. All the others
5 are subject to discretion.

6 Third point. The company can't have it
7 both ways. Either administrative costs are
8 indivisible, and total adjusted capital, that is the
9 solvency issue, that's indivisible, or they are both
10 separable. What MVP is trying to do is to say well
11 because New York business is decreasing, Vermonters
12 have to pay for that, what's going on in New York.
13 But at the same time even though MVP's total adjusted
14 capital isn't, if the rate increase here has
15 essentially no effect on their capital, that MVP
16 should still get the benefit. Vermonters should
17 still contribute as much as New Yorkers to that.
18 Those are inconsistent.

19 Finally, after all the actuarial
20 analyses were done, there is no question but that
21 this is the only state in which affordability is a
22 criterion. Ms. Lee was very careful to say she is
23 not recommending that the board raise the rate by
24 10.5 percent. She's recommending that a 10.5 percent
25 increase does not produce rates that are excessive,

1 inadequate or unfairly discriminatory. But that's a
2 far cry from recommending an increase of 10.5 percent
3 because of the affordability criterion and other
4 criteria in the statute. Thank you.

5 MR. BARBER: Thank you. So I think we
6 have a few procedural or follow-up items to discuss.
7 There were a number of questions that board members
8 asked that Mr. Lombardo said he would need to speak
9 with people in clinical department or contracting. I
10 think we need to -- I will follow up on behalf of the
11 board with those questions in writing to make sure we
12 have them all and they are clear to you.

13 Would I assume it would be feasible to
14 get those responses back prior to the due date for
15 the briefs, is that fair?

16 MR. KARNEDY: Is it fair? Would you
17 like us to do that? That's how we did it last year.
18 We will make it happen. And I think with you writing
19 questions out is very important. That's what we did
20 last year. Because we have our notes, but if we
21 misinterpreted what a particular board member was
22 asking for.

23 If there is an issue around timing, I
24 would confer with you on that if we have a hold up on
25 getting some data or something.

1 MR. BARBER: Okay. And we do have --
2 it wouldn't be ideal, but we do have the ability to
3 extend the period to take additional information from
4 the carrier. So we will follow up. I'll follow up
5 with those questions, and we can talk about timing.

6 If I understood correctly, we will be
7 getting an amendment related to the change for the
8 Non-standard Gold Plan today or tomorrow? Is that --

9 MR. LOMBARDO: The expectation for the
10 form submission would be today.

11 MR. KARNEDY: Whether that impacts the
12 rate filing, I don't know, but that would be filed
13 with the forms. So probably later today.

14 MR. BARBER: Okay. So we will get an
15 update on that today, I believe.

16 MR. KARNEDY: And would you like us to
17 submit that as a piece of evidence in this
18 proceeding, whatever it is?

19 MR. BARBER: I think it will need to
20 be. Yeah. I think it would be like the last one.

21 MR. KARNEDY: Okay.

22 MR. BARBER: I think there was a
23 request or I heard testimony that L&E would like to
24 see the calculation for the hospital budget, the .5
25 percent. So if you could provide that when you're

1 able to. And then I think, Jesse, you had committed
2 to notifying us when the forms are approved; correct?
3 Or Emily. Okay. Did I miss anything?

4 MR. KARNEDY: I believe as we did last
5 year, and I don't mean to put work on the plate of
6 L&E that they don't need, but I think we heard
7 testimony today it might be .2, it might be .3 but
8 they would actually file something more certain on
9 that.

10 MR. BARBER: Yeah. We will discuss
11 putting their calculations out there in writing too.

12 Okay. Anything else before we adjourn?
13 Okay. Oh, yes. I'm sorry.

14 MR. SCHULTHEIS: Public comment.

15 MR. BARBER: I'm sorry. First time
16 through this. So I think we are going to conclude
17 the hearing portion of this meeting.

18 And now we can move to the public
19 comment portion. So there was a sign-up sheet for
20 public comment outside. And Dale, would you like to
21 comment?

22 MR. HACKETT: Very quick. Very long
23 day. And very complicated.

24 CHAIRMAN MULLIN: Just going to have to
25 speak loudly, Dale, unfortunately.

1 MR. HACKETT: It totally had me
2 convinced my hearing aids weren't working. So after
3 listening to this, I feel like the consumer is under
4 represented in these particular hearings. I know
5 they are about rates, so I expect it to be a certain
6 way, but I seriously felt on this one in particular,
7 something was missing.

8 Consumers that are going to be very
9 concerned about what is happening right now, are not
10 here, but they really are here. Some of them don't
11 know how to be here. So I can imagine some of them
12 saying MVP is like the child that just turned 18.
13 Hi, you grew up. Please just leave when they hear
14 what these numbers are, assuming you pass it.

15 If you were to pass this kind of
16 increase, no way. I don't see a -- I see a lot of
17 consumers are going to look at their income, and
18 think of this as an annual increase possibly, they
19 don't know. This is part of what gets really scary.
20 Because it's not just healthcare. It's across the
21 board. What was it last year? It was a high amount.
22 What did their income go up? Incomes don't go up by
23 5 percent a year, 6 percent a year. They don't go up
24 by 11 percent a year.

25 I can -- and I was absolutely toying

1 with this. I want to go up there next January and
2 ask them to pass a bill that puts in a minimum wage
3 that it goes up automatically. If healthcare goes up
4 by 11 percent, the minimum wage goes up by 11
5 percent. Let's see how that goes across. But you
6 have to understand the point that the State of
7 Vermont under funds their share. And this does not
8 help the situation at all. It gets very complicated.

9 No company sells solvency and
10 affordability of a service if the solvency is theirs
11 alone. I'm not really -- they are doing what they
12 need to do. But that is more about what is the
13 consumer perspective going to be. Is that what they
14 are going to see? Is that how they are going to
15 feel? What about them? Where are they in all this?

16 We do need more testimony about what
17 Vermont's market is and what Vermonters can really
18 afford versus this is the option they came in with.
19 For their own reasons as well as this is -- we need
20 that other, as these rates go up like this or even
21 the possibility of going up like this, we need a
22 better definition rate from the start of what is our
23 market that we can actually afford?

24 And let's see, I had three comments.
25 Even though I wrote them out, I'm not going to say

1 them. They aren't bad. But some are a little too
2 strong now that I reread them. So I do believe we
3 need alternatives. I think we were getting at a very
4 interesting point. This could be upsetting or it
5 could be a disaster.

6 As these economic factors come into
7 play, and we start seeing these kind of costs, this
8 is -- if you're an inventor, if you're creative, you
9 actually get excited over scenarios like this.
10 Because you start thinking, wow, I've got some real
11 wiggle room to be creative and to see if I can't do
12 it better, and maybe more affordable. And still -- I
13 mean as an engineer, if I heard something like this,
14 we would be all over it. We would be out there
15 bidding, and we would be like, okay, give us a shot
16 at it. We can do this. I don't know if that's true.
17 It's so complex, but I think we are looking at that.
18 We are seeing some really high numbers come in. We
19 are seeing flat wages.

20 And I think the real answer is people
21 are going to say no, they want a better solution,
22 they must have a better solution. They aren't going
23 to buy it. And somebody out there is going to invent
24 something if there is enough wiggle room now, that
25 very well could be better. I think that's a consumer

1 perspective.

2 MR. BARBER: Thank you, Dale. Just on
3 the consumer perspective, like I said earlier, we
4 will have a meeting dedicated tomorrow solely to
5 comments from the public. Based on the volume of
6 written comments we received, expecting that to be
7 fairly well attended.

8 So if there are no other members of the
9 public who would like to comment, going to end the
10 hearing today and turn back over to the chair for
11 closing the meeting.

12 CHAIRMAN MULLIN: Thank you, Mike.
13 Everybody's eyes look a little bit heavy. But at
14 this time I'll entertain a motion to adjourn.

15 MR. PELHAM: So moved.

16 MS. HOLMES: Second.

17 CHAIRMAN MULLIN: So moved and seconded
18 to adjourn. All those in favor signify by saying
19 aye.

20 ALL BOARD MEMBERS: Aye.

21 CHAIRMAN MULLIN: We will be back again
22 tomorrow at 8.

23 (Whereupon, the proceeding was
24 adjourned at 3:15 p.m.)
25

C E R T I F I C A T E

1
2
3 I, Kim U. Sears, do hereby certify that I
4 recorded by stenographic means the hearing re: MVP
5 Healthcare, Inc., at the State House, 115 State Street,
6 Montpelier, Vermont, on July 22, 2019, beginning at 8 a.m.

7 I further certify that the foregoing
8 testimony was taken by me stenographically and thereafter
9 reduced to typewriting and the foregoing 282 pages are a
10 transcript of the stenograph notes taken by me of the
11 evidence and the proceedings to the best of my ability.

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

15 Dated at Williston, Vermont, this 25th day
16 of July, 2019.

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