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.
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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

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

STAFF: Michael Barber, Hearing Officer
Susan Barrett, Executive Director
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A P P E A R A N C E S

MVP Health Care

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I N D E X

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

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

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

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

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

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

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

Before we begin, I want to remind the

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

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

MATTHEW LOMBARDO
MICHAEL FISHER
JACQUELINE B. LEE
Having been duly sworn, testified as follows:

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

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

MR. KARNEDY: We have.

MR. ANGOFF: That's correct.

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

MR. KARNEDY: Thank you.

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

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

MR. ANGOFF: No, sir.

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

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

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

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

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

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

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

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

MVP recognizes the difficult choices

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

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

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

no longer be adequate.

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

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

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

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

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

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

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

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

MR. KARNEDY: We call Matt Lombardo, please.

(Ms. Lunge arrived).

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

associations?

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

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

A. Around 14 years.

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

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

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

A. Yes. Yes.

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

A. Yes. Correct.

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

A. Correct.

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

A. Correct.

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

A. Yes.

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

A. Okay.

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

A. Okay. I'm there.

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

Do you see that?

A. Yes.

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

A. Yes.

Q. What's that date?

A. May 23, 2019.

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

that date; correct?

A. Correct.

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

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

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

A. Correct.

Q. This is their amended report; correct?

A. Correct.

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

A. Okay.

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

A. Yes.

Q. And these show some increases and some

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

A. That's correct.

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

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

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

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

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

A. That's correct.

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

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

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

A. That's correct.

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

A. I do not.

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

Would you please go to page 15.

A. Okay.

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

A. Yes.

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

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

park of 10 percent less than that.

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

A. Yes.

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

A. Yes.

Q. Can you explain those, please?

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

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

A. Okay.

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

A. Yes.

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

A. Okay. I'm there.

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

Do you see that?

A. Yes.

Q. Can you explain that, please?

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

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

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

Do you see that paragraph?

A. Yes.

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

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

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

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

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

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

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

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

A. Yes.

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

A. Correct.

Q. Would you please explain the CSR subsidy program?

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

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

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

Do you see that?

A. Yes.

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

A. Correct.

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

A. Okay.

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

A. Correct.

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

A. Yes.

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

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

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

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

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

A. Correct.

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. Would you please explain what that is?

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

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

A. Correct.

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

A. Yes.

Q. We will talk more about that later.

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

A. Yes.

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

A. 1.5 percent.

Q. And what did MVP propose last year?

A. 2 percent.

Q. And what did the board approve last year?

A. 1.5 percent.

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

A. Yes.

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

What is bad debt expense?

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

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

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

A. Correct.

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

A. Yes.

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

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

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

A. That's right.

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

A. Yes.

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

A. Okay.

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

A. That's correct.

Q. You signed it; correct?

A. Yes.

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

A. Yes.

Q. So would you please explain what the purpose

of this filing is?

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

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

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

A. That's correct.

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

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

Q. You would agree with that; right?

A. Yes.

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

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

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

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

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

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

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

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. What is the cost trend?

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

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

A. Correct.

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes. Correct.

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

A. Yes.

Q. Would you read the first sentence, please?

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

Q. And do you agree with that recommendation?

A. Yes.

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

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

Q. So that's a challenge.

A. Yes.

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

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

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

A. Correct.

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

A. Correct.

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

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

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

A. Okay.

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

A. Yes.

Q. Would you read that, please?

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

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

A. Yes.

Q. And what was that percentage?

A. I believe it was 55 percent.

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

A. Yes. Correct.

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

A. It does not impact the proposed rate change.

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

A. Yes.

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

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

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

A. It does not.

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

A. Correct.

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

A. Yes.

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

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

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

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

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

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

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

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

A. If I recall, it was 0.2 percent.

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

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

With that said, we are again building in 0.5

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

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

A. Okay.

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

A. Yes.

Q. What is medical utilization trend?

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

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

Q. And do you agree with that recommendation?

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

purposes.

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

A. Yes.

Q. Would you read that sentence, please?

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

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

A. Yes, correct.

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

A. Yes.

Q. Please read those.

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

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

significant shifts in membership between carriers."

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

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

A. Yes.

Q. And you agree with that; correct?

A. Yes.

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

Do you see that?

A. Yes.

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

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

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

A. Correct.

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

Do you see that?

A. Yes.

Q. What is the program, please?

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

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

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

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

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

Q. So the last clause they say no impact on

rates. Do you agree with that?

A. Yes.

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

A. Yes.

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

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

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

A. Sure. Okay.

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

A. Yes.

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

A. Correct.

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

A. Correct.

Q. Would you read that sentence, please?

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

Q. So late March data; right?

A. That's correct.

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

A. Okay.

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

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

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

A. Correct.

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

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

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

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

A. Yes. The calculation change was immaterial.

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

A. Yes.

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

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

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

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

lower risk or lower benefit members."

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

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

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

A. Yes. That's correct.

Q. And then read the last sentence, please.

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

Q. And you agree with that 1.5 percent increase?

A. Yes.

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

A. That's correct.

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

Do you see that last bullet?

A. Are we in Exhibit 15?

Q. No. Page 15. Exhibit 9.

A. Okay.

Q. Sorry if I misspoke.

A. Let me go back.

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

A. Yes.

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

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

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

reduction in premium rate.

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

A. Yes. That's correct.

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

A. My understanding is that they were.

Q. And what did DFR call about?

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

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

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

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

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

A. That's my understanding. Correct.

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

A. That's correct.

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

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

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

A. Yes.

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

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

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

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

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

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

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

A. Okay.

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

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

A. Yes.

Q. And you testified last year MVP sought 2

percent.

A. That's correct.

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

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

A. Yes.

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

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

Q. And do you agree with that statement?

A. Yes.

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

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

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

A. Yes.

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

Would you please read those sentences?

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

Q. Do you agree with that?

A. Yes.

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

A. It will not.

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

A. Yes.

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

A. Okay.

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

A. Yes.

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

A. Correct.

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

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

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

Do you see that paragraph?

A. Yes.

Q. Would you please read those two sentences?

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

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

A. I have not.

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

A. Yes.

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

A. Okay.

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

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

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

Q. And you agree with both of those statements?

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

A. Okay.

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

Do you see that?

A. Yes.

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

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

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

A. Yes.

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

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

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

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

A. Correct.

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

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

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

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

A. Correct.

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

A. Yes.

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

A. Yes.

Q. Would you please go to Exhibit 5.

A. Okay.

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

A. That's correct.

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

A. Correct.

Q. Would you go to page 2, please.

A. Okay.

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

Do you see that?

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

A. Sounds good.

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

A. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. ANGOFF: I'm sorry?

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

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

MR. BARBER: Okay. Point is taken.

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

BY MR. KARNEDY:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

packets?

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

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

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

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

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

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

A. "MVP continues to negotiate with OneCare."

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

A. Okay.

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

A. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Vermont funding.

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

Q. And what about drug classes being considered preventative?

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

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

A. Okay.

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

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

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

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

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

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

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

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

A. Correct.

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

A. Yes.

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

A. Yes.

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

A. They are not.

Q. Is that because the rates are reasonable based

on the data that we have?

A. Yes.

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

A. With the adjustments. Yes.

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

A. No.

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

A. Yes.

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

A. Yes.

Q. So the rates here are adequate?

A. Yes.

Q. 11 percent?

A. Yes.

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

A. Yes.

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

A. No. It's not.

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

A. Yes.

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

A. It is not.

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

A. Yes.

Q. They are not separately siloed?

A. There is interdependence of them. I agree.

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

A. That's correct.

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

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

A. Correct.

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

A. Yes.

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

A. It does.

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

A. Yes.

Q. Thank you very much.

MR. BARBER: Are you finished with the questions?

MR. KARNEDY: I am.

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

MR. ANGOFF: Yes, I do.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Good morning, Mr. Lombardo.

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

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

MR. KARNEDY: Page 23?

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

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

BY MR. ANGOFF:

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

A. Yes.

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

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

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

ultimately going to pay out?

A. Yes.

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

A. That's our best estimate.

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

A. Okay.

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

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

A. That's a true statement.

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

A. That's my understanding.

Q. And therefore, you no longer include that 1

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

A. That's correct.

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

Could you explain the arithmetic there?

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

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

A. Okay.

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

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

different items.

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

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

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

A. That's correct.

Q. And why was that?

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

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

A. Yes. Could you clarify exactly?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. So you're not assuming any separate rate

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

A. I'm not.

Q. I'm sorry?

A. We are not.

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

A. Okay.

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

A. Yes.

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

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

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

A. That's correct.

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. 24 or 4?

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

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

A. Yes.

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

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

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

A. Yes.

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

A. That's correct.

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

A. Yes.

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

Q. Is it the basis for your conclusion that there

is significant volatility?

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

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

A. I do not.

Q. Would it be more than 20 percent?

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

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

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

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

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

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

A. Okay.

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

national high-cost reinsurance pool?

A. Yes.

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

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

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

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

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

A. In the ACA-compliant market?

Q. Correct.

A. I believe we have not.

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

A. Okay.

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

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

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

Could you explain that to a non actuary?

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

policy being set to zero.

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

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

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

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

A. 31 or 11?

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

A. Okay. Thank you.

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

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

A. I'm sorry.

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

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

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

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

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

wouldn't they?

MR. KARNEDY: Objection. Asked and answered.

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

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

MR. ANGOFF: Yeah.

BY MR. ANGOFF:

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

MR. KARNEDY: Same objection.

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

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

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

BY MR. ANGOFF:

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

A. Yes.

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

A. Correct.

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

A. Yes.

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

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

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

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

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

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

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

percent which would cause challenges for us.

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

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

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

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

Q. Company wide; correct?

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

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

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

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

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

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

A. In which exhibit?

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

rate filing. 29 of the exhibit.

A. Okay.

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

A. Yes.

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

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

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

A. I see that.

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

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

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

into risk adjustment to offset that.

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

A. It could. Yes. It could.

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

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

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

A. Correct.

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

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

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

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

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

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

A. That's my title.

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

A. The whole company.

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

A. Correct.

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

in New York this year?

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

MR. ANGOFF: I have no further questions.

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

MS. LUNGE: Sure. Good morning.

THE WITNESS: Good morning. How are you?

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

THE WITNESS: Yeah. Was it page 12?

MS. LUNGE: Yes. So you had talked

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

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

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

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

THE WITNESS: Last year we were only

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

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

THE WITNESS: Okay.

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

THE WITNESS: Okay.

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

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

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

Do you happen to know if those quality

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

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

MS. LUNGE: Great. That sounds perfect.

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

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

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

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

MS. LUNGE: Yeah.

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

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

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

MS. LUNGE: That would be great. And

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

THE WITNESS: That's correct.

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

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

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

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

THE WITNESS: I'm not aware of that.

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

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

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

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

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

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

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

THE WITNESS: I have not -- no one has

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

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

THE WITNESS: Yup.

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

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

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

THE WITNESS: Yes.

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

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

MR. PELHAM: Well thank you. So I have

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

THE WITNESS: I'm sorry.

MR. BARBER: Which page of the exhibit?

MR. PELHAM: Pardon me.

MS. HOLMES: Which page are you on?

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

THE WITNESS: Page 6.

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

THE WITNESS: Okay.

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

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

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

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

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

into a range that you have really solid confidence about.

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

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

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

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

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

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

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

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

THE WITNESS: Okay.

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

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

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

THE WITNESS: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. PELHAM: For all categories of --

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

MR. PELHAM: Right.

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

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

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

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

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

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

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

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

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

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

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

MR. PELHAM: Inclusive.

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

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

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

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

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

THE WITNESS: Thank you.

MR. BARBER: Ms. Holmes.

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

THE WITNESS: Okay.

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

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

MS. HOLMES: Okay.

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

MS. HOLMES: Okay.

THE WITNESS: What I guess I'll go back

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

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

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

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

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

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

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

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

THE WITNESS: Yeah.

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

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

THE WITNESS: Yup.

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

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

MS. HOLMES: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that.

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

THE WITNESS: Exactly.

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

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

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

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

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

THE WITNESS: You're welcome. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE WITNESS: I completely understand.

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

MR. BARBER: Where are you?

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

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

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

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

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

MS. USIFER: Yeah.

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

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

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

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

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

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

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

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

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

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

THE WITNESS: I'm not an expert on the

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

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

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

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

So they are trying to identify the

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

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

THE WITNESS: I do not.

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

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

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

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

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

And the reason why we think ASO clients or self-insured clients are the clients that are utilizing those benefits is because there is a direct cost that the client is experiencing. They recognize that there is a savings opportunity that exists. And they are putting a lot more marketing materials forth, a lot more member education or employee education to utilize those benefits.

We do try to educate members on that benefit through our member welcome packet or on our website. But there isn't a way for us to just kind of pick up the phone and call people directly and

tell them you should utilize the telemedicine benefit in this instance, outside of potentially when we have those programs in place like the ER, the high utilizer of the ER program. Program.

MS. USIFER: Okay. But do you embed anything within the premium rates right now for cost savings that you'll be getting whether that is moving people, you know, out of ER into primary care specialists?

THE WITNESS: What we are capturing right now is the experience that we had in 2018. Our utilization trends were volatile, so we don't have any utilization trend, and we are not building in anything for additional utilization of something like telemedicine or reduction in ER.

MS. USIFER: Okay. And then looking at, you know, the L&E recommendations. You know, several of them were because there was new information, you know, that we have, the risk adjustment, things like that. But on the medical utilization which the proposal is to increase 5.15 percent the rate, is what would have happened if L&E didn't find that?

THE WITNESS: We would have continued with operating under the assumption that we didn't

have enough data to quantify what we -- utilization trend of anything other than zero percent.

Now because utilization trend is skinning the entire market and practice patterns, it is helpful for L&E to have the entire market scan and actually be able to analyze both competitors' data to provide an estimate, because we do think that is a more appropriate approach to quantify utilization trend.

MS. USIFER: Okay. And I do have one question on confidential information. So how do you want to handle that?

MR. BARBER: So this is a public meeting. We would have to go into executive session.

MS. USIFER: Can I refer to it and not say the numbers or --

MR. BARBER: Well if the question calls for an answer that discloses the numbers -- which document are we talking about?

MS. USIFER: I'm talking about tab 3, Appendix A, page 5.

MR. BARBER: Yeah. We would have to go into executive session.

MS. USIFER: How do we do that? Later or --

MR. BARBER: We can do it after the Chair finishes his questions before we take -- do redirect and then take a break.

MS. USIFER: Okay.

(A discussion was held off the record.)

MR. BARBER: Take a break now and continue with the questioning after that. I have to take a break. Convene back in 10 minutes.

(Recess was taken.)

CHAIRMAN MULLER: Could we get the door closed, please?

MR. BARBER: Back on the record after a brief break. I think the plan is the board will -- so Chairman Mullin will be doing the questioning, and then we will take up member Usifer's questioning on the confidential document. We will discuss going into executive session to take questions on that. So Mr. Chairman.

CHAIRMAN MULLIN: And then we will go to lunch.

MR. BARBER: Then we will do redirect and then lunch.

CHAIRMAN MULLIN: Okay.

MS. HOLMES: It's all about lunch.

CHAIRMAN MULLIN: So Mr. Lombardo, you

talked about risk adjustment and how it negates some possible consequences. What percentage of actual costs are mitigated through the risk adjustment process that's in place?

THE WITNESS: Are you speaking to the CMS risk adjustment program? Or are you talking about -- can you clarify?

CHAIRMAN MULLIN: So under the Affordable Care Act, you -- because you have healthier members, have been cutting -- been basically paying money in, but your competitor is receiving money back --

THE WITNESS: Yup.

CHAIRMAN MULLIN: -- through that risk adjustment. So what percentage of actual variation due to the health status of your members actually gets taken care of through that risk adjustment process?

THE WITNESS: Our assumption is that the risk adjustment program is solving for any of those inequities in the market between MVP and our competitor. I will point to we do have an exhibit in our rate filing where we quantify what the percentage actually is that we are paying into risk adjustment as a percent of our projected claim costs. It's on

Exhibit 3, which may take me a minute to find. Sorry. It's on Exhibit 2 of the binder. Page 138.

We are projecting a risk adjustment program payment of $60 that's prior to --

MR. KARNEDY: Let him get there first.

THE WITNESS: Okay.

CHAIRMAN MULLIN: Okay.

THE WITNESS: So prior to any L&E recommendations, we are projecting a $60.53 PMPM payment into the risk adjustment program compared to the index rate prior to risk adjustment in line 30 of $414. The adjustment is somewhere just south of 15 percent. With the recommendation of L&E we would add another one and-a-half percent to that.

CHAIRMAN MULLIN: You talked about 40 percent of the hospital business being done at hospitals that aren't under the regulatory authority of the Green Mountain Care Board. Of that 40 percent what percentage would be Vermont hospitals? Specifically Brattleboro Retreat, and the state hospital that we do not have that regulatory authority?

THE WITNESS: That's actually included in the confidential information, I believe. Which exhibit was that? 3-A was the one board member

Usifer was referencing. It's not a huge impact. Those two facilities in Vermont aren't driving a lot of the impact of our trend differences.

I would like to make one clarifying point though. The 40 percent of business that is not governed by the board is hospital plus physician costs, so also included in that figure is any of our community physicians that we contract with directly in the State of Vermont. So that's not -- I just want to make it clear that's not 40 percent of the business is just leaving Vermont. It's a number that's smaller than that, if we account for physicians that are not governed by the board.

CHAIRMAN MULLIN: When you look at that trend, the 5.5 percent, do you see any co-relation between the regulation in a state on those entities versus the non regulation?

THE WITNESS: Can you clarify exactly what you're looking for? I'm sorry.

CHAIRMAN MULLIN: So if Vermont is growing at half that, do you think that has anything to do with the oversight of those hospitals, or do you think that it has more to do with what's happening in that particular geographic region?

THE WITNESS: We see direct impact of

the Green Mountain Care Board being able to match the facility trends. We actually put an exhibit together which showed how our premiums have changed since the inception of the ACA over time in a couple of our New York markets relative to Vermont. And what we have seen is that the Vermont premium rate increases and just the level has actually dipped below the New York premium levels. And they weren't always at that level.

And we do attribute a large portion of that to the fact that our trends are lower which is because of managing the actual facility trends and the facility-owned physician trends by the board.

CHAIRMAN MULLIN: So you mentioned that you negotiated directly with Dartmouth Hitchcock.

THE WITNESS: Yes.

CHAIRMAN MULLIN: As part of that, knowing that 40 percent of the volume done at the Lebanon campus is Vermonters, do you try to tie any potential increases to rates that you're seeing in Vermont?

THE WITNESS: That would be a question I would have to follow up with our contracting team. We do -- no surprise, that is the one facility that has the most utilization for our members because, you

know, a lot of southern Vermonters go over the border and access care. We do our best to actually keep the costs down. It's just always challenging to come up with the figures where the board is holding facilities to around 3 and-a-half percent.

CHAIRMAN MULLIN: In what states do you negotiate for your own versus using your national carrier? Your national contractor?

THE WITNESS: It's New York, upstate New York, for the most part, and then just Dartmouth Hitchcock. There may be one or two other facilities I'm not recalling that are on the border of New York or Vermont, but primarily it's Dartmouth Hitchcock, and then it's New York.

CHAIRMAN MULLIN: So obviously your national carrier would have negotiations in both those markets as well.

Have you concluded that because MVP is negotiating directly with Dartmouth Hitchcock that you're getting a better rate, and therefore that's why you do it that way? Or what is the historical decision point that you negotiate with Dartmouth Hitchcock versus using your national carrier?

THE WITNESS: That would be something I would have to follow up the specifics with the

contracting team. We did, MVP being we, did operate in the state of New Hampshire in the past. We withdrew from that market due to challenges with keeping costs down, offering a competitive premium rate. A number of years back we never offered an ACA-compliant product, so I believe the exit was around the time of the inception of the ACA in 2014. It was around that time.

But obviously we are still in Vermont, and we recognize how much Vermonters and also New Yorkers for that matter access Dartmouth Hitchcock, which is my understanding of why we need to negotiate with Dartmouth Hitchcock.

CHAIRMAN MULLIN: Okay. You mentioned in your testimony that you believe that you got the same percentage off that your national contract carrier receives. Obviously there is no such thing as a free lunch so how are they compensated for doing the work for you? Is it on a percentage basis, a fixed fee or what?

THE WITNESS: The national carrier doesn't have a robust network in upstate New York. So they actually leveraged our contracts for their members that want to access care in upstate New York. And then obviously -- and then we leverage their

network outside of where we contract. So it is a two-way relationship between the two carriers.

The actual terms of the contract, that would be something that I'm not privy to, but someone at MVP is privy to that information and could provide it.

CHAIRMAN MULLIN: Are there multiple options for a national contract?

THE WITNESS: In terms of could we use another carrier? So there are other national carriers. I don't know if there is another one that has gaps in their network in upstate New York where it would make as much sense, but that would be something that I would have to talk to our contracting team about.

CHAIRMAN MULLIN: Would you assume that your contract team is comparing what the percentages are on the contracts with the different options?

THE WITNESS: So I'm not sure if that information is readily available. I mean that's one -- that's the carriers -- generally one of their most confidential pieces of information. So I'm not sure how well we have the ability to understand the cost of the national carrier that we leverage versus another carrier at specific facilities.

CHAIRMAN MULLIN: Okay. You talked about this board doing an evil thing and making a couple of adjustments mid year. And I'm just curious because we have this year's filings. And one of those adjustments was for a hospital that did not ask for an increase in charges or rates this coming year because a number of carriers had told them that they could not implement the mid-year adjustment until October 1.

Do you know how MVP treated those two mid-year adjustments?

THE WITNESS: I'm not aware of that. My understanding is that it was effective on the date, but I don't know if there are actual claims that are processed reflecting those adjustments.

CHAIRMAN MULLIN: And did you do any analysis of what percentage of MVP's overall business was affected by those two?

THE WITNESS: We do have the exhibit in our filing that includes -- it's a confidential exhibit that displays utilization of MVP services by facility in Vermont versus Dartmouth Hitchcock, New York participating hospitals, and our rental network. So that's something that I can either point you to or we can address during the executive session.

CHAIRMAN MULLIN: Is it safe to assume that the percentages in that chart though could just be applied to those rate increases that were done mid year?

THE WITNESS: Yes.

CHAIRMAN MULLIN: Okay. Thank you. You talked about there were 44 different ways that MVP is trying to keep costs down while at the same time guaranteeing quality for your subscribers. And I'm curious if the designation of a particular procedure comes into that discussion, and let me give you an example.

You've probably seen a number of ads on TV for a product called Cologuard. And Cologuard is, I think, 90 to 92 percent effective. Colonoscopy is 97 percent effective. If you talk to primary care physicians a number of them will tell you that even though because there is no family history in the health status of a patient that is seeing them, they still may not recommend that lower-cost alternative because of the way it's treated in its classification. So, for example, a colonoscopy is a screening measure, and it's protected under Vermont statute, and you have to treat it one way. And what I'm told is that patients have gone for the lower-

cost option which is the Cologuard because they don't have to take a day off from work and do everything for the prep and everything else.

But if it comes back that there is something that's found, the second colonoscopy that is then necessary gets treated as diagnostic rather than screening. And so it's a huge out-of-pocket cost to the Vermont patient. And so that primary care doctors are reluctant to go to the step of going for the least-cost alternative in the beginning, because they know that in a small percentage of cases it could be very expensive to their patient in the long run.

So I'm wondering if you have those discussions.

THE WITNESS: That would be something that's discussed by our clinical team, and any of those kinds of discussions -- I mean I'm happy to provide follow up if I can go back to the clinical team and understand if those conversations are taking place and what those conversations are.

CHAIRMAN MULLIN: That would be very helpful. You talked about New York State not using RBC but using reserves to premiums, and you talked about the 12 and-a-half percent in New York. You're

currently at 14 and-a-half.

How does New York treat TPA or ASO arrangements?

THE WITNESS: In terms of measuring their -- how they account for the 12 and-a-half percent? Well ASO and self insured generally falls under a different legal entity. And how their premiums or their -- so basically the ASO client is only paying us administrative fees. How that is actually coming into the calculation, or if it's part of the calculation, I would have to follow up with a New York regulator to understand exactly what they are measuring.

So to the extent that they are only pulling in our fully-insured business, the way that MVP team has communicated back to me is the 12 and-a-half percent are fully insured premiums. Now I don't know if they have taken that for granted or with a grain of salt. The implication has been that ASO is not included in that figure, but I would have to confirm with either our financial team or New York State to be a hundred percent confident.

CHAIRMAN MULLIN: Okay. Thank you. You said a couple different times that New York book of business is in decline. Vermont is increasing.

But it's a small percentage of your overall business. If there was similarly a Vermont decline but a large increase in New York business, would you come in with a reduced administrative cost in that scenario?

THE WITNESS: What we do is we make a projection of a total dollar projection. What it's going to cost to run our business in the upcoming year. I'm really over simplifying it, but that's generally what we are doing. And then we are looking at it relative to our overall membership, you know, with some -- obviously look at how are we operating, what are we actually spending in Vermont versus New York, et cetera.

In the extreme scenario if we assume that our membership doubled, which -- enterprise wide which won't happen, but just for scenario sake, you would have a membership -- you would be taking the same total dollar figure or proportional increase for variable cost divided by a much larger base. I would anticipate in that instance we would have a reduction in the PMPM admin costs.

If it's small, we still have to account for projects that we are undertaking like updating technology and just other adjustments that we have to pay.

CHAIRMAN MULLIN: There were some questions earlier about the Ambulatory Surgery Center. Are you aware that the Green Mountain Care Board is in receipt of a letter from MVP stating that the reimbursement for procedures being done there for MVP subscribers is going to be below that of hospitals?

THE WITNESS: I'm not aware of that.

CHAIRMAN MULLIN: Okay. Are you aware that the estimated cost savings to the system is $3 million in the opening of the Surgery Center?

THE WITNESS: I'm not.

CHAIRMAN MULLIN: So if those two things I said were accurate, and that is the case, would -- should there be a small reduction in your filing to indicate those cost savings?

THE WITNESS: If the contracted rates that we are able to negotiate are lower than outpatient -- outpatient hospital setting, and we can drive utilization there, then I would agree that we would have an adjustment to our filing if that information was known.

CHAIRMAN MULLIN: Okay. I think that's all I have at this time.

MR. BARBER: Okay. So just in terms of

scheduling, I think realizing now what you said, I think we will do the questioning on the confidential document. We will come back out of executive session. We will have a lunch break. And then we will reconvene, I'm thinking around 1, for any redirect and cross on redirect. Does that make sense?

MR. KARNEDY: That's fine. I'm happy to take a short break. Whatever the board would like to do.

CHAIRMAN MULLIN: Why don't we make that decision after we finish with the executive session, how long the break is.

MR. BARBER: Okay. I'm just trying for people who want to leave and not have to come stand outside the room for the executive session.

I would say we will reconvene at 1 for finishing the questioning of this witness. Member Usifer has some questions about -- I believe it was Exhibit 3-A -- which the board has granted confidentiality for. Under the board's rate review rules, we have an obligation to omit references to these materials in the record and in public deliberations and take other appropriate measures to ensure confidentiality.

Since this is a public meeting, we would go into executive session to discuss this. The applicable statute 1 V.S.A. 313(a) allows the board to go into executive session to discuss records that are exempt from public inspection and copying under the Public Records Act. Procedurally the board would make a motion -- a motion would need to be made to go into executive session indicating specifically what the purpose is, and questioning would be limited to this document and not go outside of that. So --

MS. USIFER: Can I add one more document?

MR. BARBER: Yes.

MS. USIFER: It's going to be page -- under 5 page 8.

MR. BARBER: Okay. So two documents. Exhibit 3-A and Exhibit 5.

MS. USIFER: Yeah. Tab 5. Page 8.

MR. BARBER: Page 8. Which is not actually confidential.

MS. USIFER: It's not confidential? That was one where they -- before they just referred to -- I thought that was confidential.

MR. KARNEDY: Can I speak to that?

MR. BARBER: Sure.

MR. KARNEDY: It appears that the exhibit, there is an Exhibit 5, and there is an Exhibit 5-A. And I was being careful.

As you'll recall last time we met to make sure that we did not speak to question 4 because it has confidential information in it. For whatever reason, I believe I made a mistake, and Exhibit 5 has that information in it. And I would like to move to strike that response because that should have been confidential, and it was an error on my part. And I apologize for it. That's the confusion that you're expressing.

MR. BARBER: So you're claiming that Exhibit 5 response to question 4 is confidential? Because I believe we granted confidentiality for a portion of the top of page 3. Redaction.

MR. KARNEDY: Can I confer with the client for a second?

MR. BARBER: Sure.

MR. KARNEDY: Right. I just wanted to confirm with Matt. So there was an error on my part. I apologize for that. The Q and A on number 4 should have been marked confidential.

MR. BARBER: Should have been marked confidential.

MR. KARNEDY: Should have been marked confidential.

MR. BARBER: All right. So questioning on document 3-A and questioning on Exhibit 5. So there will need to be a motion and 2/3 vote from the board to go into executive session to discuss those exhibits or portions thereof.

MS. LUNGE: I can do the motion. I move that we go into executive session to discuss Exhibits 3-A and Exhibit 5, specifically the confidential information contained therein for the reason that we have a duty under the statute to provide confidentiality for those items.

MR. BARBER: Is there a second?

MS. HOLMES: Second.

CHAIRMAN MULLIN: All in favor signify by saying aye.

ALL BOARD MEMBERS: Aye.

MR. BARBER: Opposed?

(No response).

MR. BARBER: Okay. So the board has decided to go into executive session. We would need in the room, I believe, obviously Health Care Advocate and their attorneys, our staff, L&E. I don't believe anyone else is necessary, so if

everyone else could please leave the room. Sorry. If you could shut off the recording. We are going to continue our recording and continue the transcription. We will come out. We will take a break for lunch and reconvene at 1.

(An executive session was held. The testimony continues in a confidential transcript).

(Public Transcript).

MR. BARBER: Okay. So I think at this point we are going to break for lunch. Be back at 1 with any redirect.

(Recess was taken.)

MR. BARBER: Call this meeting to order. We are back on the record in the case of GMCB-005-19-rr in re: MVP Healthcare 2020 Vermont Health Plan Rate Filing.

I was asked to just remind folks that we have a sign-in sheet outside the door for people for attendance as well as a sign-up sheet if anyone would like to make public comments.

We had just finished board questions for MVP's witness, Matthew Lombardo. And Mr. Karnedy, did you have any redirect for this witness?

MR. KARNEDY: No redirect.

MR. BARBER: Okay. You can be excused. I think that's the procedure -- that's typically what we have done; right?

MR. KARNEDY: That's fine. I just wanted Matt to be nervous all through lunch.

MR. BARBER: So next we are going to hear from Department of Financial Regulation. Jesse Lussier is here. Also like to recognize Gavin

Boyles, Department of Financial Regulation's General Counsel.

Jesse, I don't think you were here at the beginning. Could you stand and raise your right hand?

JESSE LUSSIER

Having been duly sworn, testified as follows:

MR. BARBER: Okay. Thank you. So whenever you're ready.

THE WITNESS: Good morning. My name is Jesse Lussier. I'm an examiner and analyst --

CHAIRMAN MULLIN: I guess you have to speak really, really loud.

THE WITNESS: I can do that.

MR. BARBER: I think we can just proceed.

THE WITNESS: Good morning everyone.

CHAIRMAN MULLIN: Afternoon.

THE WITNESS: Afternoon. It is. My name is Jesse Lussier. I work for the Department of Financial Regulation. I'm an examiner and analyst for the department. I have been there for a little over eight years now.

We have reviewed the department's role in solvency in the past, so I just want to give a very high level update. But if you have any more specifics, you can let me know. For the analysis piece we reviewed financial statements on a quarterly basis, and we also receive a more robust financial

package at year end, and that's on a routine basis.

For the examination side, it's more robust in nature. It's more akin to a financial audit, and it happens every three to five years.

As we have also noted from the past, insurance regulation is state based, so that every state is responsible for those companies that are domiciled within that state. In MVP's case their lead regulator is New York. So New York will perform substantially similar examination and analysis procedures as Vermont or any other states. And like all state regulation we will rely on New York for those companies, in this case we will rely on New York for MVP's analysis.

With respect to this year's solvency it's relatively similar to the prior year, and we have read some of this already. But I'll just read the final paragraph: Based on the entity-wide assessment above, and contingent upon GMCB's actuary's findings that the proposed rate is not inadequate, DFR's opinion is that the proposed rate will not have a negative impact on MVPHP's solvency.

There are a couple reasons why that is similar to previous years. One, is just the overall footprint of MVP's business in Vermont relative to

its full book of business. Like discussed previously it's around 5 percent which is relatively small.

And also, we have not received any solvency-related concerns or communications thereof from the New York department. That's what I have so far. Trying to keep it short. I know we are going to be short on time. Does anybody have any questions?

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

MR. KARNEDY: I do. Thank you very much.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. So Mr. Lussier, you're an insurance examiner and analyst for the department; correct?

A. Yes.

Q. Do you have your CPA?

A. I do.

Q. And you would -- I think you have in front of you Exhibit 10 which is the letter from DFR; correct?

A. Yup.

Q. And you're adopting that letter as your testimony on behalf of DFR; correct?

A. Correct.

Q. Would you please read on the first page of that exhibit the sentence under "Summary of Opinion" please?

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

Q. You stand by that opinion; correct?

A. Correct.

Q. Okay. Would you please read on page two, there is a heading "MVPHP Solvency Opinion." And then there is three bullets. Do you see that?

A. Yes.

Q. Would you please read the three bullets?

A. "DFR has been in communication with MVPHP's primary solvency regulator, the New York Department of Financial Service and has not learned of any solvency concerns. Further, MVPHP currently meets Vermont's foreign insurer licensing requirements. Finally, in 2018, all of MVP Holding Company's operations in Vermont account for approximately 4.8 percent of its total premiums written. DFR has determined that MVPHP's operations pose little risk to its solvency. Nonetheless, adequacy of rates and contribution to surplus are necessary for all health insurers to maintain strength of capital that keeps

pace with claims trends."

Q. Thank you. I want to focus on the notion in that last sentence, I think in the third bullet. In the sentence before you indicate that MVP -- only about 4.8 percent of its premium is written in Vermont; right?

A. Correct.

Q. Yet the adequacy of those rates and contributions to surplus are important when you look at Vermont. Said another way, even though Vermont is a small percentage of MVP total premium, would you agree you still look at the Vermont premium and this rate to determine whether it's adequate?

A. Yes. I would say that's correct.

Q. And you read in your opening the sentences, or sentence I should say, under impact of the filing of solvency, you stand by that as your testimony; right?

A. Yes.

Q. And this letter, Exhibit 10, was based on DFR's review of the original MVP filing; correct?

A. Correct.

Q. And in that filing MVP saw a 1.5 percent contribution to reserves; correct?

A. Correct.

Q. You heard testimony here, I saw you today, heard testimony of Mr. Lombardo?

A. Yes.

Q. And you also heard testimony about L&E's recommendations; correct?

A. Yes.

Q. So based on L&E's recommendations, your testimony that MVP has increased its proposal from 9.4 to approximately 10.5 on based on L&E's recommendations and then another .5 due to hospital budget proposals for a total of 11 percent. You heard that testimony, right?

A. Yes.

Q. Do you have an opinion that this increase to the 11 percent will likely have the impact of sustaining MVPHP's current level of solvency?

A. That is correct. It wouldn't change our opinion.

Q. It would not change your opinion?

A. Correct.

Q. And when it comes to solvency, would you agree with me it's not a good idea to kick the can down to later years and perhaps have a lower contribution in one year, say 1 percent, figuring you'll just make up for it down the road with a 3 percent increase in the next year?

A. From a solvency perspective, I would agree with that, yes.

Q. Are you familiar with statistics on proposed

CTR filings for single risk-pool filings across the company -- excuse me -- across the country over the last two years?

A. Am I familiar with them?

Q. Yes.

A. No, other than what I read in the L&E memo.

Q. Okay. Let's go to that Exhibit 9, please. If you go to page 14. And you heard Mr. Lombardo's testimony today about the two paragraphs under section 15 about reasonableness checks. Correct?

A. Yes.

Q. And you've read these paragraphs before?

A. I did. Yeah.

Q. And this is L&E comparing CTRs nationally; isn't it?

A. Yeah.

Q. Would you agree with me that based on a comparison to these filings nationally, their reasonableness check, that MVP's CTR is reasonable in light of the underlying risks?

A. The memo appears reasonable, but I'm not an actuary, so I can't opine on them.

Q. Would you agree with me this appears to show that a contribution below 1.5 percent would appear to be an outlier. That less than 20 percent of the proposed

CTRs would fall in that category; is that right?

A. I would agree on that based on the numbers we have here. Yeah.

Q. I believe you testified last year that the DFR review of solvency doesn't end with RBC. It reviews a large amount of data, is that fair?

A. That is fair, yes.

Q. Recognizing you're relying on the New York regulators; correct?

A. Correct.

Q. And if you go to page 1 of your report, please. Exhibit 10. Under "Background."

Would you read the second and third sentences, first paragraph -- paragraph under background?

A. Starting with "Whether an insurer"?

Q. Sure. Exhibit 10 under the heading "Background."

A. Yeah.

Q. There is a paragraph that starts "DFR." And that has three sentences. I would ask you to read the second and third sentences, please.

A. "Whether an insurer is solvent is more complex than simply determining whether at any given moment the insurer has more assets than liabilities. Rather, it is an intricate analysis of many factors to discern how close

or far away from insolvency the insurer is and in what direction it will move in the future."

Q. And that's what DFR did this year, reviewing it, recognizing you're relying on the New York regulators as well?

A. Yes.

MR. KARNEDY: Thank you very much.

MR. BARBER: Okay. Questions for this witness?

MR. ANGOFF: Yeah.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Does DFR do any independent analysis of MVP's solvency?

A. We receive the financial statements, so I review those at a high level.

Q. You review their annual statements.

A. At a high level. Yeah.

Q. But you or DFR staff people don't do any independent analysis; correct?

A. We don't do a full-blown analysis. The New York Department does that.

Q. And you don't go behind the annual statement?

A. Pardon?

Q. You don't -- you review the annual statement.

You don't go behind the annual statement.

A. I might look at the basic financials and then I would most likely look at the supplemental healthcare exhibit, and the NLR calculations, just to see if those would affect Vermonters. If there would be a regional effect.

Q. You review what's filed with New York and filed with HHS and filed with the NAIC.

A. Yes.

Q. Did you do any type of analysis where you attribute a certain amount of MVP's capital to Vermont?

A. No.

Q. And you say in your solvency opinion in the first bullet on page 2 that you have been in touch with the primary regulator in New York, and they didn't have any solvency concerns; right?

A. Correct.

Q. Did they tell you that if this rate increase was not approved in full, that they would have solvency concerns?

A. They did not say that.

Q. Did they tell you if no rate increase is approved that they would have solvency concerns?

A. No.

Q. Did they tell you that if a decrease was

approved they would have no solvency concerns?

A. No, they did not say that.

MR. BARBER: Does the board have questions for Jesse?

MS. LUNGE: I have one question which, Jesse, you may not be able to answer so feel free to tell me -- to just say that. Do you know the status of MVP's form filing, specifically the Gold Plan that's being revised?

THE WITNESS: No. That would be rates and forms section, so I'm not involved in that.

MS. LUNGE: Okay. Thank you.

THE WITNESS: Would you like us to get back?

MS. LUNGE: Yes. It would be great if we could get an update on the form filing when it's approved. I don't have anything else.

CHAIRMAN MULLIN: Tom?

MR. PELHAM: Hi. A quick one here. So I'm looking at the sentence in the commissioner's letter that says: "Nonetheless adequacy of rates and contribution to surplus are necessary for all health insurers to maintain strength of capital that keeps pace with claims trends."

But my thought would be anyhow is that

it's not just rates and surplus. There are -- rates are certainly important, but it could also be a tax credit that could be admitted, it could be bad management that could be starving the bottom line. There is a whole bunch of factors that at the end of every year result in what falls to the bottom line for surplus. Is that a fair assumption?

THE WITNESS: Yeah. I think we would say there is quantitative and qualitative factors that go into any company, and so those certainly get taken into account. For instance, if the entire executive team quit at once from a company, that would be certainly very risky, and we would wonder why.

So it's not necessarily a numerical item that we would be looking at. Does that answer your question?

MR. PELHAM: I think so. I mean you could have, for example, a technological investment that went sour, and all of a sudden it starts bleeding. It has happened in state government from time to time. Bleeding the organization of capital that therefore cannot fall to the bottom line as surplus.

So there is a whole bunch of moving

parts here that you have to take into consideration at a certain point in time.

THE WITNESS: Yeah. I would say that's fair.

CHAIRMAN MULLIN: Ms. Holmes.

MS. HOLMES: Just one question. I think you said that there is -- every three to four years there is a deeper dive, more like an audit, of the insurer.

THE WITNESS: Yeah.

MS. HOLMES: When was the last time or when is the next time that's going to be done?

THE WITNESS: For MVP?

MS. HOLMES: Yeah.

THE WITNESS: I would have to double check that. It's the -- statutorily it's every three to five years. I could get back to you. I'm not exactly sure when -- New York would have done that. And I don't think -- Vermont would not have been involved.

MS. HOLMES: Okay. Well if you can get back to me, that would be great.

THE WITNESS: Sure.

MS. HOLMES: Thank you.

MR. BARBER: Ms. Usifer, do you have

any questions?

MS. USIFER: No.

CHAIRMAN MULLIN: No.

MR. BARBER: Okay. Thanks for your testimony.

THE WITNESS: Thank you.

MR. BARBER: So the next witness we have on deck is Jacqueline Lee from Lewis & Ellis to be directed by Associate General Counsel Aborjaily. Whenever you're ready.

JACQUELINE B. LEE

Having been previously duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. ABORJAILY:

Q. Thank you. Good afternoon.

A. Good afternoon.

Q. Would you please state your name for the record and tell us where you're employed?

A. Yes. Jacqueline Lee. I'm employed at Lewis & Ellis.

Q. And what does Lewis & Ellis do?

A. We are an actuarial consulting firm. We are in the Dallas office that's represented by the Green Mountain Care Board. And we consult insurance companies, state regulators, on actuarial issues.

Q. And what is your educational background?

A. I received a Bachelor of Science in math from Texas Lutheran University. After college I became a credentialed actuary, so I'm a fellow in the Society of Actuaries and a member of the American Academy of Actuaries.

Q. So about how long have you been practicing as an actuary?

A. I have been an actuary for 15 years.

Q. And how long have you been retained by the board to provide actuarial services to the State of Vermont?

A. We have been employed by the board since 2014.

Q. Since 2014. In that time how many Vermont health insurance rate filings have you worked on?

A. We have worked on about 65 filings in Vermont.

Q. And in what market segments have those filings been in?

A. The market segments that we have worked in have been the merged individual and small group filings, and then we also have reviewed large group and association compliance.

Q. So given that experience, how familiar are you with the Vermont health insurance marketplace?

A. We are very familiar with the Vermont health insurance marketplace now.

Q. And how about other states? How many rate filings have L&E worked on?

A. We have worked on countless rate filings. We have assisted about over 20 states since the inception of the Affordable Care Act working specifically on issues with the Affordable Care Act.

This year we are working with nine states to -- similar to here -- where we are reviewing rate filings.

Some of the times we are -- have that same type of purview. Others we are more in a guidance role. But in either case we are involved in all the filing process.

Q. So given that you've done this work with other states, what kind of comparative look would you say you have at the nationwide health insurance marketplace?

A. Given that we have worked in a lot of the states, it's helped us to better understand what the variables are between the various states. It also helps us get a handle on what's changing from a market-wide perspective, but also how different states are handling some of their regulatory environment changes. And we keep up with that through just our contacts, but also just through keeping up to speed on, you know, news and new changes in regulations.

Q. So moving to reviewing a health insurance rate filing. How do you go about doing the review in general terms?

A. Generally speaking, we have three actuaries that touch a filing in Vermont. The first level for this particular filing was Josh Hammerquist. He does a deep dive. He has the most correspondence with the carriers reviewing the initial filing that they have provided through SERFF. And then I work as a peer reviewer. I do a fairly deep review alongside of him talking through key

issues, making sure that he's caught all of the questions that we need ask.

And then Dave Dillon also helps out because he has a similar role in the Blue Cross filing that I do, but we talk about them in great detail to make sure that we are consistent between the two filings as well as making sure we are accounting for all the market-wide changes that happen.

Q. You mentioned the term is SERFF. Could you explain a little bit what SERFF is?

A. SERFF is the NAIC's platform for the submission of rate filings, and it's the way we communicate with the carriers to ensure that all of it is available via public record so there is transparency to the process.

Q. And when you are reviewing a health insurance filing and you are assisting the board, what is it that you are assisting the board with in terms of evaluation?

A. So our charge to the -- is to help the board determine if the rates that have been submitted are reasonable. And how we go about that is look at all of the underlying assumptions to build up to the rate as well as the starting point, and make sure that it's properly supported, that the support appears to be reasonable. And that they have accounted for all of the pieces that they

need to within the rate.

Q. And when you're making your determination about whether you believe rates to be reasonable, are there certain criteria that are defined in professional guidelines or in state statutes that you're looking at?

A. Yes. We have a lot of guidance regarding rates. Some are at the federal level. Some are at the state level. And we have to abide by those.

We also -- from the actuarial profession we have standards of practice that we call actuarial standards of practice or ASOP that we have to follow as well. Those provide us guidance that is a little bit more specific to our role to make sure that we are accounting for all the pieces that we need to do so.

Q. And so after a company's filing their information into SERFF, how do you go about getting more information should you need it during the review?

A. Typically it begins with an inquiry letter that we send through SERFF to each of the carriers. We give them a defined time frame to respond so we can get our responses back. We have that back and forth several times through the process.

Q. And that was true with this filing as well?

A. Yes, it was.

Q. And how long do you have to review a filing

from the time it's submitted to the board?

A. We have 60 days.

Q. And what happens at the conclusion of the 60 days?

A. We have to submit a final report that becomes publicly available to all the parties.

Q. And is it your understanding that the 60 days is a statutory deadline?

A. Yes.

Q. So talking about today's rate filing, what was your role in L&E's review of this?

A. My role was a peer reviewer of the filing itself. So I took a deep dive alongside Josh Hammerquist to make sure that we understood all of the underlying reasons for the rate increase, and asked sufficient questions to make sure that we were in agreement, or if there were disagreements, where we differed.

Q. And were you involved in writing the actuarial report with respect to the findings?

A. Yes.

Q. And is that Exhibit 9, I believe?

A. Yes. It is.

Q. Now on page 2 of Exhibit 9 you'll see that there is a paragraph labeled "Standard of Review." Is this your standard of review, or is this the board's

standard of review?

A. This is the board's standard of review.

Q. And the standard of review is from the statute?

A. Yes, it is.

Q. And what is L&E's standard of review?

A. Our standard of review incorporates some of the portions of the board's standard of review. Ours is defined through ASOP 8 where we are evaluating whether the rates are excessive, inadequate or unfairly discriminatory.

Q. Have you defined ASOP for everyone?

A. Yes. Actuarial standard of practice.

Q. Thank you. I might have missed that. And how do you determine whether a rate is excessive according to the actuarial standard of practice?

A. The actuarial standard defines excessive as having rates that are charged that exceed the amount that are needed to pay for claims, admin, taxes, fees and a reasonable contribution to reserves or profit.

Q. And how is adequate defined?

A. Adequate is very similar, except it kind of takes the opposing view where we are assessing whether the rates are sufficient to cover the claims, admin expenses, taxes, regulatory fees and a reasonable profit.

Q. And how is the term unfairly discriminatory defined?

A. Unfairly discriminatory is defined as charging rates to a specific cohort of individuals that is not supported by their respective costs or not supported by federal or other regulatory guidance.

Q. And earlier this morning we heard some testimony briefly from MVP about affordability. Just to be clear, did L&E review this filing for affordability?

A. We did not.

Q. And are there actuarially defined standards for affordability?

A. There is not.

Q. So moving to the language in your memo. At various points throughout this you said that the carrier's assumption is reasonable and appropriate. Could you give a little explanation of what you mean when you say it's reasonable and appropriate?

A. Sure. We use that term to basically state it's not excessive, not inadequate, and not unfairly discriminatory. When we make a recommendation it is typically because it has violated one of those.

Q. Moving to your recommendations which I believe are listed back on page 15.

A. Yes.

Q. Could you give a brief overview of -- before we go into each specific one, could you just sort of skip to the end and just tell us what the ultimate projected rate increase would be if all of your recommendations were implemented?

A. Yes. MVP's initial rate increase was 9.4 percent. If all of our recommendations were taken into account, then the rate increase changes to 10.5 percent.

Q. Okay. And just to be clear, we heard some testimony this morning about budget submission information, updated information, and hospitals submitted their budgets. Is there any recommendation as to that included within the recommendation of 10.5?

A. There is not.

Q. And we can circle back to that in just a bit. I'm going to walk through the rest of these, but I'll start from the top.

So what is the medical trend MVP originally filed as described on page 5?

A. Medical trend as filed -- the allowed medical trend is 4.2 percent.

Q. And what is the basis of the unit cost trend assumption for this filing?

A. The unit cost trend assumption is, in fact, the 4.2 percent. It is accounting for the changes in the

hospital contracts between the two years.

Q. Okay. And earlier this morning there was some testimony about an error that was discovered as part of this during the review. Could you explain a little bit more about your questions to MVP and what the result of those conversations were?

A. Sure. As part of our review we want to ensure that the unit cost assumed within the filing are matching hospital budget process since it is well defined within the Green Mountain Care Board's hospital budget process. So we always ask them to itemize that by facility. In performing that, they recognize that they, meaning the carrier, recognized that they had accidentally used the initial submission of trends rather than the final, approved and ordered unit cost trends.

Q. So turning back to page 15, that would be the first bullet point?

A. Yes. We recommend that they do, in fact, reflect the order unit cost increases which reduces the premiums by about .9 percent.

Q. And do you have any other recommendations regarding the cost trend?

A. Yes. As we have discussed earlier today, some updated information regarding the hospital budget process since it has begun has been published in the form of

narratives. That typically happens every year, so we were anticipating that happening again.

Our recommendation is -- to the board is that the most up-to-date information be used with finalizing and producing the work.

Q. And have you had an opportunity to review submissions for this year?

A. Yes.

Q. Have you had an opportunity -- well it sounds like you had an opportunity then to review hospital budget submissions and draft orders for past years as well; is that right?

A. Yes. That's correct.

Q. And let's say just for the last three years, what's been the relationship between the budget submission and the rates as they are proposed and then the final budget order from the board?

A. The final budget order from the board is typically lower than the original submissions for the hospitals.

Q. And you heard some testimony this morning from MVP about what their assumption is based on the budget submissions as they are now. And do you have an opinion on MVP's assumptions?

A. I do not have a formal opinion because we have

not seen the breakdown. However, we did an independent calculation as well, and our figure closely matches the .5 percent that Mr. Lombardo quoted earlier. We would like to see the backup of that.

So we do agree that if the proposed trends were incorporated, that would be the rate change.

Q. You mentioned independent calculation. And I realize we didn't cover something earlier, but when you were reviewing the filing, do you do independent calculations on everything that's submitted, or are there some instances when you are simply checking the calculations that the carrier has done?

A. We typically do a mixture of both. The bigger an assumption is, the greater impact is, we will typically review what the carrier has submitted but also perform our own independent analysis to ensure that either using a different methodology or using different backup data that we come to a similar conclusion.

Q. So turning to the other portion of the medical trend. What is the basis of the utilization trend in this filing?

A. The initial utilization trend filed by MVP was zero percent. They had performed an analysis where they looked at a closed cohort due to their very recent, large increase in membership. They didn't want to include the

newer members because they didn't have as much history of data on those individuals. This proved to be very volatile in its -- in its results. And so they determined it was inconclusive and filed a zero percent which is what they have done since 2014.

Q. And do you agree with that assumption?

A. We do not agree with that assumption.

Q. Could you expand upon that?

A. We performed -- given the results of their analysis and the credibility issues that they were experiencing, we determined that a market-wide study would be helpful. So we gathered confidential data from both carriers in the market to do a market-wide scan of the utilization.

We came up with some results that can be seen on page 7 of Exhibit 9 of our report. These were all showing non-zero positive trends. So we felt like that it was appropriate to make an adjustment.

Our recommended range for the market is having a utilization trend between 1 and 4. For MVP we have recommended a 1 percent utilization trend, and that was based on all of the data we were reviewing, not just the market. We recognize that there is a difference between the populations covered between MVP and Blue Cross, and that MVP's specific data has shown some downward trend in

their past, but in 2018 both carriers did experience an increase which we felt should be reflected but maybe not to the same extent as the high end of the ratio which was 4.

Q. Thank you. Move back to page 15 again. Looking at the next bullet point we were talking about AHP morbidity impacts. Can you explain a little bit about the Association Health Plans, we heard a bit about this morning. So just a brief overview.

A. Yes. Mr. Lombardo's summary was quite good. He outlined that in the last year AHPs have been allowable again, which allows small groups to band together to create a larger group called Association Health Plan and to seek coverage. There's been a lot of changes over the last six months and even last month on this issue with DFR's bulletin saying that in 2020 these plans will not be allowed to renew. So given that information, MVP said that they are no longer requesting the rate increase of .8 percent for this particular issue.

Q. And what is your recommendation regarding --

A. Our recommendation is to remove the AHP morbidity load on claims which would reduce the projected premiums about .8 percent.

Q. Moving on to a discussion about risk adjustment. Could you briefly explain what makes the risk

adjustment calculation so challenging?

A. The risk adjustment calculation is challenging from a carrier perspective because it requires them to have knowledge of the other carriers in the market that is confidential such as their risk scores and risk profiles of their populations. Therefore, they aren't very easily able to understand their position in that particular calculation.

Additionally, for the 2020 calendar year CMS is making changes to the risk adjustment formula. So there were changes in coefficients or weightings for some of the particular diagnoses, and that was also producing some question marks for each of the carriers as well.

Q. And in terms of the timing of the CMS the CMS risk adjustment calculation, could you explain a little bit more about when the information comes in, and at what point you're sure they know what they are looking at?

A. Yes. During -- the filing here in Vermont was due roughly around May 11. And the risk adjustment calculation payment transfer information comes out at the end of June. So it's kind of right in the middle of our review period, which proves challenging because that's not too far away from the 60-day deadline that we discussed earlier, and it makes it challenging to have a quick turnaround on that type of information.

So to mitigate that, over the past couple of years, we have requested the information that they provide to CMS individually so that we can provide a preliminary calculation earlier in the process, typically provide that to them sometime in May. So that they can provide us with an assessment of how they are going to change their rates and what rate impact that would have earlier in the process.

Q. And after having done that work, does L&E have a recommendation regarding risk adjustment?

A. Yes. So after performing that work we also did perform an analysis on what the 2020 coefficient change would be. And if you combine those two adjustments, we recommended these rates will increase by 1.5 percent.

Q. And moving on to our last bullet point for recommendations on page 15 "Changes to Actuarial Value." As we discussed briefly a bit earlier in this morning's testimony there is an outstanding issue of one of MVP's Non-standard Gold Plans.

Could you explain where things stand now from your perspective in your recommendation?

A. Our recommendation was based on correspondence of a few weeks ago. It's my understanding there is still some loose ends to be tied up here in the next week or so.

I don't know that that will have a material change, but we do have an estimate as of a couple of weeks ago, that those changes to the plan will reduce the overall projected premiums by about .2 percent.

Q. The recommendations that we have gone through so far have been recommendations involving a change to -- that would have a rate impact, and I just wanted to touch on one more recommendation that we have listed here. And that's the new high-cost member program.

A. Yes.

Q. Could you tell us about your recommendation with regard to that?

A. Yes. Mr. Lombardo testified already to what the new high-cost program is. And we just recommended to be compliant with instructions that the -- that assumption be included under the net reinsurance section rather than the risk adjustment section they put it under in the original filing.

Q. And to be clear, will that have an impact on rates?

A. No, it will not.

Q. So let's just briefly turn to contribution to reserves. In your analysis for your report do you review for solvency and contribution to reserves?

A. Yes, we do.

Q. Is it your understanding that DFR is the -- has the primary responsibility for reviewing for solvency?

A. They do.

Q. And did you prepare any confidential information reviewing for company solvency?

A. We did.

Q. Do you find the company's assumption of a 1.5 percent contribution to reserve to be reasonable and appropriate?

A. Yes, we do.

Q. So with the recommendation that you have outlined in this report, do you find the filing excessive?

A. I do not.

Q. Is it inadequate?

A. It is not.

Q. And is it unfairly discriminatory?

A. It is not.

MS. ABORJAILY: I have no further questions.

MR. BARBER: Okay. Do you have questions for Ms. Lee?

MR. KARNEDY: I do.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Good afternoon, Ms. Lee. How are you?

A. I'm good. How are you?

Q. I'm well. It sounds like you've got your report in front of you which is Exhibit 9. This is your actuarial opinion; correct?

A. Yes, it is.

Q. If you go to page 2, I think you were asked about this. I just want to read, understand or review where it starts. "This letter is to assist the board in determining whether the requested rate is affordable, most quality care, most access to healthcare, protects insurer solvency, is not unjust, unfair, inequitable, misleading or contrary to the law, and is not excessive, inadequate or unfairly discriminatory."

Did I read that correctly?

A. Yes, you did.

Q. Okay. Is that a correct statement of the tasks?

A. Yes.

Q. And the board should consider this report in drawing its conclusions in this year's rate filing; correct?

A. Yes, they should.

Q. Okay. Let's go to page 17, please. Let me know when you're there.

A. I am there.

Q. Is that your signature in the middle?
A. Yes, it is.
Q. Okay. So you're signing off on this report; right?
A. Yes, I am.
Q. And what do those letters after your name mean?
A. FSA means Fellow in the Society of Actuaries.
Q. Yeah.
A. And MAAA means Member in the American Academy of Actuaries.
Q. And there is a signature above of Josh Hammerquist; correct?
A. Yes.
Q. So Josh signed off on this as well?
A. Yes, he did.
Q. And he's an actuary?
A. He is a fellow.
Q. And he has those same letters after his name; right?
A. Yes, he does.
Q. Okay. There is a signature below by Mr. Dillon who I think is here today. Correct?
A. Yes.
Q. And he has those same letters after his name;

right?

A. Yes.

Q. And he's a principal at Lewis & Ellis?

A. Yes.

Q. So three actuaries have signed off on this report; correct?

A. Yes.

Q. And I think you said you've done 65 filings in Vermont alone; is that right?

A. That's correct.

Q. And in other states, you've done filings in more than 20 states or around 20 states?

A. Yes.

Q. And this year you've got at least nine states you're working in?

A. That's correct.

Q. Okay. Page -- go to page 18, please. There is a Disclosures in Actuarial Reports." Do you see that --

A. Yes.

Q. -- as a heading? Would you read the fourth bullet?

A. "The responsible actuaries"?

Q. Please.

A. "The responsible actuaries identified above

are qualified as specified in the qualification standards of the American Academy of Actuaries."

Q. Thank you. And would you read the second bullet, please?

A. "Lewis & Ellis is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work."

Q. So is it fair to say that L&E is not beholden to MVP; is it?

A. That's fair.

Q. And your opinions are governed by a Code of Professional Conduct; correct?

A. That's correct.

Q. And the ASOPs?

A. And the ASOPs. Yes.

Q. And the third bullet, would you read that, please?

A. "The purpose of this report is to assist the board in assessing whether to approve, modify, or disapprove the rate filing."

Q. And my presumption is that you're not told in advance by the board some preordained number for a rate increase that they might like you to find. You're

providing an independent objective opinion; correct?

A. That is correct.

Q. And would you agree with me that such independence and objectivity add significant credibility to your actuarial opinions?

A. It does.

Q. As an actuary you aren't influenced by public opinion. That doesn't enter in your calculus; does it?

A. No, it does not.

Q. And that objectivity is illustrated in Exhibit 9. If your opinion is that MVP's approach on a particular issue is reasonable and appropriate, you've said so; haven't you?

A. That's correct.

Q. And that's indicated in the exhibit; correct?

A. Yes.

Q. And if you don't agree with MVP, you say so. Correct?

A. That's correct.

Q. And you recommend a change?

A. We quantify the change. Yes.

Q. Okay. Even if your recommendation results in a higher rate than even MVP's requesting in any given year; correct?

A. That's correct.

Q. Like an umpire in a baseball game, you call them as you see them; don't you?

A. That's correct.

Q. And the percentage rate increase that you're recommending this year, the 10.5, is what you believe the board should adopt; correct?

A. I think the board should adopt 10.5, but there are a few items that are still outstanding.

Q. Fair enough. Fair enough. You heard Matt's -- Mr. Lombardo's testimony regarding a .5 percent increase relating to the July 16 completed, proposed budgets of the hospitals?

A. That's correct.

Q. And that's the most recent data we have as we sit here today; correct?

A. That is correct.

Q. And it sounds like you concur with the calculus where they came to a .5 percent change, but you want to confirm and see their backup; is that right?

A. That's correct.

Q. Last year when this issue came up, not saying numbers line up, but just coincidentally, MVP -- similar situation on hospital budgets. They came up with a .5, and you reduced that to .2 relying on historical data. Do you recall that?

A. Yes.

Q. Have you done that this year?

A. I have not had an opportunity to do that this year.

Q. Based on your experience do you expect that if you do that, there will be a difference of opinion? It won't be .5?

A. I do expect there to be a difference of opinion.

Q. Do you expect it will be in the range of .2, or do you know?

A. I would say .2 to .3.

Q. Thank you very much. Now last year when you and Mr. Lombardo had a respectful disagreement about how to approach that, you didn't have the benefit of knowing that the board in really 2019 made a change to some hospital amounts that they can charge; correct? That hadn't occurred; right?

A. Correct.

Q. But you're familiar with that occurring this year?

A. Yes.

Q. So do you believe you can predict with a hundred percent certainty that the board is going to reduce -- reduce from the proposed budgets?

A. No.

Q. And this year you're recommending an increase above what MVP has originally filed; correct?

A. Yes.

Q. So with all the numbers, the variables and issues that are in MVP's report, and in your good report, they are at 11 percent, and you're at maybe it's 10.7 or 10.8, we're not sure, but close; correct?

A. That's correct.

Q. And that was the only issue of disagreement this year, the hospital budget issue; right?

A. Yes.

Q. And you heard Mr. Lombardo's testimony this morning?

A. I did.

Q. I don't believe he testified this afternoon. And MVP agreed with all of your recommendations on page 15 of your report. Correct? All the bullets?

A. Yes.

Q. And you heard that Mr. Lombardo -- he's also a member of the American Academy; right?

A. Yes.

Q. And you know that Eric Bachner who works with Mr. Lombardo also signed the amended filing; correct?

A. Yes.

Q. If I count that up right, that's five actuaries; is that correct?

A. That's correct.

Q. Three from L&E, two from MVP recommended a 10.5 percent increase with a caveat that MVP would say go to 11 percent, and L&E would say maybe go to 10.7, 10.8 percent. We're not sure yet.

Is that a fair summary?

A. That is correct.

Q. But they all agree on the increase over the 9.4; correct?

A. Yes.

Q. Would you agree with me that five heads are better than one?

A. Yes.

Q. And that multiple, very smart people, have all agreed with the proposed rate increase with this caveat of about 10.7 or 10.8 versus 11; correct?

A. Yes.

Q. I want to ask you a little bit about administrative costs.

Would you please go to page 13. Page 13 of the exhibit.

A. I'm there.

Q. And there is a number 13, "Changes in

Administrative Costs." Do you see that?

A. Yes.

Q. The first paragraph -- read the third sentence, please.

A. "Because the premium is also increasing from the 2019 exchange filing."

Q. I think I might be on the wrong page. Bear with me a second. Oh, I'm sorry. I said the third sentence. I think you're reading the fourth sentence. I tricked you. So could you please read the third sentence?

A. "The overall rate impact is a decrease of 1 percent."

Q. And you reference the 42 PMPM in the first sentence; do you see that?

A. Yes.

Q. And then in the next paragraph the second sentence you said: "These costs have fallen substantially since 2013 when they were 46.57 PMPM." Do you see that?

A. Yes.

Q. Do you stand by that statement?

A. Yes.

Q. And then the second paragraph, would you read the last sentence, please?

A. "In light of the steps taken by MVP to reduce administrative costs over the recent years, the assumed

administrative 2020 costs are reasonable and appropriate."

Q. So it's your opinion as an actuary for Green Mountain Care Board that MVP has substantially reduced administrative costs over recent years; correct?

A. Correct.

Q. Okay. Let's go to unit trend on page 5. Unit cost trend. I asked Matt about it this morning. Just cleaning up a typo, and I just want to make sure it didn't change your opinions in anyway.

That last bullet on page 5 it says: "Approximately 40 percent," and goes on from there. Did you see that?

A. Yes.

Q. That number in the original L&E filing was 55 percent. And that was a mistake. It was changed to 40; correct?

A. That's correct.

Q. That doesn't change your opinions in anyway?

A. It does not.

Q. Okay. On "Contributions to Reserves." Let's go to page 14, please. Would you read -- there is one paragraph -- the last paragraph of 15. Would you read the first sentence in that last paragraph starting "L&E believes."

A. "L&E believes the CTR assumption is reasonable

and does not recommend any changes to the CTR."

Q. And would this be true if you increased to the 11 percent suggested by MVP or the 10.7/10.8 percent that may be suggested by L&E?

A. Yes.

Q. And then I wanted to clean up another typo just so the record's clear. Not trying to point anything out. If you look at the very first paragraph in 15, "Changes in Contributions to Reserves." I think there is a typo in there. So let me first ask you the question.

Do you recall last year MVP requested 2 percent and the board approved 1.5 percent?

A. I will trust your statement.

Q. Okay. So it looks like the inference could be drawn that the board only approved a .5 percent last year. Would that be an error? It was actually 1.5 percent?

A. I believe so.

Q. All right. Point is, in this paragraph MVP's requesting a lower CTR than it did last year; right? It requested 2 percent last year and 1.5 percent this year?

A. That's correct.

Q. Okay. And we reviewed with interest your reasonableness checks which are referenced in the second and third paragraphs under section 15 on page 14. Do you see that?

A. Yes.

Q. Would you explain what you did there, please?

A. Yes. We utilized the publicly-available data from the URRTs to assess where the contribution to reserve figure landed relative to the other filings for the prior two years.

Q. And what did you find?

A. We found that the average submitted CTR was 2.95 percent, and the median was 3.15 percent. And that MVP's assumption of 1.5 percent would rank as 629 out of the 777 filings.

Q. So for -- it's the first year. For 2019, 82 percent of the filings were higher than the 1.5 percent; is that right?

A. Yes. That's correct.

Q. And for 2018, in that next paragraph, 79 percent of the filings were higher than 1.5 percent; right?

A. That's correct.

Q. Do you know on that -- I'm visualizing a curve. What percentage was at 1 percent or less?

A. I do not know that.

Q. As an actuary you want to be conservative in considering CTR, so you've set aside sufficient monies; correct?

A. Agreed.

Q. As an actuary you don't want to set aside too much or too little; correct?

A. That's correct.

Q. And you don't want to be an outlier on that bell curve; do you?

A. You do not.

Q. I want to -- you were asked about medical utilization trend. I just want to go to that briefly.

If you go to page 15, just for point of reference. Bullet 3. That's the medical utilization trend conclusion which would increase the rates by approximately 1.5 percent; correct?

A. Correct.

Q. And you heard more questions about this medical utilization trend just before the lunch break; correct?

A. Correct.

Q. Okay. If you go to the bottom of page 6 of your report, please. And there is a sentence that starts "Because." Could you read that sentence, please?

A. "Because of the atypical results produced by MVP's analysis using their own data, L&E analyzed utilization trends by using market-wide utilization data, i.e., a combination of utilization data from both QHP

carriers."

Q. So L&E used more data; correct?

A. Correct.

Q. And that was appropriate in your opinion; correct?

A. Yes.

Q. And you stand by this conclusion; don't you?

A. Yes.

Q. If you go back to page 15, please. L&E makes a recommendation on a variety of issues to modify MVP's proposal; correct?

A. Correct.

Q. And would you agree with me that all these issues are interrelated? They all impact the final number?

A. Yes. They are all interrelated.

Q. There's some pluses, there's some minuses, but they all impact that final number; correct?

A. Correct.

Q. Thank you very much.

MR. BARBER: Mr. Angoff.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Good afternoon, Ms. Lee.

A. Good afternoon.

Q. You found that a 10.5 percent increase would produce rates that are not excessive, inadequate or unfairly discriminatory; correct?

A. Correct.

Q. You didn't find anything with respect to whether or not that 10.5 percent rate increase would be affordable?

A. Yes. I did not.

Q. And that's not your job; right?

A. That is not.

Q. Similarly you didn't find that the 10.5 percent increase would promote quality care?

A. Did not.

Q. And you didn't find that it would promote access to healthcare?

A. We did not.

Q. Okay. This might be just be a quibble, but on page two you say: Under "Standard of Review," you say that, "The purpose of this letter is to assist the board in determining whether the requested rate is affordable and contains" -- and then you go on to repeat all the standards in the statute.

That's an overstatement; isn't it? Your purpose is to assist the board in determining whether or not the rate is excessive, inadequate and unfairly

discriminatory; correct?

A. We are assisting the board by providing the information regarding the filing. They make the determinations on all of those pieces, but we do provide that information.

Q. They make the determination on all those pieces?

A. Right.

Q. But your expertise is limited to whether or not the rate is excessive, inadequate or unfairly discriminatory; correct?

A. That's correct.

Q. I take it that you found the 9.4 percent increase proposed by MVP would produce inadequate rates?

A. That's correct.

Q. Okay. You know Mr. Lombardo; right?

A. Yes.

Q. Mr. Lombardo's an actuary; correct?

A. Yes.

Q. A credentialed actuary?

A. That's correct.

Q. Why would MVP submit an increase -- submit a proposed rate that produces inadequate rates?

A. We had more information than he did. Based on his knowledge he did submit a rate that was adequate. But

based on more information, we determined that it was potentially inadequate.

Q. I'm sorry. You determined that what?

A. It was potentially inadequate because we had more information.

Q. Potentially inadequate. Could you please turn to page 2? I'm sorry. Page 4 in the L&E report Exhibit 9. And you see paragraph 1 there under the chart where you say that URRT shows that the 2018 allowed claim experience was 1.4 percent lower than projected?

A. Yes.

Q. Okay. And so what does that mean?

A. That means that the experience came in favorably for that in that time frame.

Q. I'm sorry. I didn't catch the last part of it.

A. In that time frame.

Q. I'm sorry. I'm hard of hearing. Could you get closer to the mic and speak louder?

A. I don't think the mic's working.

Q. That would explain it.

A. I think I said that that means that they had unfavorable claim experience during that time frame.

Q. Okay. And so they paid out less than they projected they were to pay?

A. That's correct.

Q. And less than you projected that they would pay out; correct?

A. That's correct.

Q. Could you turn, please, to page 6. And under "Utilization Trend and Intensity." You see that -- you note that MVP assumed a zero percent trend?

A. Yes. That's correct.

Q. Okay. And were they using the same methodology they used in the past?

A. I believe the last two years they have performed an analysis, but I would have to go back and review my notes. In some of the years they felt their data was not credible enough, and so they didn't provide us with a lot of information. But I do believe the last two years they performed a similar closed-court analysis.

Q. As you say in the middle of page 7, "There is a wide range of results when different analyses -- analysis methods are used;" right?

A. That's correct.

Q. Okay. So was your conclusion that their method of analysis, based on which they came up with the zero percent utilization trend, was defective?

A. No. They had a disadvantage. On page 6 I state that, "Since 2017 MVP has approximately tripled its

membership."

That's great from the perspective of gaining market share, but it is not great for being able to predict what that population is going to do in the future. They haven't been around long enough.

Q. So you have another method which you think is superior?

A. Correct.

Q. But that -- does that mean that you reject their method? Does that mean that you think their method is unacceptable? Actuarially unacceptable?

A. No. We utilize their information as well.

Q. Say that again.

A. We utilize their information as well alone. No.

Q. Let me ask it this way. Do you believe that the methodology they used that produced the zero percent trend was actuarially unacceptable?

A. Based on the information that they had, no.

Q. So you chose a 1 percent trend rather than the zero percent trend; correct?

A. Correct.

Q. Can you show me where that is in your chart on page 16?

A. On page 16 the second chart, there is a line

number three, trend from 2019 to 2020. They originally had 4.8. Now it's 5.1. That change is embedded in there as well as -- I'm sorry. The one prior to it as well. 2. Difference in trend between '18 and '19. A combination of those two has it included.

Q. Okay. So I'm not going find the 1 percent directly reflected, but it's embedded in two of the lines, 2 and 3?

A. Correct. And unfortunately this is based on the URRT, and the URRT splits that over two years which makes it challenging to directly see it.

Q. What did you find was a reasonable prescription trend?

A. You mean prescription drugs?

Q. Yes.

A. 8.2 percent as filed by the carrier.

Q. And could you go to Exhibit 6, page 3, please.

A. Okay. I'm there.

Q. And does the fact in 2017, the latest year for which data is available, that the drug trend was -- the actual drug trend was so much lower than what was proposed by either MVP or L&E, does that give you any pause about assuming the trend you are assuming this year?

A. It does not because I -- because I don't think that -- it does not tell the whole story in that

MVP's book of business is healthier on average and there is a risk adjustment per component that makes it challenging to look at claims information in isolation of that very large trigger.

Q. Can risk adjustment account for a difference that is that great?

A. Yes.

Q. Have you seen it account for a difference that great?

A. MVP's payable's quite large. And even on a PMPM basis it's quite large.

Q. I'm sorry. I missed the last statement.

A. Even on a PMPM basis it is quite large.

Q. What is quite large?

A. The risk adjustment payable.

Q. Is it large enough to make up the difference between the 4.4 and the 11.1?

A. I have not done that calculation because you can't break that out as easily, but I can see that being the case. Yes.

Q. Last year MVP assumed that because of the zero penalty for the individual mandate that healthy people would leave the company; correct?

A. Yes.

Q. And you all assumed the same thing; correct?

A. Yes.

Q. And that didn't prove to be true; did it?

A. No.

Q. And MVP accounts for that in the filing; correct? MVP accounts for the fact that its assumption about people leaving because of the zero individual mandate penalty proved to be incorrect. They account for that in the filing.

A. Yes. They do.

Q. Can you explain how MVP handles pooling claims above 100,000?

A. Yes. I'll turn to their exhibit or their memo. They remove claims over a hundred thousand dollars to ensure that they are not overreacting to large claims and to single out their experience period data so that it's not impacted by large claims.

Q. Do you know is that methodology typical among companies?

A. Yes.

Q. Any companies use the actual rather than the expected?

A. Very rarely. I wouldn't recommend it because then in some years you could have a great increase due to one claimant that may or may not be around in the next time period.

Q. Sure. But you haven't seen that. Have you seen that type of increase here?

A. Can you rephrase? What is your question, please?

Q. Have you seen a huge increase with an MVP claim that would make it improper to do the analysis based on the actual rather than the expected?

A. They have always performed this calculation to smooth out the data.

Q. They have also done the expected?

A. Correct.

Q. Can you turn to the top of page 10.

A. Of Exhibit 9?

Q. Yes, please.

A. I'm there.

Q. And that chart there shows five years of an average age factor; correct?

A. That's correct.

Q. Okay. And what is the average age factor measure?

A. The average age factor generally measures the average age of the population, and that's associated with a rate impact for that age.

Q. Okay. Does that mean as the average age factor goes down, that the average age goes down?

A. Right.
Q. And all things equal, the claims will go down?
A. Yes.
Q. And you see that -- you see, in fact, the average impact, it does go down, right?
A. Yes. On that chart.
Q. But MVP has used the same age factor despite the fact that the average age factor hasn't been going down; correct?
A. That's correct.
Q. At the bottom of page 10 there is a discussion of how the rate would be affected by the change in AHP law. Do you see that?
A. Yes.
Q. And L&E agrees, doesn't it, that because AHPs are not permitted in Vermont in 2020, that the original assumed increase based on prior AHP law should be backed out; correct?
A. Yes.
Q. Would it be reasonable for AHP to also reduce the rate because some people who are in AHPs in 2019 would be coming back into the exchange market?
A. The experience period is 2018, and AHPs were not allowable in 2018.
Q. But would it be reasonable to assume that some

people who are now in AHPs, or AHPs in 2019, would it be reasonable to assume that some of those people will be coming back to the private market, whether Blue Cross or MVP?

A. Yes.

Q. Could you turn to page 11, please. Number 9: "Changes Due to Reinsurance." You assumed that MVP should pay -- you concluded that MVP should pay the additional -- should increase the rate by the additional .24 because it does not anticipate any claims over a million dollars in 2020; correct?

A. That's correct.

Q. Okay. Do you know whether MVP has ever had claims over a million dollars?

A. I do not, no.

Q. You don't know?

A. No.

Q. Could you turn to the next page, page 12. Could you explain the risk adjustment methodology that MVP employed in its original filing?

A. In its original filing it made an estimate based on the most recent data they had available which was the interim report, which was what they included as their assumption.

Q. And is that the same methodology that they

used in past years?

A. Yes.

Q. And there are places in this filing, aren't there, where you conclude that because the company used this certain methodology in past years, it's reasonable and appropriate for it to use the same methodology this year; correct?

A. For other assumptions, yes.

Q. So, for example, on the top of page 9, read the last sentence in the first paragraph which is an incomplete paragraph.

A. "As this methodology is consistent with MVP's other filings, L&E does not propose any change at this time."

Q. So why not just accept the methodology that MVP was using for risk adjustment, that it had used in past years?

A. Because there was no new information since the filing of their -- the submission of their filing, there were changes to the risk adjustment formula as well that -- and it is a different population.

Q. And whether it's MVP assumptions regarding risk adjustment or L&E's assumptions regarding risk adjustment, they are all estimates; correct?

A. No. The first set of that is no longer an

estimate.

Q. I'm sorry. First what?

A. The first figure, the first recommendation, is a final figure.

Q. You mean you don't -- the amount that you -- that you in your report say that MVP will have to pay under the risk adjustment?

A. For the 2018 figure, yes.

Q. For 2018.

A. That's correct. That's what we are recommending.

Q. Okay. What about 2019?

A. 2019, that's irrelevant to this filing.

Q. Say that again.

A. That is irrelevant to this filing.

Q. So you're saying the 2018 risk adjustment number's a hard number?

A. Yes.

Q. You're certain that that will be the amount?

A. Yes.

Q. Okay. I guess we will see next year.

Did you consider in this filing whether MVP could or should be a tougher negotiator with healthcare providers?

A. Will you ask the question part again, please?

Q. Yes. Did you consider whether or not MVP should be a tougher negotiator with healthcare providers?

A. No.

Q. Do you know that MVP asked New York for a 6.5 percent rate increase?

A. I did not know that.

Q. Would that trouble you at all?

A. No.

Q. Why not? With the fact that MVP asked for a 6.5 percent increase in New York but 11 percent -- you recommended between the 10.5 and 11 percent increase in Vermont, why would that difference not bother you at all?

A. It's a different population they are assessing and determining the rate increase on.

Q. Does L&E advise any insurers in connection with their exchange rates this year?

A. Not that I'm aware of.

Q. L&E is not advising any insurers this year regarding the individual rates on the exchange?

A. Not that I'm aware of. No.

Q. Does MVP do any work for individual market insurers this year?

A. I don't work for MVP. I don't know.

Q. I'm sorry. I didn't hear you.

A. I don't work for MVP. I don't know.

Q. My mistake. Does L&E do any work for individual market insurers in 2019?

A. Not that I'm aware of.

Q. Did it last year?

A. Not that I'm aware of. I do not believe we have any clients that participate in the individual and small group markets.

Q. Does MVP do any work -- pardon me again. Does L&E do any work in any state that has a statutory standard governing the lawfulness of the rate like Vermont's?

A. A lot of the states have increased their oversight. I still believe that Vermont is one of the toughest though.

Q. Do you know of any other state that has the same standard that Vermont does?

A. Exactly, no.

Q. And in fact you don't know of any state that requires the regulator to consider affordability; do you?

A. No.

MR. ANGOFF: I have no further questions.

MR. BARBER: Board members. Starting with Ms. Lunge.

MS. LUNGE: Should I attempt to use the mic or should I just yell?

MR. BARGER: Just yell.

MS. LUNGE: Jackie, I just had a couple of questions. Are you familiar with the board's hospital budget guidance for 2020? In general?

THE WITNESS: The general process?

MS. LUNGE: Or the actual guidance that we issued.

THE WITNESS: No.

MS. LUNGE: Okay. Thank you. When you are reviewing rates in other states, as part of that are you generally familiar with the Affordable Care Act standards for effective rate review program?

THE WITNESS: Yes.

MS. LUNGE: Am I correct that that standard requires that states review filings in excess of 10 percent at minimum?

THE WITNESS: Yes.

MS. LUNGE: But not all states review filings under 10 percent; is that right?

THE WITNESS: That's correct. Not all states do. The states we work with do, but that's not a requirement.

MS. LUNGE: Okay. And when you did your reasonableness check and pulled the 777 filings, did you exclude states that did not review filings

under 10 percent?

THE WITNESS: I would have to defer that question to Dave, but I don't think we did. We used all the data that we had available to us.

MS. LUNGE: Thank you. No further questions.

MR. BARBER: Mr. Pelham.

MR. PELHAM: Hi. So I'm looking at page 3 of your report. And the second paragraph down where it says: Exhibit 3 shows the index rate development starting from MVP's experience period claims, encompassing about 320,000 total member months, from ACA-compliant individuals, small group employers as well as grandfathered small groups that will be migrating to this block by 2020."

How many of those 320 member months are Medicare? Insured by Medicare?

THE WITNESS: I would say zero percent.

MR. PELHAM: Right answer I think. I ask that because we are looking at hospital budgets where a third of the population -- a third of the cash flow is from Medicare, and in the last three years that's run at a very high rate.

So I was, again, concerned about a

switching from a process where we have been looking, you know, in the rear-view mirror to kind of try to figure out where we are going to go, to riding on an important process that hasn't even begun to unfold. We have had no hearings, we have had no deep analysis of these hospital budgets.

As I just said, the trend from '16, '17 and '18 has been the proportion of hospital budgets from Medicare is growing, yet this population is not a Medicare population. So I worry that the analysis hasn't been done to try to even filter that out of the analysis to -- if it can be filtered out.

THE WITNESS: Are you referring to the rate -- the increases that they are doing for the unit cost increases?

MR. PELHAM: The rate I'm -- is the actual revenue to Vermont hospitals from Medicare. I can give us the numbers if you want.

THE WITNESS: The reason I ask is I did believe that UVMMC does provide a break out for commercial alone and its subsidiaries. So that we do have broken out versus Medicare.

MR. PELHAM: The Green Mountain Care Board data, we have commercial data, we have Medicare data, and we have --

THE WITNESS: Right.

MR. PELHAM: -- Medicaid data. And it all rolls up to the entire amount of NPR, you know, in the hospitals' budgets.

THE WITNESS: Right. I just think they break it out. The only reason that that's helpful --

MR. PELHAM: They break it out by hospital.

THE WITNESS: I think they are the only facilities that don't. Well, right. It's broken out by hospital, and they have their facility, and they do break out what commercial is versus the other pieces. The others, from what I understand, don't. But they actually did, and since they are such a large percentage, that does give a little bit of weight in what the numbers that they are using. If that answers your question.

MR. PELHAM: Well I don't know if it answers it. It just means to me there is some noise in that comparison.

THE WITNESS: That's true. Yes.

MR. BARBER: Member Holmes.

MS. HOLMES: Yeah. Thank you, Jackie. One quick question. Two questions actually.

Given the submissions of both carriers,

I'm wondering if you've done any kind of assessment of what you expect the market share to look like, you know, given the rate differential and expected growth in MPV's enrollments.

THE WITNESS: Definitely over the last several years we have noted that MVP's seen significant enrollment shifts, and that was highly due to the fact that their rates dipped below the Blue Cross's rates several years ago. That has persisted, and even at substantial -- some substantial margins.

So I suspect that MVP will continue to gain more market share in the coming years if the -- as modified by our recommendations, if those are ordered, then that same differential would be there. So I think it would still continue to grow.

MS. HOLMES: And does that have any impact on things like administrative costs per member per month or other types of, you know, aspects of the rate filing, the rate request, if the market share grows?

THE WITNESS: Correct. Yes. It will have impacts on several pieces. Right now MVP has a lot of healthy members because those are the ones that are typically the most price sensitive that will

jump sooner than others. So I would suspect that their healthy population will start to deteriorate, because now you're going to get members who do utilize but that are going to switch over. So that's going to stabilize a little bit. So it also means that the risk adjustment environment might change.

From an administrative cost perspective, it really depends on how an organization determines their administrative costs. I know MVP has had to talk a lot about that today. My reaction to that is I think the way that MVP has done it to include New York is not beneficial for the current situation, but when the situation was reversed and they didn't have a large market share, we didn't see a lot of movement here on the MVP side. We actually -- or on the Vermont side. We actually did see a decrease because of all their initiatives but not due to a substantial increase and/or decrease of their block.

So while I understand it's not assisting this Vermont filing which is unfortunate, I do wonder about if the roles start to change we also don't want administrative costs to start to skyrocket if they start to lose that membership. But I do think there is some correlation depending on how the

organization determines their administrative costs.

MS. HOLMES: And my second question that actually relates to something you just talked about. On page two of your report. You have an initial distribution by metal level based on the submitted rate request. And then on page 16 with the revision of the L&E recommendation, you have a new distribution by metal level.

So if you compare the table on page 2 to the table on page 16, you see some movement within metal categories of membership. And I'm wondering if you can talk a little bit about how you came up with that change in that distribution and, in particular, how that relates to how we think about risk adjustment in the sense that the impact of the risk adjustment payment depends a little bit, it seems to me from what I've read on the metal distribution, the higher the impact on low-risk Bronze members, you know, that impact is higher than they are on high risk.

THE WITNESS: Yeah, that's correct.

MS. HOLMES: How does that all play out?

THE WITNESS: Right. So in a perfect world, risk adjustment would match up one for one

from a claims cost perspective. But it's not. And so CMS recognized that, and that's why they have changes for the 2020 to better align. It had its greatest impact on those low claimants who were healthier, which obviously impacted MVP the most, because that was -- as you can see, that's where their groupings are.

And how we can handle that is we looked at what the -- what the changes where to that risk adjustment so that we could better assess that from a global perspective, and we're hopeful going forward that's going to start to match up one to one. And then this distribution will change primarily just due to premium differences between the two carriers.

Again, low-cost members tend to be more price sensitive because they are not, you know, really working with a doctor very closely on a particular diagnosis that they have so they are willing to change PCPs versus somebody who's had a long-term illness that they have been working with the same doctor that maybe isn't covered under both, or it makes them nervous to switch because they don't know how that will impact their out-of-pocket costs due to the, you know, the complexity of health insurance.

So to see the shift really is going to be due to premium changes most likely. And as those grow, people will likely shift more.

MS. HOLMES: So I understood that. Thank you, I think. One of the things -- so this, you know, in the page 16, this distribution that you predicted of percent of membership that obviously has changed from page 2 to page 16. So the factors that go into that prediction are not only the rate changes within MVP but also the relative comparison to Blue Cross Blue Shield and how competitive each metal level is. Both of those factors weigh into your distribution calculations.

THE WITNESS: Yes. And I want to look into that figure here, because oh, so the numbers in the -- on page 16 match the numbers that are here on page 2. They are just in the second chart. So it's the 2019 changes. So those are based on 2019 membership. They match.

And then I'm going to have to look -- that's different up here. Maybe this is 2018 and this is 2019. This is not a prediction. These are actual figures.

MS. HOLMES: Okay. I thought --

CHAIRMAN MULLIN: We used to have a

footnote.

MS. HOLMES: Okay. I thought this was based on the L&E recommended overall change, this is what you would expect in the percent membership.

THE WITNESS: No. That is to help us calculate the overall number.

MS. HOLMES: Okay. Do you do an analysis that predicts the distribution of metal count based on --

THE WITNESS: We have done that for you. But we have not published that in our report. No.

MS. HOLMES: Okay.

THE WITNESS: Sorry for the confusion.

MS. HOLMES: No problem. Thank you.

THE WITNESS: But I will clarify that for you.

MS. HOLMES: Thank you.

MS. USIFER: Just a couple questions.

THE WITNESS: Yes.

MS. USIFER: On page 16. On the chart there. Can you say where the negative .9 percent for the budget projection changes from hospitals, is that in line 3?

THE WITNESS: So the .9.

MS. USIFER: MVP resubmitted.

THE WITNESS: Correct.

MS. USIFER: And they put like 8.4. I look at it as we are going from 8.4 to the 10.5 --

THE WITNESS: Correct. That would be in lines 2 and -- well no. I would say primarily line 3 because it's for 2019 figures.

MS. USIFER: Okay. That's what I assumed.

THE WITNESS: Yes.

MS. USIFER: And then just talking about risk adjustment where we have had a lot of discussion on risk adjustment. And because we are really, you know, two primary insurers in the state, do you really look at that as flipping between one to the other? So where we are seeing a one and-a-half percent increase on top of their 4.4. So when I look at MVP's rate change 5.9 percent is due to risk adjustment.

THE WITNESS: That's correct.

MS. USIFER: And I'll come back to that part in a second, the 5.9. But the change you're putting in of the 1.5, you're then offsetting that in Blue Cross's submission so that the numbers tie out; is that correct?

THE WITNESS: We are not recommending such that when you add them up they are zero. That's really complicated. Because they have two separate projections for membership, and that's -- the figure is highly tied to how much membership that they have. And so we haven't done that direct comparison to make sure when you multiply out their projected membership by the PMPM, and that it actually matches up with zero.

We have projected what we think or recommended that we think is the most appropriate figure for both of those, and that it will be close enough on a PMPM.

MS. USIFER: The intent is that it pretty much balances.

THE WITNESS: Correct.

MS. USIFER: And then if MVP grows, if they do get more people coming in to their -- buying insurance, and there is such a large risk adjustment on a PMPM, has that been correct -- assuming then they can't keep getting just the healthier people. It has to kind of balance out; right?

THE WITNESS: Right.

MS. USIFER: So how does that work? Because we are calculating on a PMPM. It's a pretty

significant PMPM number that are in the rates.

THE WITNESS: Correct.

MS. USIFER: As they get more people, that number would go down, and we just correct that next year?

THE WITNESS: Yes. As they get more people, that number will go down. When you go to review the Blue Cross filing, you can see too that their number has kind of done the opposite and gone up. It's highly correlated, and that's why even a couple of years ago when MVP had a really large amount of payable, but not many members, PMPM was really high for them. That number is going to continue to drop if membership continues to go up.

I also think, as we discussed earlier, that they can't continue to just get healthy members only. So that's also going to stabilize, which might bring -- that will just hopefully take it down across the board since they are related to one another such that MVP is not making such a big payment into the pool as well.

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

THE WITNESS: You're welcome.

MR. BARBER: Okay. Any redirect?

MS. ABORJAILY: I just had one question, I think.

REDIRECT EXAMINATION

BY MS. ABORJAILY:

Q. The HCA brought up the people who are currently enrolled in the 2019 AHPs, and I was wondering whether in your report you address if there is any calculation done to address the people who are possibly returning to the marketplace from the 2019 AHPs.

A. No.

Q. And would you explain why that is?

A. Right. So the 2018 is the experience period that is being utilized here. And there were not AHPs present during that time, so we are not anticipating anybody coming back on, because they were included in our experience period. The only thing that happened was they were removed from the rate which is a 2019 rate, the impact of thinking that those individuals would be leaving.

MS. ABORJAILY: Thank you.

MR. BARBER: Anyone else?

MR. KARNEDY: No, thank you.

MR. BARBER: Anything else? Thank you, Ms. Lee.

THE WITNESS: Thank you.

MR. BARBER: So that we are done with testimony, right? I'm losing my mind. I don't think we have any more witnesses.

So would the parties like to -- sorry. I am losing my mind. Sorry. Mike Fisher.

MR. FISHER: Good afternoon.

MR. BARBER: Are you leading Mr. Fisher questioning?

MR. ANGOFF: I'm sorry?

MR. BARBER: Are you going to be leading his testimony?

MR. ANGOFF: I was assuming like the Commissioner last year, we would just be presenting.

MR. KARNEDY: Can I speak to that? Last year that is how it worked. I did at the outset say I might have to be politely rude and object if he's saying something I would object to. It didn't happen last year, but I just wanted to set a table.

MR. FISHER: I won't take offense. I'm Mike Fisher, and I'm the chief --

MR. BARBER: He was sworn in.

MS. HOLMES: Sorry. Yeah.

MR. FISHER: I was sworn in this morning.

MIKE FISHER

Having been previously duly sworn, testified as follows:

MR. FISHER: I'm Mike Fisher. I'm the Chief Health Care Advocate, and thank you for the opportunity to speak for a few moments.

I come from a bit of a different perspective than you've heard all day. And speaking of all day, it's been a long day. We are all tired. I am tired. I think I can be pretty brief. And I want to recognize that I don't have anything to say today that isn't broadly understood by most Vermonters.

Healthcare, the cost of buying coverage and getting care, is a barrier that prevents some people, some Vermonters, from getting the care they need. It's important, though, even though this is broadly known, to take a few moments here to make sure that at least it's said out loud in these proceedings, to focus on and consider the consumers' perspective.

The stress that Vermonters experience when they need care and don't know how they are going to get it, and how they are going to pay for it, is real. Affordability is a consideration of the

consumers' ability to pay for coverage and care. Simply put, can Vermonters -- can Vermont families reasonably get the care they need or the care their providers recommend and do things like put food on the table or heat their homes. And can Vermont's small businesses provide a meaningful healthcare benefit to their employees and survive given the margins of their business.

We recognize -- I recognize -- that the board can't achieve full affordability in this rate filing. Zero percent rate increase wouldn't achieve this. This means the question before us today is not if health insurance will be affordable to all Vermonters. The question is how many more Vermonters will be priced out of the ability to get the care they need. The push and pull of the financial well-being of Vermonters and the financial well-being of MVP Healthcare in this case are competing pressures.

The board has a tremendously difficult task in front of you in considering these competing interests. I appreciate that. I recognize it. There is no easy answer here. Yes, we need healthy carriers. And yes, we need rates that consumers can buy plans that they can afford to use. It's been

interesting for me to listen today about -- to all the actuarial considerations without any consideration of the consumer.

I think we need consumers in this in order for this to work. The ability of Vermonters to afford coverage is key to the success of healthcare financing. It's not a nice afterthought after the experts have set the rates. To give an extreme example, none of us would celebrate a rate that was as actuarially sound as possible if only Warren Buffett and Bill Gates could afford it. It wouldn't work.

According to the 2018 Household Health Insurance Survey, I believe that's Exhibit 17 in your book today, 40 percent of us are -- under the age of 65 in the commercial marketplace are under insured. 40 percent. That number, by the way, four years earlier in 2014 was 27 percent. So it's climbing. I know these proceedings are not about plan designs, but when premiums rise, more and more Vermonters are forced into paying higher and higher out-of-pocket costs. Some of the people in that 40 percent category live day-to-day with the reality of what a 15 thousand dollar deductible means when they have loved ones who need care. Others may not be worried

about out-of-pocket costs because they are healthy at this moment. But we all know what that gamble means.

At the Healthcare Advocates' help line we get calls most days, every day, from Vermonters with affordability concerns, but today I'm going to focus my comments on the comments that were submitted to the board in the last few days and weeks. It's an interesting list of comments that have come in. To break them into a few themes, many people said, "These rates are unaffordable. These rates will force us to drop coverage. Deductibles are also unaffordable. I don't go to the doctor because my fear -- because of my fear of the bill. Health insurance is our biggest household expense. This rate will hurt my business." This said by employers and employees by the way. "Health insurance costs keep me from being able to put money into savings, retirement, college funds. Health insurance increases are far out pacing wage increases in Vermont. This is unsustainable."

I'm going to quote from just two and be very brief. Comment number 38. A woman who identified herself as Amy said, "Monthly premiums plus high and ever-increasing deductibles are already a huge financial burden at 20 percent of my gross

income. Another increase without anticipated increase in income only makes it worse. I'm also a healthcare provider who accepts insurance and have not seen reimbursement increases across the board making a premium increase request even more frustrating."

Another commenter recognized herself as a small business owner who owns a -- runs a developmental care home. She said: "Our family of four has no options for health insurance but privately paying for it at about 16 hundred dollars per month. Yes. $20,000 a year. We would like to save for college. We would like to take a family vacation before our kids leave us. We would like to pay our mortgage and save a bit for retirement. We fear going without insurance desperately trying to keep our family safe. How can anyone afford this?"

Another point of information that I found interesting and that is that this year Rutland Regional Medical Center in its hospital budget submission is requesting a 2.65 percent rate increase effective October 1. They indicated that this increase is -- this rate increase directly relates to the increase in their free-care program. Their need to provide free care has increased by 2.5 million

dollars from budget to budget. They report that they have not changed the eligibility of free care, rather this is a result of an increase in patients who have insurance but can't afford deductibles and copays. Nearly 48 percent of their free care is provided to patients who have some level of insurance.

I know you've heard me say something very similar to this before, and I'm sure you've heard many others say very similar concerns. There is a risk that we become desensitized and distance ourselves from these expressions of fear and frustration. Let me put it another way. While there have been times in my life where my family had less income, I've never had to face the fear of being scared to death of what it would mean if I had a family member that needed care, and I had no idea how I would pay for it. I know about the pressures of affordability in my job, but only from a more distant perspective. For me, it was a really powerful experience.

I don't know if you have had the opportunity to do it yet, but I'm sure you will, but it's a powerful experience to take the time to read the comments that came to you in the last couple of days. Yeah, some of them were shaky. Some of them

were not completely on target. But many of them were from regular Vermonters, Vermont families doing their best, desperately wanting and doing their best and desperately wanting the rules of the game to give them a fighting change.

Thank you for your work on this, and thank you for your consideration.

MR. BARBER: Mr. Karnedy, do you have any questions?

MR. KARNEDY: I do.

MR. BARBER: Sure.

CROSS EXAMINATION

BY MR. KARNEDY:

Q. Good afternoon, Mr. Fisher.

A. Good afternoon.

Q. You're not an actuary; are you?

A. I am not an actuary.

Q. That's all I have.

A. I should have said that at the very beginning.

MR. BARBER: Board members, do you have any questions of Mr. Fisher?

CHAIRMAN MULLIN: I do.

MR. BARBER: All right.

CHAIRMAN MULLIN: So Mike, you're a close follower of everything that happens in the

healthcare world, and you've seen a period where there have been very, very small increases in Medicaid especially and Medicare.

So would you agree that when a rate filing comes in that's higher than the medical inflationary rate, that government needs to take some responsibility?

THE WITNESS: Absolutely.

CHAIRMAN MULLIN: Thank you.

MR. BARBER: Okay. I think you're done. Thank you.

THE WITNESS: Thank you.

MS. HOLMES: Actually I just want to make one comment which is just to your point about me becoming desensitized. I want to assure you and everybody that you work with and speak with that at least I can say to you that I'm not desensitized. I hear it. I hear it all the time when I'm out. People hear I'm on the Green Mountain Care Board, you can imagine what the next conversation is.

I just want to assure you and everybody else I know, we read all the public comments, and we have a special forum tomorrow night, and we welcome those comments. I want to make -- assure you that we are not desensitized, and we are listening.

THE WITNESS: Thank you.

MR. PELHAM: If I could make a comment. So you wrote an Op Ed a little while ago, and in it you said: "But when a sizeable portion of Vermonters can't afford to get their care they need, those same neighbors and policy makers to see the crisis."

And then it went on to say -- well I assumed I was one of those regulators. And I took a little bit of offense to it. Because, you know, that -- in my concurring opinion last year on this rate filing, the first sentence in that opinion was: "I write separately, however, to discuss my deep concern with the evidence presented as to the affordability of the proposed rates." And I went on and had a fairly lengthy proposal that as a former finance committee I think is a very -- finance commissioner, I think is a credible proposal.

So but in order to move forward on that, we need some help from the state entity to give us a number to work toward. So when these plans were presented last February, I asked the folks from DVHA could they give us a number. And they said they would. And then when -- on June 7 it was another meeting and I asked again for the update. And I still haven't received it. And for me, until I know

what the price tag is on something, it's hard to advocate for it except conceptually.

So I'm just going to ask you will you help get that number from DVHA to understand so we can have a measurement of what a subsidy is above 400 percent of poverty to 500 percent of poverty below the 9.86 percent threshold. There is a number there. And if we knew it outside of this process, but if we knew it, we might be able to work collectively to solve some of these problems.

THE WITNESS: I'm happy to engage in trying to get that number. It's a number understanding sort of what it would cost to finance a reasonable slope, the way I would put a reasonable slope to 4 and 500 percent of poverty is a great activity, a worthy activity, and I will engage in that.

And I do want to say, I put that desensitization or that recognition in my own terms. I didn't -- I don't intend in any way to call any out as being insensitive or not recognizing the needs of Vermonters. I don't have the experience of knowing that fear and desperation, that panic.

One commenter said something very good. He said stress -- the financial stress of figuring

out how to pay for healthcare isn't conducive to anybody's health. So I recognize the tremendous work and the tremendously impossible box that you are all in. I think the main task I'm here to say is this is a balancing act. I don't know whether the right -- I like the metaphor of the stone pile that you can't upset. I don't know whether the base of that stone pile is appropriately the consumer or the actuarial analysis. I think it depends on your perspective a little bit. But we need to have a balance. Thank you.

MR. BARBER: Thank you, Mr. Fisher. Mr. Karnedy, do you have any rebuttal witnesses?

MR. KARNEDY: I do not.

MR. BARBER: Okay. And the parties wish to make closing arguments?

MR. KARNEDY: Briefly, if that's appropriate.

MR. BARBER: Okay. You can begin.

MR. KARNEDY: So MVP has proposed 11 percent increase. L&E and MVP agree on 10.5. And the delta between those is a .5 percent that we provided evidence on.

L&E testified today they need to check the numbers themselves, but it's going to be roughly

2.7 or 2.8. It depends. You'll see that before you make a final decision, I presume.

So after a multitude of factors, and considering all the statutory criteria, the actuaries are virtually identical and in agreement. Got two MVP actuaries, got three L&E actuaries, they all agree. There is no contrary expert evidence supporting a different number.

In considering a final number, we would respectfully request that the board consider the rate within what is actuarially sound and reasonable and statutorily adequate.

I did mention the stack of stones this morning, and how the actuaries have found just the right balance to meet all the statutory criteria. You have information to consider all the statutory criteria. We would just ask that the board not pull a large non-actuarial stone from the middle of that stack and cause the rate to be inadequate and all those stones to come tumbling down. Thank you very much.

MR. BARBER: Mr. Angoff.

MR. ANGOFF: Thank you, Mr. Hearing Officer. Mr. Chair, Members of the Board, four quick points.

Number one, looking just at the actuarial analysis, they are all kind of different methodologies, different types of analyses in connection with which the board has discretion and connection with which both the carriers and L&E were wrong last year. They were both wrong in raising the rate substantially because they assumed that zeroing -- having zero penalty for an individual mandate would make a difference.

They were both wrong about morbidity. There are many provisions in the analyses where judgment or lots of judgment is allowed. So for example, they may choose -- an actuary may choose to use a straight average where the trend is down, and it would make just as much sense to follow the downward trend and to weigh the most recent data more heavily. So on those issues the board has discretion, and I think should err on the side of trying to promote affordability to the maximum extent possible.

On the other hand, if there really is a hard number, for example, if Ms. Lee is right about risk adjustment, their risk adjustment methodology using hard numbers, objectively, verifiable numbers that's different. Then I would agree with L&E that

if it's a hard number, that is something that the board would be hard pressed not to adopt. But the only hard number in the analysis, if Ms. Lee is right, is the risk adjustment number. All the others are subject to discretion.

Third point. The company can't have it both ways. Either administrative costs are indivisible, and total adjusted capital, that is the solvency issue, that's indivisible, or they are both separable. What MVP is trying to do is to say well because New York business is decreasing, Vermonters have to pay for that, what's going on in New York. But at the same time even though MVP's total adjusted capital isn't, if the rate increase here has essentially no effect on their capital, that MVP should still get the benefit. Vermonters should still contribute as much as New Yorkers to that. Those are inconsistent.

Finally, after all the actuarial analyses were done, there is no question but that this is the only state in which affordability is a criterion. Ms. Lee was very careful to say she is not recommending that the board raise the rate by 10.5 percent. She's recommending that a 10.5 percent increase does not produce rates that are excessive,

inadequate or unfairly discriminatory. But that's a far cry from recommending an increase of 10.5 percent because of the affordability criterion and other criteria in the statute. Thank you.

MR. BARBER: Thank you. So I think we have a few procedural or follow-up items to discuss. There were a number of questions that board members asked that Mr. Lombardo said he would need to speak with people in clinical department or contracting. I think we need to -- I will follow up on behalf of the board with those questions in writing to make sure we have them all and they are clear to you.

Would I assume it would be feasible to get those responses back prior to the due date for the briefs, is that fair?

MR. KARNEDY: Is it fair? Would you like us to do that? That's how we did it last year. We will make it happen. And I think with you writing questions out is very important. That's what we did last year. Because we have our notes, but if we misinterpreted what a particular board member was asking for.

If there is an issue around timing, I would confer with you on that if we have a hold up on getting some data or something.

MR. BARBER: Okay. And we do have -- it wouldn't be ideal, but we do have the ability to extend the period to take additional information from the carrier. So we will follow up. I'll follow up with those questions, and we can talk about timing.

If I understood correctly, we will be getting an amendment related to the change for the Non-standard Gold Plan today or tomorrow? Is that --

MR. LOMBARDO: The expectation for the form submission would be today.

MR. KARNEDY: Whether that impacts the rate filing, I don't know, but that would be filed with the forms. So probably later today.

MR. BARBER: Okay. So we will get an update on that today, I believe.

MR. KARNEDY: And would you like us to submit that as a piece of evidence in this proceeding, whatever it is?

MR. BARBER: I think it will need to be. Yeah. I think it would be like the last one.

MR. KARNEDY: Okay.

MR. BARBER: I think there was a request or I heard testimony that L&E would like to see the calculation for the hospital budget, the .5 percent. So if you could provide that when you're

able to. And then I think, Jesse, you had committed to notifying us when the forms are approved; correct? Or Emily. Okay. Did I miss anything?

MR. KARNEDY: I believe as we did last year, and I don't mean to put work on the plate of L&E that they don't need, but I think we heard testimony today it might be .2, it might be .3 but they would actually file something more certain on that.

MR. BARBER: Yeah. We will discuss putting their calculations out there in writing too.

Okay. Anything else before we adjourn? Okay. Oh, yes. I'm sorry.

MR. SCHULTHEIS: Public comment.

MR. BARBER: I'm sorry. First time through this. So I think we are going to conclude the hearing portion of this meeting.

And now we can move to the public comment portion. So there was a sign-up sheet for public comment outside. And Dale, would you like to comment?

MR. HACKETT: Very quick. Very long day. And very complicated.

CHAIRMAN MULLIN: Just going to have to speak loudly, Dale, unfortunately.

MR. HACKETT: It totally had me convinced my hearing aids weren't working. So after listening to this, I feel like the consumer is under represented in these particular hearings. I know they are about rates, so I expect it to be a certain way, but I seriously felt on this one in particular, something was missing.

Consumers that are going to be very concerned about what is happening right now, are not here, but they really are here. Some of them don't know how to be here. So I can imagine some of them saying MVP is like the child that just turned 18. Hi, you grew up. Please just leave when they hear what these numbers are, assuming you pass it.

If you were to pass this kind of increase, no way. I don't see a -- I see a lot of consumers are going to look at their income, and think of this as an annual increase possibly, they don't know. This is part of what gets really scary. Because it's not just healthcare. It's across the board. What was it last year? It was a high amount. What did their income go up? Incomes don't go up by 5 percent a year, 6 percent a year. They don't go up by 11 percent a year.

I can -- and I was absolutely toying

with this. I want to go up there next January and ask them to pass a bill that puts in a minimum wage that it goes up automatically. If healthcare goes up by 11 percent, the minimum wage goes up by 11 percent. Let's see how that goes across. But you have to understand the point that the State of Vermont under funds their share. And this does not help the situation at all. It gets very complicated.

No company sells solvency and affordability of a service if the solvency is theirs alone. I'm not really -- they are doing what they need to do. But that is more about what is the consumer perspective going to be. Is that what they are going to see? Is that how they are going to feel? What about them? Where are they in all this?

We do need more testimony about what Vermont's market is and what Vermonters can really afford versus this is the option they came in with. For their own reasons as well as this is -- we need that other, as these rates go up like this or even the possibility of going up like this, we need a better definition rate from the start of what is our market that we can actually afford?

And let's see, I had three comments. Even though I wrote them out, I'm not going to say

them. They aren't bad. But some are a little too strong now that I reread them. So I do believe we need alternatives. I think we were getting at a very interesting point. This could be upsetting or it could be a disaster.

As these economic factors come into play, and we start seeing these kind of costs, this is -- if you're an inventor, if you're creative, you actually get excited over scenarios like this. Because you start thinking, wow, I've got some real wiggle room to be creative and to see if I can't do it better, and maybe more affordable. And still -- I mean as an engineer, if I heard something like this, we would be all over it. We would be out there bidding, and we would be like, okay, give us a shot at it. We can do this. I don't know if that's true. It's so complex, but I think we are looking at that. We are seeing some really high numbers come in. We are seeing flat wages.

And I think the real answer is people are going to say no, they want a better solution, they must have a better solution. They aren't going to buy it. And somebody out there is going to invent something if there is enough wiggle room now, that very well could be better. I think that's a consumer

perspective.

MR. BARBER: Thank you, Dale. Just on the consumer perspective, like I said earlier, we will have a meeting dedicated tomorrow solely to comments from the public. Based on the volume of written comments we received, expecting that to be fairly well attended.

So if there are no other members of the public who would like to comment, going to end the hearing today and turn back over to the chair for closing the meeting.

CHAIRMAN MULLIN: Thank you, Mike. Everybody's eyes look a little bit heavy. But at this time I'll entertain a motion to adjourn.

MR. PELHAM: So moved.

MS. HOLMES: Second.

CHAIRMAN MULLIN: So moved and seconded to adjourn. All those in favor signify by saying aye.

ALL BOARD MEMBERS: Aye.

CHAIRMAN MULLIN: We will be back again tomorrow at 8.

(Whereupon, the proceeding was adjourned at 3:15 p.m.)

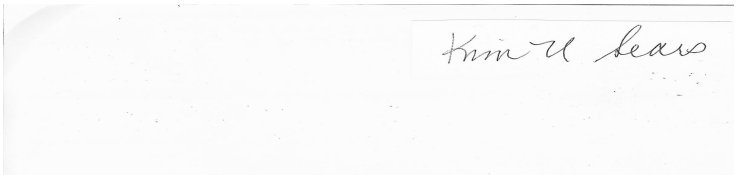
C E R T I F I C A T E

I, Kim U. Sears, do hereby certify that I recorded by stenographic means the hearing re: MVP Healthcare, Inc., at the State House, 115 State Street, Montpelier, Vermont, on July 22, 2019, beginning at 8 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 282 pages are a transcript of the stenograph notes taken by me of the evidence and the proceedings to the best of my ability.

I further certify that I am not related to any of the parties thereto or their counsel, and I am in no way interested in the outcome of said cause.

Dated at Williston, Vermont, this 25th day of July, 2019.



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