STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD
GMCB-005-24-RR
GB-006-24-RR

MVP HEALTH CARE
2025 VISG RATE REVIEW HEARING

July 24, 2024
8:04 a.m.

Hearing held Remotely before the Green Mountain Care Board via Microsoft Teams on July 24, 2024, beginning at 8:04 a.m.

P R E S E N T

BOARD MEMBERS:
Michael Barber, Hearing Officer
Owen Foster, Board Chair
Robin Lunge, Board Member
David Murman, Board Member
Jessica Holmes, Board Member
Thom Walsh, Board Member
Laura Beliveau, Attorney

A P P E A R A N C E S

MVP Health Care

Gary Karnedy, Attorney

Ryan Long, Attorney

Hannah Lebel, Attorney

Eric Bachner, Witness

Lewis & Ellis (L&E)

Jacqueline Lee, Witness

Department of Financial Regulation

Jesse Lussier, Witness

Vermont Office of the Health Care Advocate

Charles Becker

Eric Schultheis

Michael Fisher, Witness

Remote via Teams
July 24, 2024
8:04 a.m.

P R O C E E D I N G S

HEARING OFFICER BARBER: Thank you. So good morning, everyone. Again, my name is Michael Barber. I'll be the hearing officer for today's hearing. This hearing is being held remotely via Microsoft Teams. As Chair Foster said a minute ago, the purpose of this hearing is to take evidence and argument on MVP Health Plan Inc.'s 2025 individual and small group rate filings. The docket numbers for MVP's individual rate filing is GMCB-005-24-RR. And the docket number for the small group filing is GB-006-24-RR.

The hearing is being held pursuant to Title 8 of the Vermont Statutes Annotated, Section 4062, as well as Section 2.307 of the Green Mountain Care Board's Rate Review Rule, Rule 2. We have all five of the Green Mountain Care Board members present this morning. We also have Gary Karnedy, Ryan Long, and Hannah Lebel, [Lee-bell]. I'm not sure how you pronounce that.

MS. LEBEL: [La-bell].

HEARING OFFICER BARBER: [La-

bell], sorry.

MS. LEBEL: Thank you.

HEARING OFFICER BARBER: Sorry. From the law firm of Primmer Piper Eggleston & Kramer, who are here representing MVP. Representing the interests of health insurance consumers today is Charles Becker and Eric Schultheis from the Office of the Health Care Advocate. The Board's attorney, Laura Beliveau, is also with us, and she'll be leading the direct testimony of the Board's contract actuaries from Lewis & Ellis, and may also have some questions for other witnesses as we go.

We are recording today's hearing. We also have a court reporter here to transcribe the proceedings, and we will provide the parties with a copy of the transcript when we receive it. I want to just take a minute because we're doing this remotely to. Make sure we can all hear each other.

So I'm just going to -- bear with me. I'm just going to do a roll call. And if I call your name, if you could please just take yourself off mute and confirm that you can hear everything okay. Chair Foster is all set. Board

Member Holmes, are you all good?

MS. HOLMES: Yeah. I think so.

HEARING OFFICER BARBER: Board Member Lunge?

MS. LUNGE: Good morning.

THE COURT: And Board Member Murman?

MR. MURMAN: Good morning.

HEARING OFFICER BARBER: Good morning.

Ms. Beliveau?

MS. BELIVEAU: Good morning.

HEARING OFFICER BARBER: Good morning.

Mr. Karnedy?

MR. KARNEDY: Yes. Good morning.

HEARING OFFICER BARBER: good morning.

And Mr. Becker?

MR. BECKER: Hello. Good morning.

HEARING OFFICER BARBER: Good morning.

Okay. So if anybody has any technical difficulties as we go forward today, you can text me and let me know, and I'll pause

the hearing while we try to get that sorted out. So I know the parties have my number already, but just for anyone who doesn't, it's (802) 585-4829.

If there are any members of the public here this morning, we will be taking public comment at the end of the hearing before we close the meeting. But it's really difficult to predict when that will be, so we have scheduled a public comment forum for tomorrow from 4 to 5, and that that meeting will be dedicated exclusively to hearing from members of the public on both MVP's individual and small group rate filings, as well as the individual and small group rate filings from Blue Cross.

Information about that meeting can be found by going to the Board's website and clicking on the link for 2024 board meeting information. You can also access that information from the Department of Library's home page. And if you can't make it to that meeting, we do accept public comment in writing. So you can just write us email us information on how to do that. Again, it's on our website.

I want to spend a few minutes on the exhibit binders. So we received binders from

MVP on July 18th. And then on July 19th, we received corrected versions of the exhibit list and Exhibit 27. We also received Exhibit 28, I believe, which was not initially in the binders. And then we received, I think it was Exhibit 48.

It looks like the documents, as with yesterday's hearing, the documents that contain confidential information have been identified in the exhibit list. And a little bit different from yesterday -- or Monday, sorry -- the information that is confidential within those documents is marked with unexecuted redactions, I believe. So it should show up for you as a red box around the confidential materials.

Gary, I believe I believe that's the case. Did I misstate that?

MR. KARNEDY: I think that's correct. If you'd like, I can put on the record just to confirm what you said, but just going through the list. Would you like me to do that?

HEARING OFFICER BARBER: I don't think that's necessary. But thank you.

MR. KARNEDY: I think, I believe you described it. And just for future reference, was the red boxes, is that how you wanted us to

do it? You said it was different than Monday.

HEARING OFFICER BARBER: I believe that is the -- is what our guidance says, so yes.

MR. KARNEDY: Okay. Thank you.

HEARING OFFICER BARBER: Thank you. I don't know how we got to a different space with the other carrier, but.

So the exhibit list groups, the exhibits, I just want to take a minute to go through this. So section one is titled stipulated exhibit list. And there are three kind of subsections one for MVP, one for the Health Care Advocate, and one for the Health Care Advocate exhibits that are not included in the binder. And my understanding is that the parties have stipulated as to the admissibility of all of these exhibits in section one; is that the case?

MR. KARNEDY: That's correct.

MR. BECKER: Yes. That's correct.

HEARING OFFICER BARBER: Thank you. So I'll go ahead and admit those now.

And then section two is titled nonstipulated exhibit list. And there's a subsection there for MVP that includes Exhibits 28 through 31. And these were the subject of a

motion to admit, that the Health Care Advocate opposed and that I denied. So those are not admitted. And then there's a subsection for the Health Care Advocate with one exhibit, Exhibit 41, which I understand is not stipulated, and which the Health Care Advocate will be seeking to introduce at the hearing. Did I understand that right, Mr. Becker?

MR. BECKER: In full candor, in the past few days, as I've developed my witness outlines, I've determined I'm not going to use that exhibit. And I'm sorry for the trouble I've put your staff through, Mr. Karnedy, but I'm not going to use that exhibit.

MR. KARNEDY: No. Happy to hear that.

HEARING OFFICER BARBER: Okay. So the documents in section two then, are not admitted in total, in full.

And is there anything else we need to talk about with respect to the exhibits?

MR. BECKER: Nothing comes to mind.

HEARING OFFICER BARBER: Okay. So I know that the parties and the board members now

are pretty experienced at this, but I just want to remind everybody at the outset that if you have questions about the material in the binders that is labeled as confidential, please don't ask those in the public session.

You can let me know that you have questions about that stuff, and we can go into a nonpublic session to do that. We should have time for that probably in the afternoon if we need to do that.

So anything else that the parties need to talk about before we move to opening statements?

MR. KARNEDY: I have one minor preliminary matter, and that is, I expect I'll have a few questions this year for Mr. Fisher. And that may go beyond -- he usually makes a statement or is direct exam, whatever you want to call it. And I think it makes sense to just, by stipulation, I don't call him as a witness in my case.

Instead, I'd just be allowed to ask him those questions when he testifies at the end of the day, even if some of them may go beyond what he talks about. So I just wanted to

raise that now so there's no confusion and just would ask if we could stipulate to that.

MR. BECKER: I don't anticipate that being an issue from us. I mean, I think it's common practice for Mr. Fisher to be open to questions from MVP or from the Board. I mean, I would just reserve I mean, if the questioning goes way off the mark, I might raise an objection.

MR. KARNEDY: I don't think it will go off the mark, but that's kind of the point of do I need to call him separately to ask him questions? I don't think it's necessary. It'll all be around these issues of the hearing.

MR. BECKER: I don't think it's necessary either.

MR. KARNEDY: So if you're content, then we just stipulate to that, that's what I would do.

HEARING OFFICER BARBER: Okay. I understand stipulation is to not having to call him as your own witness, but ask questions on cross and if there are objectionable questions, we'll deal with it.

MR. KARNEDY: Thank you.

HEARING OFFICER BARBER: Okay. It's already hot in here. Okay. So we'll go on to opening statements then, and start with MVP.

MR. KARNEDY: Thank you very much, General Counsel Barber. As we've indicated, my name is Gary Karnedy, and I work at Primmer Piper Eggleston & Kramer. And I'm here, again, representing MVP in these rate proceedings, along with Ryan Long and Hannah Lebel from my firm.

We recognize that the Green Mountain Care Board finds itself regulating health care in challenging times. Health care insurance regulation is driven largely by those larger health care challenges. The evidence will show that both MVP and L&E made prudent and necessary decisions to propose increased rates for 2025 to align with these health care costs.

The evidence will also support findings on all of the statutory criteria. I would like to highlight three issues for the Board to be listening for as it hears the evidence today.

First, this evidence will show that L&E is recommending that the board increase MVP's rate proposals overall for individual and

small group, increase, not decrease. The evidence will show that no actuary is opining that MVP's overall proposed rates should be cut, not the Board's own actuary and not MVP's. MVP agrees that L&E's five recommendations on the overall rate adjustments are actuarially reasonable.

Second, the evidence will show that precision on the amount of rate increase for 2025 is critical. Another year of losses for MVP in 2025 is not sustainable. We are a small state with only a few insurance options. The evidence will show that MVP is managing its administrative costs better than most carriers in the first percentile of nationwide carriers as a percentage of premium. Administrative costs make up roughly 10 percent of the premium costs, however.

And despite this high score on managing administrative costs that are within MVP's direct control, the evidence will show that losses over the last six years, including estimates for 2024, are in the range of $38.8 million. We welcome your regulatory involvement to turn this around so that MVP's Vermont product line is independently sustainable for the long

haul. Regional not-for-profit plans need to remain profitable in order to serve the communities we live in.

Third, in its decision last year, the Board asked the carriers to provide more nonactuarial evidence going forward on how the proposed rates are affordable, promote quality care, and promote access to health care. With this 2025 filing and hearing, MVP is responding to that call. In prior years, MVP has provided substantial evidence of nonactuarial criteria in its pre-filed testimony in lieu of the extensive nonactuarial live testimony.

In light of the Board's request, this year, we'll hear more live testimony from Eric Bachner regarding steps that MVP has taken to make its insurance more affordable, promote quality care, and promote access to health care. We appreciate the opportunity. And just a heads up, consequently, Eric Bachner's testifying time will be expanded today as compared to last year in the MVP witness. Thank you very much.

HEARING OFFICER BARBER: Thank you.

Mr. Becker?

MR. BECKER: Thank you. So good morning. For the record, my name is Charles Becker. I'm a staff attorney with the Office of the Health Care Advocate, representing the interests of Vermont health care consumers in this matter. Hearing Officer Barber, Chair Foster, members of the board, Mr. Karnedy, I'm sure most of us here today saw the headline in VTDigger about a month ago that read, Consultant Deems Vermont Health Care System Badly Broken. The article was, of course, about the Act 167 work being done by Dr. Bruce Hamory, which everyone here is amply familiar with.

And I don't want to risk mischaracterizing Dr. Hamory's findings by taking one quote out of context. But that headline, which I read at my desk at work last month poring over these rate filings, certainly was jarring, and the full-quoted sentence was no less jarring. "The health care system in Vermont, unfortunately, is badly broken". So that's what the experts are saying about our health care system.

What are ordinary Vermonters saying? One MVP customer who submitted a public

comment about this rate filing said, "My MVP monthly premiums for my family of four cost more than my mortgage. When the advanced premium tax benefits dry up after 2025, which I have to assume they will, I'm going to drop coverage. It will be cheaper to pay for care out of pocket, which is depressing and utterly unaffordable and unacceptable".

Can anyone here disagree with that Vermont mother of four that premiums, just the premiums for a family of four, cost more than a mortgage on a house is depressing, utterly unaffordable, and unacceptable? You can really hear the emotion in that comment. And here's another one. "Stop. Please stop. The double digit increases year after year are crushing people. My family plan has nearly doubled in costs the last few years. My salary certainly hasn't. Enough is enough".

Vermonters have again come out in large numbers to comment on the rate filings. With the comment period still open, we've heard from more than 75 Vermonters already, and I'm sure you won't be surprised to hear that not a single comment expresses approval of the proposed

rates. No, Vermonters don't seem to be expressing any positive emotions about these rate filings, but they are expressing shock and dismay, disapproval, resignation, frustration, even bewilderment.

Here's another Vermonter commenting on the rate filings. "My monthly health insurance premium is the highest bill I have ever had, higher than my mortgage payment, which includes taxes and insurance, higher than my student loan payment, higher than any car or other installment loan I've ever had. Why is the cost of health insurance so disproportionate?" That's a great question.

Really, it's the question that's at the core of this hearing. Why is health insurance in Vermont so expensive? And the cost of health insurance in Vermont is undisputably very expensive. We have some of the highest and fastest growing QHP rates in the nation. And how did that come to be, because it wasn't always the case?

The answer is highly complicated. It couldn't be distilled into an opening statement, and I wouldn't be the best one to try

to explain it. But suffice it to say, there are a multitude of factors that contribute to Vermont's high health insurance rates, and only some of those factors can be influenced by insurers like MVP. Even fewer factors are within the insurer's complete control.

Regardless, it is undeniable that Vermont health insurance premiums are high because we have high health care costs, as the insurers say, the premiums pay for member's claims. And in recent years, at least, despite pumping tens of millions more dollars into the system in premiums, it's still not enough.

So it's clear that just throwing more premium dollars at the problem is not going to solve the problem. And while we can do clever things like silver alignment, which this year at least, will allow people who purchase policies in the individual market to buy richer plans with fewer of their own dollars, it's all really just spinning plates, and at any moment it could all come crashing down. Indeed, there are signs that a crash may be imminent.

So what are the solutions available to get us out of this mess? Let's turn

again to what Vermonters have to say. Here's one comment. "I don't think rates should increase more than the cost-of-living increase of 3.2 percent". That's a reasonable idea, similar even to the hospital budget guidance. But since premiums pay for claims, then we'd have to keep claims growth at 3.2 percent.

MVP can't do that alone. With spending at hospitals under GMCB jurisdiction amounting to nearly 50 percent of claims, there will need to be greater pressure exerted on the other side of the equation to keep costs down, which, yes, is going to be a difficult thing to do when you also want to promote access and quality.

But holding rates to 3.2 percent is not what we're going to hear today. What I expect we'll hear today from the witnesses is, first, we need to fully fund these proposed rates. Don't cut them. In fact, give MVP more than they asked for because well, it looks like they've been underestimating their drug trend.

As the representative of Vermont consumers in these proceedings, I won't encourage you to give MVP everything they asked for and

more. I would encourage you to find some way to cut these rates. Here are three. One, have MVP assume hospital costs increase by no more than 3.4 percent, which is the hospital budget guidance. Then of course hold Vermont hospitals to no more than 3.4 percent cost growth systemwide.

Two, require MVP to use their own medical utilization trend of 0.1 percent. And three, require MVP to rely on their original projected trend of 7.4 percent in the individual market and 7.3 percent in the small group market.

But let's be honest, even if you make these cuts and identify a few more, it's still not really going to make a dent in these increases. And come 2025, Vermonters, particularly in the small group, are going to experience significantly higher insurance rates.

So I guess this is as good a point as any to wrap this up. In doing so, I will say these rate increases are a serious matter. The stakes are really high. Vermonters are feeling defeated and frustrated by what they're seeing in these health insurance markets. I suspect all of us here are.

Yes. The Board can do good things like silver alignment, which is a bright spot for people this year in the individual market. And yes, short of radically changing the system, we need solvent insurers in Vermont, and so premiums need to be sufficient to pay for claims.

Let's hope over the course of this long day, we can give the board the information they need to carefully evaluate and balance the relevant factors. And let's hope there's real resolve to come up with the long-term solutions our badly broken health care system needs. Thank you.

HEARING OFFICER BARBER: Thank you, Mr. Becker.

Mr. Karnedy, you can please call your first witness.

MR. KARNEDY: Thank you very much. That would be Eric Bachner.

MR. BACHNER: Hello. Good morning.

HEARING OFFICER BARBER: Good morning. Let me just take a second to pin you on my screen, and then I'm going to administer an oath.

Whereupon,

ERIC BACHNER,

a witness called for examination by counsel for the MVP, was duly sworn, and was examined and testified as follows:

HEARING OFFICER BARBER: Okay. Mr. Karnedy, please go ahead.

MR. KARNEDY: Eric, first, I just want to test your mic there. Can you say your full name?

MR. BACHNER: Sure. My name is Eric Bachner.

MR. KARNEDY: Can you turn that up in any way?

MR. BACHNER: Is this better or worse?

MR. KARNEDY: That is better. Thank you. Eric, where do you work?

MR. BACHNER: I work at MVP Health Care.

MR. KARNEDY: Again, it sounds distant. My apologies, but I thought we should get this squared away before we move too far down the road.

MR. BACHNER: Let me do this then.

Is this better or worse?

MR. KARNEDY: That's much better. Thank you.

MR. BACHNER: Sure.

MR. KARNEDY: So let's start over. Where do you work, please?

MR. BACHNER: I work at MVP Health Care.

MR. KARNEDY: And what is MVP Health Plan Inc., please?

MR. BACHNER: MVP Health Plan, Inc. is a not-for-profit subsidiary of MVP Health Care.

MR. KARNEDY: And is MVP Health Plan, Inc. the filer of the two rate filings this year?

MR. BACHNER: That's correct.

MR. KARNEDY: And are you a member of any professional groups or associations?

MR. BACHNER: Yes. I am an associate of the Society of Actuaries.

MR. KARNEDY: And how long have you worked in the insurance industry -- the health insurance industry? Excuse me.

MR. BACHNER: So I've worked in the health insurance industry since June of 2013, so approximately 11 years.

MR. KARNEDY: And of those 11 years, how many did you work at MVP?

MR. BACHNER: I've worked at MVP for approximately 9 of those 11 years.

MR. KARNEDY: And was there a period when you weren't working and then you came back? Describe that to the Board.

MR. BACHNER: Sure. So I went and worked at Cigna Healthcare for two years, in 2022 and '23, and I came back to MVP in January of 2024.

MR. KARNEDY: Thank you. Have you worked on rate filings before the Green Mountain Care Board prior to this year?

MR. BACHNER: Yes. So I've worked on approximately forty rate filings that have fallen under Green Mountain Care Board jurisdiction. I've worked in various roles starting with more technical roles moving up to this year where I'm the first year as the lead actuary on the filing.

MR. KARNEDY: Thank you. And that

would include the small of -- small group and individual and large group filings?

MR. BACHNER: That's correct.

MR. KARNEDY: What are your job duties at MVP?

MR. BACHNER: Sure. So my primary job duties include being responsible for all of our commercial rate filings. So we operate in New York and Vermont. I'm responsible for the large group, small group, and individual rate filings in those states. I'm also responsible as the reserving actuary here at MVP. So I handle corporate reserving and incurred but not reported estimates. And then finally, I also work on commercial forecasting and what goes along with that, which is budget to actual estimates and comparison of budget to actual results.

MR. KARNEDY: You referenced IBNR. What is that, please?

MR. BACHNER: Sure. So incurred but not reported is what IBNR stands for. It's an estimate of claims that either have been received by MVP or have not been paid or claims that have not been received, but we are reasonably expected to have to pay for an

incurred month. So as part of our statutory filings, as part of our gap financials, we have to include an estimate of what we think the claims will look like for any given month. And those claims take, in some cases, several months, even a couple of years to be fully paid. So we have to make an estimate every month to account for that.

MR. KARNEDY: Thank you. And in your work, do you review cost drivers and health care costs?

MR. BACHNER: Yeah. That's correct. I primarily focus on the commercial line of business.

MR. KARNEDY: Thank you. And as part of your job, do you interact with other departments in MVP? And did you do so in your work in preparing for today in this filing?

MR. BACHNER: Certainly. So specifically related to this filing, I've worked with numerous departments, including our sales and marketing department, our pharmacy department, our clinical department, and our product development department.

MR. KARNEDY: Are you an

economist?

MR. BACHNER: I am not an economist.

MR. KARNEDY: Okay. So what I'd like to do first, which I've done in prior years, and I think it's helpful, is go to the exhibit binder and kind of acclimate everybody to what we have there. So if you'd please go to your exhibit binder, and there's an exhibit list at the front, which you General Counsel Barber going through earlier. Let me know when you're there.

MR. BACHNER: I'm there.

MR. KARNEDY: So Exhibits 1 and 2, just bear with me a second, 1 and 2, 3, 4, 6 through 16, 24 and 25, that's the two rate filings for individual small group and all of our interrogatory objection responses. And you're familiar with all of those?

MR. BACHNER: I am.

MR. KARNEDY: And you'd adopt those as your testimony, correct?

MR. BACHNER: Yes, that's correct.

MR. KARNEDY: And that would include the confidential versions that have the red boxes around them, correct?

MR. BACHNER: Yes.

MR. KARNEDY: Okay. And then Exhibit 5, that's the expert witness disclosure, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And that is your CV attached to it, and you prepared that CV or familiar with it?

MR. BACHNER: I did.

MR. KARNEDY: And then Exhibit 16 is your July 12th pre-filed testimony?

MR. BACHNER: That's correct.

MR. KARNEDY: And you've reviewed that and are familiar with it, and it also includes some confidential information in the red boxes, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And then Exhibit 17 and 18, those are the two July 12th letters from DFR on solvency for our two filings, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And you've reviewed those and are familiar with them?

MR. BACHNER: I have.

MR. KARNEDY: And then next we

have Exhibits 19, 20 and 21. These are Lewis & Ellis exhibits, the July 12th actuarial memorandum for individual and small group, and Jackie Lee's pre-filed testimony of July 12th; do you see that?

MR. BACHNER: Yes.

MR. KARNEDY: And you review those and are familiar with them, correct?

MR. BACHNER: I have, that's correct.

MR. KARNEDY: And next, to continue on our list, you go to Exhibits 22, 23, 26, and 27. 22 is the MVP carrier calculation of July 15th. 23 is the July 16th notice of disagreement, which we filed as a supplemental pre-filed. Exhibit 26 is MVP's updated rate increase summary table and Exhibit 27 is MVP's Vermont historical rate cut summary. Are you familiar with all of those? And did you help prepare those?

MR. BACHNER: I did, yes.

MR. KARNEDY: Next, we have, going to Exhibit 48. That's a July 5th, 2023, L&E actuarial opinion that's from last year, their opinion from last year. And it just has a

section 12 on contribution to reserves, page 1 and then 17 and 18, which is that section. Are you familiar with that document?

MR. BACHNER: Yes, I am.

MR. KARNEDY: And you've reviewed it, correct?

MR. BACHNER: Yes, that's correct.

MR. KARNEDY: So these exhibits we've just reviewed, the ones that are MVP exhibits, you adopt them as your testimony in the case, correct?

MR. BACHNER: Yes, I do.

MR. KARNEDY: And then going to Exhibit 1, please, by way of example. Exhibit 1, the first page you'll see, assuming you have the color copies in your binder and direct the Board, there's a number in the bottom right-hand corner, page number 1; do you see that?

MR. BACHNER: Yes.

MR. KARNEDY: So when you and I are talking in your direct examination, I'll be referencing page numbers and I'll try to reference those, we call them Bates numbers, as we go along. So you can follow, okay?

MR. BACHNER: Okay.

MR. KARNEDY: So let's then turn to the substance. We're going to start first at a high level. And I'd like to start by going to just focus on the numbers, and then we'll talk about the substance and the issues after that. Starting with the numbers, go to Exhibit 1, please.

MR. BACHNER: Okay.

MR. KARNEDY: And go to page 2, please.

MR. BACHNER: I'm there.

MR. KARNEDY: And you see in the top left-hand corner, it says general information?

MR. BACHNER: Yes.

MR. KARNEDY: And do you see there's an overall rate impact reference and a number, could you read that, please?

MR. BACHNER: Sure. The overall rate impact for this filing was 11.68 percent.

MR. KARNEDY: So this is the individual filing that was filed back on May 13th, 2024, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So 11.68 is what MVP

was originally seeking, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Thank you. And go to Exhibit 2 please. This is the small group filing of May 13th, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And if you go to page 2, please. Same spot, general information, left-hand corner, overall rate impact. What does it say, please?

MR. BACHNER: So the overall rate impact for the small group filing as of May 13th was 9.34 percent.

MR. KARNEDY: Okay. And that's sort of the average premium rate, correct?

MR. BACHNER: Yeah. That's the premium weighted average increase of all of the plans that we're proposing to sell for 2025.

MR. KARNEDY: Thank you very much. Next, I would ask you to go to Exhibit 19, please, Exhibit 19. Let me know when you're there.

MR. BACHNER: I am there.

MR. KARNEDY: This is the July 12th L&E actuarial memorandum as it relates to

the individual rate filing, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. I want to ask you to go, please -- they have a nice page that has the list of recommendations. It's on page 19. Let me know when you're there.

MR. BACHNER: I'm there.

MR. KARNEDY: Would you read the last sentence on that page?

MR. BACHNER: Sure. The last sentence says, "After the modifications, the anticipated rate change for the individual market is roughly 15 percent plus any impact from updated hospital budget information."

MR. KARNEDY: So MVP original filing was 11.7. And here, L&E is recommending going to 15, subject to any impact on the hospital budgets, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So the hospital budgets aren't part of that number at this point, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Next, I'd ask you to go to Exhibit 20, please. Let me know when

you're there.

MR. BACHNER: I'm there.

MR. KARNEDY: So this would be the small group rate filing actuarial memorandum of L&E dated July 12th, 2024, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And go to page 17, please.

MR. BACHNER: I'm there.

MR. KARNEDY: Read that last sentence, please.

MR. BACHNER: "After the modifications, the anticipated rate change for the small group market is roughly 11.6 percent, plus any impact from updated hospital budget information."

MR. KARNEDY: So MVP as the small group starts out in May at 9.3 percent and L&E in July is recommending 11.6 percent, not including anything relating to the hospital budgets, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. If you go back to, please, Exhibit 19, and go to the recommendations page. Let me know when you're

there.

MR. BACHNER: I'm there.

MR. KARNEDY: Okay. So this is for the individual filing. There are five recommendation bullets, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So before we get into the substance of those, I just want to walk it through so the Board can follow you on where we have agreement and where we don't, okay?

MR. BACHNER: Okay.

MR. KARNEDY: So the first item, Brattleboro Retreat budget, do we agree with -- well, first of all, what does L&E say about this issue? And do we agree?

MR. BACHNER: Sure. L&E identified a technical issue with our rate filing and how it relates to the trend that was applied for Brattleboro Retreat, and MVP does agree with this recommendation.

MR. KARNEDY: And that didn't have a material impact on the rate, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Thank you. And the second issue, would you read that sentence,

please?

MR. BACHNER: Sure. Once 2025 hospital budget requests are submitted, L&E recommends that this new information be considered in the unit cost assumption.

MR. KARNEDY: And does MVP agree with that recommendation?

MR. BACHNER: We do.

MR. KARNEDY: And then the third issue that's about RX trend, correct?

MR. BACHNER: Yes.

MR. KARNEDY: And --

MR. BACHNER: So MVP -- oops. Sorry. Go ahead.

MR. KARNEDY: No, you go ahead, please.

MR. BACHNER: L&E identified an issue with MVP's historical pharmacy trends that as it applies to the filing, and MVP agrees to this recommendation.

MR. KARNEDY: Thank you. And then the fourth item, House Bill H766.

MR. BACHNER: So MVP provided L&E with data regarding how Bill H766 will impact the filing for 2025. MVP agrees with the

recommendation of L&E.

MR. KARNEDY: And that would result in the increase -- well, why don't we hold off on the numbers? Okay. So we have agreement on that. And then the fifth one, please?

MR. BACHNER: Sure. So L&E expects carriers to reflect updated risk adjustment transfers when they are final, and MVP agrees with this recommendation.

MR. KARNEDY: Okay. So of the five recommendations, how many do MVP agree with?

MR. BACHNER: All five.

MR. KARNEDY: And that relates to the individual filing, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And is it true that the only difference would be some required mathematical true up that you'll be testifying about later?

MR. BACHNER: That's correct.

MR. KARNEDY: And we don't know yet, you'll be testifying later, about the hospital budgets and the numbers, the impact on the rates, we don't know yet if L&E will agree to those calculations, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So this year, as to the individual filing, we don't have any substantive disagreement with L&E, correct, subject to the hospital budget issue?

MR. BACHNER: That's correct.

MR. KARNEDY: If you'd go to Exhibit 20, please, page 17?

MR. BACHNER: I'm there.

MR. KARNEDY: Would you agree with me it's the same five recommendations? The numbers may be slightly different, but it's the same five issues and recommendations, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So this year on the five recommendations made by L&E, how many does MVP agree to?

MR. BACHNER: We agree to all five on the small group as well.

MR. KARNEDY: And it would be -- the only difference would be some required mathematical true up, and then it remains to be seen on the hospital budgets. That's still outstanding, correct?

MR. BACHNER: That is correct.

MR. KARNEDY: Overall, the Board's actuaries at L&E are suggesting an increase in the proposed small group rates, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And today, I'll be using Exhibit 19 as we walk through the various issues, which is the individual filing. But I'm going to presume that your testimony applies to both individual and small group, unless you tell me different. Does that make sense?

MR. BACHNER: Yes.

MR. KARNEDY: Would you go to Exhibit 22, please?

MR. BACHNER: I am there.

MR. KARNEDY: Would you identify the document and the date of the document, please?

MR. BACHNER: Sure. This document is dated July 15th, 2024, and it is MVP's calculation of L&E actuarial memorandum rate impact.

MR. KARNEDY: Thank you. And this document doesn't reference or speak to the hospital budget issues, correct?

MR. BACHNER: That's correct.

Just the four issues that L&E explicitly made a recommendation about.

MR. KARNEDY: Okay. And is this something that L&E asks for each year from MVP?

MR. BACHNER: correct.

MR. KARNEDY: And why is that? Why do we do the calculation for them?

MR. BACHNER: Yeah. So we provide a ton of things to L&E in terms of our rate filing, but they don't have full insight into every piece of our calculation. And so L&E usually uses very broad numbers in terms of how they analyze the impact of specific items, but then they trust us with plugging in their recommendations and seeing how the recommendations are actually impacted in our rate filing.

MR. KARNEDY: And don't we have like the rate filing software that does this with better precision?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. Okay. Thank you. So let's go through this. Would you walk me through each item and read it, and then just tell me what it means?

MR. BACHNER: Sure. So the first item is the Brattleboro Retreat budget increase. MVP agrees that these corrections would have no material impact on the requested rates. The second one is RX trend. MVP agrees that the updated pharmacy trend would result in a 1.2 percent increase in the individual filing. For the small group filing, L&E states it would result in a 1.5 percent increase. However, MVP has calculated a 1.4 percent increase.

MR. KARNEDY: So let me interrupt you there.

MR. BACHNER: Sure.

MR. KARNEDY: So is that an example of where when we ran through the numbers there is a true up there?

MR. BACHNER: Sure. And I have to be clear that oftentimes we're talking about less than 0.1 percent, right? So a 1.5 percent increase may be 1.46 percent and MVP calculated it at 1.44. So these are not substantial disagreements in terms of substance.

MR. KARNEDY: Thank you. Okay. Keep going.

MR. BACHNER: Sure. So the third

bullet point is impact of H766. MVP agrees that the adjustment would result in a 0.9 percent increase in the individual filing. For the small group filing, and states it would result in a 0.9 percent increase. However, MVP has calculated a 0.8 percent increase.

And the fourth bullet point is updated risk adjustment. Where in the individual filing, L&E states that the updated risk adjustment would result in a 0.9 percent increase. However, MVP has calculated it to be a 0.8 percent increase. For the small group filing, L&E states it would result in a 0.3 percent decrease. However, MVP is calculated it at a 0.2 percent decrease.

MR. KARNEDY: And then the totals, please?

MR. BACHNER: Sure. So the last bullet point is a total rate change. And it says with all of these adjustments, L&E calculated a new increase of 15.0 percent for the individual filing. However, MVP calculated the new increase as 14.9 percent. L&E calculated a new increase of 11.6 percent for the small group filing. However, MVP calculated the new increase of 11.5

percent.

MR. KARNEDY: Okay. So before the hospital budget consideration, those are L&E's numbers, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And as of July 15th, before we looked at the hospital budget considerations, we agreed with those numbers, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: As modified in Exhibit 22, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Would you go to Exhibit 23, please?

MR. BACHNER: I am there.

MR. KARNEDY: And would you identify the document?

MR. BACHNER: Sure. So this document is MVP's supplemental pre-filed testimony from myself regarding the notice of disagreement with L&E.

MR. KARNEDY: And would you read on page 3, there's an answer five, which is I understand it is summarizing the figures we just

talked about. Would you please read it, and then I have a question for you?

MR. BACHNER: Sure. So answer five says that MVP's requested average rate increase for the individual filing of 11.7 percent is increased by 2.9 percent for a modified total average rate increase request of 14.9 percent by MVP. MVP's requested average rate increase for the small group filing of 9.3 percent is increased by two percent for a modified total average rate increase request of 11.5 percent by MVP.

MR. KARNEDY: And that last sentence you just read, when I look at it, there's a 9.3, and if you add the 2 to it, that would get you to 11.3, not 11.5 if you just do straight math. So could you explain how this is calculated?

MR. BACHNER: Sure. So I use the example of your mortgage payment or your car loan. I guess that's a little bit more depressing. So on the positive side, you could use your savings account. If you have a certain chunk of money in there and you increase it by two percent, the part of the money is multiplied

by two percent. So if you have $1 and 9.3 cents in your savings account, and you increase it by 2 percent, then you have not $1 and 11.3 cents, but a $1 and 11.5 cents.

MR. KARNEDY: So the response in A5 that you just read as of -- the date of this document is July the 16th, as of that date, that was the rate that MVP was seeking, basically agreeing with what L&E had recommended, correct?

MR. BACHNER: Yes. This notice of disagreement did not actually disagree with anything that L&E put forth.

MR. KARNEDY: Thank you. Would you go back to Exhibit 19, please?

MR. BACHNER: Sure.

MR. KARNEDY: And go to page 19 of Exhibit 19.

MR. BACHNER: I'm there.

MR. KARNEDY: Okay. So I want to go through each of these items and now talk substance. So let's start with the first item, please. What is that all about?

MR. BACHNER: Sure. So L&E identified that MVP was not using the Green Mountain Care Board approved trend for

Brattleboro Retreat, which has come under Green Mountain Care Board jurisdiction. So MVP agrees that that is the case. And we plugged in the Green Mountain Care Board approved trend for 2024. The reason why it has no material impact on the rates is, for one, the difference between MVP's assumed trend and the Green Mountain Care Board approved trend was only a couple of points, and there are not a lot of claims in each of the filings at Brattleboro Retreat. So the ultimate impact is zero, rounded to a few decimal places.

MR. KARNEDY: Thank you. And the second item, the hospital budgets, the first clause says once 2025 hospital budget requests are submitted; do you see that?

MR. BACHNER: Yes.

MR. KARNEDY: And so after L&E's Exhibit 19 on July 12, the hospital budgets were submitted, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. So would you please go to Exhibits 24 and 25? We'll start with 24.

MR. BACHNER: I'm there.

MR. KARNEDY: And if you look at

Exhibit 24, the very first page, this is a July 17th objection letter that MVP is responding to. So it's from L&E, correct?

MR. BACHNER: Yeah. L&E sent the letter on the 15th and MVP responded on the 17th.

MR. KARNEDY: And this is about the hospital budgets?

MR. BACHNER: That's correct.

MR. KARNEDY: Would you please read question 1 and then the A, B and C?

MR. BACHNER: Sure. So question 1 says, "Please provide the rating impact of assuming each of the following scenarios. A, hospital budgets are approved as recently submitted. B, hospital budgets are approved at zero unit cost change for fiscal year 2025. And C, hospital budgets are approved at a uniform ten percent unit cost increase for fiscal year 2025 for all facilities."

MR. KARNEDY: Okay. So those are three different scenarios that they're asking you to, to plug numbers in on, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. So when we originally filed our rate filings in May, what

was the plugin as to hospitals?

MR. BACHNER: Sure. So we did not have, obviously, we did not have hospital budget information for 2025 at the time of our rate filings in May. So what we assumed was the Green Mountain Care Board approved rate increase for 2024, apply that to 2025. So to use an example, if a hospital was increased by four percent for 2024 over 2023, we then also assume that they would go up by four percent for 2025 over 2024.

MR. KARNEDY: Okay. So basically what happened last year you applied to this year, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. So A, would be what they're requesting this year, what the hospitals are requesting this year, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. And B, what is B again?

MR. BACHNER: Sure. So B, says that hospital budgets are approved at zero unit cost change for fiscal year 2025. So that would be rather than assuming the same increase, whatever the hospital got as a rate in 2024, it

would not increase by anything for 2025.

MR. KARNEDY: And then C is a 10 percent increase?

MR. BACHNER: That's correct.

MR. KARNEDY: And then if you go to Exhibit 25, please?

MR. BACHNER: I'm there.

MR. KARNEDY: Do you see, this is -- is this the same letter just as to small group, and I understand the numbers may be different?

MR. BACHNER: Yeah. That's correct. The numbers are slightly different, because each filing has different weights in terms of what hospitals are utilized by the population.

MR. KARNEDY: So going back to Exhibit 24 then, please. Okay. Would you read the first sentence, which is the response? Read the first sentence and the response as it relates to A, B, and C.

MR. BACHNER: Sure. The impact of scenarios A, B, and C on the total rate increase are 0.5 percent, negative 2.3 percent and 2.7 percent, respectively.

MR. KARNEDY: Would you explain that? Why there's a positive and a negative? Just give your actuarial view on that.

MR. BACHNER: Sure. So scenario A points out the fact that the hospital proposed budgets for 2025 are higher than the approved budgets for 2024. So if we were to move from the proposed rate increase -- excuse me -- the approved rate increases in '24 to the proposed rate increases in '25, it would increase the rate by 0.5 percent.

Hospital B -- or excuse me. Scenario B is a negative adjustment, because the hospitals are going from what we assumed was something greater than zero to zero percent. And then scenario C is an increase, because we assumed the hospitals would go up by something less than 10 percent. And if they go up by 10 percent across the board, it would increase the rates.

MR. KARNEDY: Thank you. And then would you go to Exhibit 25, please?

MR. BACHNER: Sure.

MR. KARNEDY: And same thing. Would you read that response, the first sentence,

please, and explain it?

MR. BACHNER: Sure. The impact of scenarios A, B, and C on the total rate increase are 0.8 percent, negative 2 percent, and 2.8 percent, respectively. So once again, as I said before, these numbers are different because there is a different utilization mix among hospitals at each of the filings. But all of my comments regarding scenarios A, B, and C on the individual side would apply here as well.

MR. KARNEDY: Thank you. Would you describe for the Board, I think they're familiar with it, but the timing of the hospital budget hearings and the challenges that that caused?

MR. BACHNER: Sure. The timing of the hospital budgets is difficult for MVP, because obviously, the hospital budgets for 2025 are not even proposed until a week before the rate hearing. And they're certainly not approved before our final rates are approved. That presents a challenge because we don't fully understand what the unit cost increases are going to be for 2025 when we file and have our rates approved. So MVP urges the board to align

whatever unit cost increases are ultimately going to be approved in the hospital budgets with the rate filing.

MR. KARNEDY: Thank you. I think we've got all that testimony, the words you were saying, but your screen kind of stifle up a bit. We'll keep our eye on it.

MR. BACHNER: Okay.

MR. KARNEDY: I'm going to ask General Counsel Barber, were you able to hear all that? Thank you. Okay.

MR. KARNEDY: Thank you. That's helpful. And then as it relates to these numbers, we just went over in Exhibit 24 and 25 and the choice, ultimately, that the Board will make on the hospital budgets, what is your concern as it relates to this rate filing and the hospital budget hearings that come after this?

MR. BACHNER: Sure. So MVP's concern would be that the Green Mountain Care Board would approve a hospital budgeted rate increase in the rate filings and then approve something higher than that for the hospital budgets when they are approved in September. That would cause a disconnect between the rates

that are ultimately charged and the claim cost, and would put MVP at a disadvantage.

MR. KARNEDY: So MVP could get caught short in the amount of premium they charge as it relates to what the hospitals are allowed to charge, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So what would the goal then be to limit that as much as possible?

MR. BACHNER: Yeah. The goal would be to align whatever is approved in the rate filing with what will ultimately be approved in the hospital budgets.

MR. KARNEDY: Thank you. Let's go back to Exhibit 19, please. Exhibit 19, and the third item, which was the RX trend. Let me know when you're there.

MR. BACHNER: I'm there.

MR. KARNEDY: Would you please tell us what this is about?

MR. BACHNER: Sure. So historically, in our rate filings, MVP has relied on our pharmacy benefit manager to help us understand pharmacy trends and apply those trends in our rate filings. The understanding is that

they know the pharmacy market much better than we do. So they provided us with utilization trends, their understanding of unit cost increases, which are in some sense a projection based on manufacturer cost increases and new drugs coming out to the market. So we've historically relied on those trends.

L&E undertook a study to look at our historical data, our historical actual observed trends, and how they compare to our proposed trends for the past few rate filings. And what L&E has found is that our actual observed trends are higher than what we have proposed in terms of pharmacy trend in the last few filings. So L&E has proposed an equal weight between historical trends that have been seen and our PBM's projected trends in terms of our actual approved pharmacy trend in this filing, and MVP agrees to that recommendation.

MR. KARNEDY: And did you find L&E's recommendation? Actuarially reasonable?

MR. BACHNER: Yes.

MR. KARNEDY: Let's go to the next bullet then, please, House Bill H766. Would you please -- I think the Board is familiar, but

if you wouldn't mind, tell us what this is about?

MR. BACHNER: Sure. So House Bill 8766 was signed into law. Then was amended with another bill that delayed some of the provisions that were set to be included in 2025. There were some provisions that are still left, and there's our restrictions on prior authorization claims, prepayment reviews, and prescription drug step therapy.

So MVP analyzed the portion of the legislation that will be going into effect for 2025. We expected that rate increase to increase by either 0.8 or 0.9 percent, depending on the filing. We provided those numbers to L&E, and L&E is agreeing to those. So in some sense, L&E is agreeing to -- we are agreeing with what L&E agreed to that we originally presented.

MR. KARNEDY: You said agreed a lot in that last statement there. Very good.

MR. BACHNER: That's correct.

MR. KARNEDY: Does the bill relate -- we don't need to go into great depth, but how does it relate to prior authorization?

MR. BACHNER: Sure. So prior authorization is a tool that health insurance

companies have historically used in order to gain or to have the members and the providers gain authorization to perform certain services. It's a way for insurers to control costs and delay or defer unnecessary utilization.

MR. KARNEDY: And does the bill do anything about step therapy? And what is that?

MR. BACHNER: Sure. So step therapy is another tool that insurers have historically used where we've said you must utilize a certain type of drug or a certain brand or generic version of a drug prior to utilizing a higher cost drug with the goal that some positive outcomes will be seen with the original treatment and therefore the higher cost drug will not need to be utilized.

MR. KARNEDY: Okay. And what about prepayment review?

MR. BACHNER: Yeah. So this is -- we're in some cases insurers are allowed to amend parts of a claim prior to it being submitted and paid to -- paid by the insurer. So it's an upfront adjustment rather than a retrospective claim adjustment.

MR. KARNEDY: So going back then

to the description of the House bill at bullet 4, these are choices that the Vermont legislature and the governor ultimately made about these three items, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And it resulted in an increase of premium, correct?

MR. BACHNER: Yes. It will result in an increase to claims and an increase ultimately to premium.

MR. KARNEDY: Let's go to the next item, please.

MR. BACHNER: Sure.

MR. KARNEDY: Would you identify what risk adjustment transfers are and how that applies this year?

MR. BACHNER: Sure. So risk adjustment transfers are a program that was instituted as part of the Affordable Care Act. And they apply to small group and individual insurance companies in each of the states. And the function of the risk transfer is to transfer money from carriers with better risk to carriers with worse risk. So all the members for both carriers or all carriers within a given state are

scored a risk score based on their demographics, based on their plan design, based on their conditions that they've observed within the year.

Those risk scores are compiled together and carriers with a lower risk score or what is perceived to be better claim risk, have to pay money to carriers with worse claim risk or higher risk scores. And so the problem with the risk adjustment formula, again, is that the risk adjustment transfers for 2023 are not finalized until it was delayed by a couple of weeks. It was just on Monday.

So MVP and all the carriers within a market don't have full insight into the 2023 risk adjustment results when the time -- when they file. In this case of the State of Vermont, we worked with an actuarial consultant who was given data from both carriers, and they were able to estimate what the risk adjustment results would ultimately look like. Now, that data is not complete, it does not have full run out, and they have to make some assumption for how the claims will ultimately run out.

So that's the basis of MVP's risk adjustment assumption in our rate filing.

Subsequent to that, L&E took the full complete data from both carriers, ran it through their model, and determined what the final risk adjustment result will be, which ultimately tied to what was released on Monday. And so this recommendation is just to true up the estimated risk adjustment transfer to the final risk adjusted transfer.

MR. KARNEDY: Thank you. I want to shift gears and talk about long-term sustainability. So let's go to Exhibit 27 please. Exhibit 27.

MR. BACHNER: I am there.

MR. KARNEDY: I'm not yet. Okay. If you look at Exhibit 27, it's entitled, "Vermont historical rate cut summary", correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And do you see how this year we put numbers in the columns 1 through 10?

MR. BACHNER: Yes.

MR. KARNEDY: But what I'd like you to do is go through the columns and just describe what it's showing, and then we can talk more substance after that, okay?

MR. BACHNER: Okay. So column 1 labels the market and the year for the six-year time period from 2019 to 2024. Prior to 2022, the markets were combined. 2022 through 2024 the markets are separate.

Column 2 is the profit load that was built into the rates. This was MVP's filed risk margin in each of the filings.

Column 3 is the overall cuts that were proposed by L&E. So these are cuts that MVP did not stipulate to. They were things like COVID vaccine assumptions or assumptions as they relate to utilization trend that MVP did not agree with.

Column 4 is overall -- excuse me -- additional overall cuts by the Green Mountain Care Board. These include things like cuts to risk margin and explicit premium cuts in the name of affordability.

MR. KARNEDY: And those would be on top of the cuts in column 3, correct?

MR. BACHNER: That's correct. Yeah. Those two are multiplicative.

Column 5 is the total allowed premium by the Green Mountain Care Board. This

is our earned premium for each year for each market after all of the cuts were made.

Column 6 is MVP's losses. So this would be equivalent to our operating income for each of the filings for each of the years.

Column 7 is the L&E cut impact. So it's effectively applying column 3 to column 5 and determining what the amount of lost revenue was from the cuts that were proposed by L&E.

Column 8 is the board cut impact. So this is, again, taking column 4 this time and applying it to column 5 and determining what the revenue loss was due to overall cuts by the board.

Column 9 is the total dollar impact of the rate cuts. This is the summation of column 7 and column 8.

And then column 10 is losses without cuts. This is what MVP's losses would have been should columns 8 and column 9 would not have been there. It's the addition of column 6 and column 9. Excuse me. The difference. Column 6 minus column 9.

MR. KARNEDY: Thank you. And would you, before we dig into the numbers, would

you explain to the Board the 2024 numbers and, I believe to some extent, the 2023 numbers?

MR. BACHNER: Sure. So I can take a step back and say that we expect that 2022 and prior are reasonably certain to be complete. We may still have a high-cost claimant or somebody come in for 2022, but all of the risk adjustment and everything has been settled for those years. For 2023, this was our best estimate of operating income at the time of this when this document was created. There are still some outstanding items. We do still have a little bit of claim reserves, expect some run out of claims, expect things like risk adjustment to still come in.

And then 2024 is just still just a very high-level projection. Obviously, we don't have -- we only have claim expense for the first six months of the year. Even that claim expense is not very complete. We have to apply IBNR to it. And we have no insight into the risk adjustment for 2024. So if I had to draw it sort of brackets around 2024, that would be fairly wide in terms of the expected outcome relative to what's currently on the page.

MR. KARNEDY: And you referenced

when this document was prepared. It's my understanding that was in July, correct?

MR. BACHNER: Yeah. That's correct. It was prior to the final risk adjustment results.

MR. KARNEDY: Thank you. So when you look at these totals --

Strike that. Let me ask it differently.

When you look at data in a table like this as an actuary, why look at all of these years? Why not just look at the most recent time period to estimates about rate cuts?

MR. BACHNER: Sure. So if you're running a business, first, you want to look at a longer-term aggregate number, right? We don't necessarily work in one-year increments. We're looking at a block of business over a long period of time. So that would be why we would add the summation rows at the bottom.

But to compare year over year, it helps us to identify trends. Is this, we've seen losses over this time period. Is it very volatile? Are all the losses in the same direction year over year? It helps us to

establish whether this is a persistent pattern or this is subject to somewhat of random noise.

MR. KARNEDY: So looking at this table, Exhibit 27 the totals, what actuarial conclusions do you draw about trends and losses for MVP?

MR. BACHNER: Sure. So we've included 2020 for just for full transparency, which at this point the individual market appears as if it will be profitable. But over the long-term time period, so over the six-year period, we have experienced $38.8 million in losses. Those losses are heavy. They are very big. And they're also sustained year over year over year. So with the exception of 2020, which was heavily impacted by COVID and the individual market for 2024, we've lost money in every single one of the years and markets.

The other thing to note would be that of that $38.8 million in losses, more than half of it, 26.9 million has been subject to rate cuts by either L&E or the Green Mountain Care Board. So while we would still have lost money $11.9 million without those cuts, the losses are significant in light of the cuts that have been

experienced.

MR. KARNEDY: Thank you. So moving away from that exhibit, I want to ask you about risk margin. So what is MVP proposing for 2025 for the risk margin?

MR. BACHNER: MVP is proposing 1.5 percent risk margin for both filings for 2025.

MR. KARNEDY: And what did MVP propose last year and what was approved?

MR. BACHNER: Sure. MVP also proposed 1.5 percent last year and that was approved by the Board.

MR. KARNEDY: Thank you. And what's the purpose of including risk margin in the 2025 rates?

MR. BACHNER: Sure. So there's a number of different purposes, but the main one is in order to help MVP sustain years where there are wild variations in claim costs and also to bolster our reserves. So we have to keep some amount of money in surplus in order to be able to prepare for a catastrophic event. That is money that is statutorily required to be held by the company. And so the risk margin is an explicit assumption that will allow MVP, if everything

goes to plan and the premium rates are exactly correct, in order to fund those reserves over time.

MR. KARNEDY: Thank you. I would ask you to go to Exhibit 19, please. Back to Exhibit 19.

MR. BACHNER: Okay.

MR. KARNEDY: And go to page 16, and you'll find a heading for section 12. Let me know when you're there.

MR. BACHNER: I'm there.

MR. KARNEDY: So the very first paragraph on that page makes reference to bad debt of 0.3 and a risk margin of 1.5; do you see that?

MR. BACHNER: I do, yes.

MR. KARNEDY: And that aligns with the table just below it. It says, 0.3 for bad debt and 1.5 for risk margin, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: But I want to just discuss the term of art, so we're talking about apples to apples. If you see below the table in the third paragraph, can you read up to the word consistent?

MR. BACHNER: Sure. So the proposed risk margin of 1.5 percent is consistent.

MR. KARNEDY: All right. So that 1.5 is referencing the 1.5 above which is the risk margin, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And then if you go to page 17?

MR. BACHNER: I'm there.

MR. KARNEDY: The first paragraph under that table?

MR. BACHNER: Sure.

MR. KARNEDY: You'll see it says MVP's filed based CTR of 1.5 percent; do you see that?

MR. BACHNER: I do, yes.

MR. KARNEDY: And in your view, after reviewing this as an actuary, that 1.5, does that align with that table on 16 that we just talked about the risk margin of 1.5?

MR. BACHNER: Yes. I would assume that this this would have said the MVP's filed base risk margin of 1.5 percent.

MR. KARNEDY: And does that

align -- does the table just above on page 17, that table with the bars, does that support your conclusion and why?

MR. BACHNER: That's correct. The light blue bar, which is highlighted is under the category of 1 to 1.5 percent. So that would be my understanding, would be that they were looking specifically this table was looking at the risk margin.

MR. KARNEDY: Okay. And the bad debt, the 0.3, that's separate from that 1.5, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So let's walk through this section and I want to ask you some questions. Go back to page 16.

MR. BACHNER: Okay.

MR. KARNEDY: Well, first I think we talked about it, but the second paragraph under the table, so it's the second paragraph on the page that starts MVP provided?

MR. BACHNER: Um-hum.

MR. KARNEDY: That's about bad debt, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And it references 0.3 percent for bad debt, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And is that consistent with the 2024 rate filing?

MR. BACHNER: That is correct.

MR. KARNEDY: And then, bear with me. I want to ask you about the historical risk margin table; do you see that down below?

MR. BACHNER: Yes.

MR. KARNEDY: What does this table show? And could you explain these amounts over the years comparing actual to expected?

MR. BACHNER: Sure. So this table is for the time period of 2021 to 2023, comparing actual risk margin to expected risk margin. So the expected risk margin would be the filed risk margin in our rates, less any explicit cuts to that risk margin made by either L&E or the board. And then the actual would be equivalent to the table that we just looked at over Exhibit 27. That would be our actual risk margin as experienced in those three years.

MR. KARNEDY: And how do you react to these numbers? What do they show you as an

actuary?

MR. BACHNER: Yeah. They show, again, continued sustained losses. The losses are fairly large in each year. We're talking 6 percent lower than expected, 9 percent lower than expected and 10-ish percent lower than expected for the 3-year time period.

MR. KARNEDY: Thank you. Now, the paragraph below that table. It's the last paragraph on this page 16; do you see that?

MR. BACHNER: Yes.

MR. KARNEDY: And that references a reasonableness check. This is something that L&E has done for a number of years, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And it references that they looked at 377 carriers on exchange, individual and small group, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And that's nationally?

MR. BACHNER: Yes.

MR. KARNEDY: And would you read the last two sentences of that paragraph, please?

MR. BACHNER: Sure. The filed CTR

varied from negative 17 percent to plus 8 percent, but most often fell between 0 percent and 5 percent. The premium weighted average CTR for all carriers was filed as three percent.

MR. KARNEDY: And go to page 17, please, back to page 17.

MR. BACHNER: Okay.

MR. KARNEDY: And would you please explain what this table shows as it relates to those percentiles?

MR. BACHNER: Sure. So of the 377 carriers which we just talked about, they would all be graphed and they would be broken down into these cohorts of their risk margin. So you're looking at like half percent increments. So and then each bar represents how many carriers would fall into that distribution.

So the light blue bar, which is one percent to 1.5 percent is where MVP would fall. And according to the to the data point just below it, it's around the 20th percentile. So if you've lined up 100 people or 100 carriers, there would be approximately twenty who would be lower than MVP, and there would be approximately 80 who would be on the other side higher than

MVP.

MR. KARNEDY: Thank you. Staying on page 17, going down to the last paragraph that says, it is concerning, I want to ask you some questions about that paragraph, please.

MR. BACHNER: Okay.

MR. KARNEDY: So what I'd like you to do is to read each sentence and then comment on it.

MR. BACHNER: Sure. "It is concerning that MVP has experienced consistent material losses in the last few years. However, MVP's RBC has been steadily increasing in recent years."

So MVP does agree that we have experienced consistent material losses and that it is concerning. It is also true that our RBC has been steadily increasing in recent years. The RBC for MVP health plan takes into account not just Vermont business, but takes into account New York business. It's also not just a measure of commercial business. It's also our Medicare Advantage business in New York and Vermont. It's also our government program. So our Medicaid essential plan business in New York State as

well. Vermont business accounts for approximately nine percent of MVP's overall business. So once again, Vermont small group and individual accounts for only nine percent of MVP's overall business.

MR. KARNEDY: And do you agree with that?

MR. BACHNER: Yeah. That's correct.

MR. KARNEDY: In that first sentence you read, do you agree with what they said about the contrast between the losses and RBC increasing, as you described it?

MR. BACHNER: Yes.

MR. KARNEDY: Okay. Thank you. So go ahead. I apologize for interrupting.

MR. BACHNER: So L&E recognizes that this is a small part of MVP's overall business, which contributes to the increasing RBC despite consistent losses observed for the Vermont business.

MR. KARNEDY: So what are they saying there?

MR. BACHNER: Sure. So what they're saying is that our RBC could be

increasing, but because this Vermont filing is such a small portion of our business, it's possible to be sustaining even severe losses in this market while also having an increase to our RBC.

MR. KARNEDY: And do you agree with that as an actuary?

MR. BACHNER: Yes, I do.

MR. KARNEDY: Thank you.

MR. BACHNER: However, actuarily sound rates are sustainable without other subsidization.

MR. KARNEDY: So what do you understand they're saying there? And do you agree with it?

MR. BACHNER: Sure. So what they're saying here is that every market has to be priced in a vacuum, essentially, as if there were no other products that MVP were to sell for 2025. In an extreme scenario, we could exit all of our markets other than as Vermont small group and individual market, and as an actuary, we're forced to, by actuarial standards of practice, price our rates as if they were actuarially sustainable for every block of business.

MR. KARNEDY: Okay. Next sentence, please?

MR. BACHNER: Sure. "L&E notes that it is not sustainable to have long term losses and therefore a higher CTR could be justified."

MR. KARNEDY: So what are your thoughts on that? Do you agree with it?

MR. BACHNER: Yes, I agree with it. Actuarially sound rates should be sustainable without subsidization from other markets. If you think about it and you're running a business, if you have -- if you're selling a product where you lose money continually year over year over year, you have to start to think about what is driving those losses and whether that a product is something that will be sustainable for the long term.

MR. KARNEDY: Next sentence?

MR. BACHNER: "Given that a lower utilization trend assumption could also be justified, as discussed previously in this report, L&E is not recommending a higher CTR."

MR. KARNEDY: So what is your view on a higher CTR?

MR. BACHNER: So a higher risk margin would be --

MR. KARNEDY: Excuse me. I misspoke. Higher risk margin. Yeah. Let's focus on that.

MR. BACHNER: Sure. So a higher risk margin would obviously help to shore up our reserves would help to make this product sustainable over the long term. MVP does agree with the fact that a lower utilization trend could be justified and it would be actuarially reasonable. However, these things are all related. So what L&E is saying, is that a lower utilization trend would lead to a higher chance that MVP would not be able to retain all of that risk margin that was filed.

MR. KARNEDY: Thank you. And would you read the last sentence, please?

MR. BACHNER: Sure. "L&E strongly emphasizes that reducing the CTR assumption from the filed 1.5 percent presents significant risk of inadequate premium rates that are not actuarially sound."

MR. KARNEDY: Now, in your experience as an actuary, do actuaries choose

your words carefully?

MR. BACHNER: I would say that's correct.

MR. KARNEDY: So when you read this sentence as an actuary and read the words that are used in that sentence could you comment on that?

MR. BACHNER: Sure. So when L&E says things like, L&E strongly emphasizes that and that reducing the CTR assumption would present significant risk of inadequate premium rates, those, to me, are adjectives that are necessary, but they're also larger than -- greater than what is previously been spoken about MVP. So these are -- to me, these indicate that L&E is significantly concerned more so than in recent years, about the inadequacy of potential premium rates, should the risk margin be cut.

MR. KARNEDY: Thank you. Please go to Exhibit 26, 26. Let me know when you're there.

MR. BACHNER: I'm there.

MR. KARNEDY: And would you please identify this exhibit?

MR. BACHNER: Sure. So this is

MVP's updated rate increase summary table.

MR. KARNEDY: And would you walk us through it please, and explain?

MR. BACHNER: Sure. So this table has different scenarios or different points in time during the rate filing process. And what the rate increase has looked like during those points in time. So the first row is our initial proposal of 11.68 percent for individual and 9.34 percent for small group. So those numbers tie back to Exhibits 1 and 2, which we started the morning talking about.

The second row is adjusted for agreed changes from the L&E memo, which leaves individual at 14.92 percent and small group at 11.52 percent. So those tie out to the exhibits that MVP presented, where we took L&E's recommendations and plugged them into our rate filing software and determined what the agreed changes would look like.

And then the final row is updated budgets and agreed changes from L&E memo and the updated budgets has an asterisk, which says that MVP's best interpretation of the proposed budgets, as calculated in the response to

objection seven. And that increase would be 15.5 percent for individual and 12.39 percent for small group.

MR. KARNEDY: Okay. That objection seven, that was Exhibits 24 and 25, where the Board had asked us to answer questions about the various hospital budget scenarios, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And so which scenario did MVP use in Exhibit 26 to arrive at the 15.5 and the 12.39?

MR. BACHNER: Sure. So we would have used scenario A.

MR. KARNEDY: Okay. And scenario A was just taking the budgets as proposed by the hospitals, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And on last Friday, July 19th, did UVM update their budget proposal?

MR. BACHNER: That's correct. MVP received a letter from UVM via email that said that they were increasing their hospital budget, which I believe has been delivered to the Green Mountain Care Board.

MR. KARNEDY: So --

MR. BACHNER: So this data does not reflect that change.

MR. KARNEDY: Okay. So Exhibit 26, the 15.5 and the 12.39 don't reflect the change by UVM that we received on Friday, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So had have you had an opportunity to crunch those numbers and include the impact of UVM's changes? And if so, what are those numbers?

MR. BACHNER: Yes. So they would increase these rates by another 0.4 percent approximately depending on market. So we'd be looking at somewhere in the neighborhood of 15.9 percent and 12.8 percent for individual and small group, respectively.

MR. KARNEDY: So can you say those numbers again, just the totals, what you ended up with, please?

MR. BACHNER: Sure. And these are approximations. We haven't -- I haven't put it exactly through, but it would be 15.9 percent and approximately 12.8 percent.

MR. KARNEDY: Thank you. Next, I'd like to ask you about administrative costs. If you'd go back to Exhibit 19, please, Exhibit 19.

MR. BACHNER: I'm there.

MR. KARNEDY: Just a second. Go to page 13, item 10. Okay. So that's at the bottom of page 13. And that's the administrative cost section of the individual rate filing, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And would you tell the board what L&E found in terms of overall rate impact?

MR. BACHNER: Sure. So --

MR. KARNEDY: For administrative cost?

MR. BACHNER: Yes. So L&E found that the overall rate impact of our proposed administrative costs is a decrease of 0.1 percent.

MR. KARNEDY: Oh, I meant to ask you, what's the percentage roughly of premium that's attributable to administrative costs and other non-health care costs?

MR. BACHNER: Sure. So as you can see here, administrative costs specifically are about between 5.8 and 6 percent of premium, including taxes and fees and filed risk margin and bad debt. This would be somewhere in the neighborhood of 7.5 to 8 percent of premium is nonclaim expense.

MR. KARNEDY: Thank you. Okay. Let's go to page 14, please. I want to ask about the second paragraph. It's the paragraph under the expenses table.

MR. BACHNER: Okay.

MR. KARNEDY: So what is this looking at, please?

MR. BACHNER: Sure. So L&E was comparing our 2025 assumed administrative costs on a PMPM or per member per month basis, and comparing that to our 2021 to 2023 supplemental health care exhibits, which are a statutory filing where we have to file our admin costs for those time periods. And MV -- excuse me -- L&E found that our 2025 administrative cost increase is approximately three percent average annual increase from our 2023 filed supplemental healthcare exhibit to our proposed rates.

MR. KARNEDY: Thank you. And below that, there's a paragraph, and then there's a couple of tables going into page 15; do you see that?

MR. BACHNER: That's correct. Yes.

MR. KARNEDY: What is this part about? And what does it show?

MR. BACHNER: Sure. So L&E undertook a similar comparison as they did on the risk margin side, where they took all of the carriers who were in individual and small group market across the country in 2024. And once again, they lined them all up in terms of their administrative costs. That was built into their rates. They did it in two different ways. They did it as a percentage of premium, and they also did it as a per member per month basis.

This recognizes the fact that there are different cost structures within each state. So the administrative cost might be a lower or higher percentage of premium simply because the claim cost is higher or lower in any of those markets. So once again, the light blue bar would be the bar where MVP would fall in this

filing.

And on the page 15 in the middle, it shows that MVP is in the first percentile among all carriers nationwide as a percentage of premium and the 32nd percentile on a PMPM basis. So once again, just to frame that, if you lined up 100 carriers, MVP would be the first or would have one carrier lower than them and would have 99 carriers higher than them in terms of percentage of premium. And the 32nd percentile would be, MVP would have 32 carriers at or lower than them, and 68 carriers at or higher than them.

MR. KARNEDY: Thank you. If you'd go to page 15, and read the sentence just above the paragraph numbered 11?

MR. BACHNER: "L&E considers the assumed 2024 administrative costs to be reasonable and appropriate."

MR. KARNEDY: Now, as you read this and your familiarity with the filings, is that 2024 a typo? Should it be 2025, in your view?

MR. BACHNER: The tables that are above are based on 2024 data. But yes, I would

assume that this, which would be 2025 administrative cost to be reasonable and appropriate.

MR. KARNEDY: And are you of the opinion as an actuary that our administrative costs referenced in these filings are reasonable and appropriate?

MR. BACHNER: Yes.

MR. KARNEDY: Would you please go to Exhibits 17 and 18? Let me know when you're there.

MR. BACHNER: I am there.

MR. KARNEDY: So we previously identified these during evidence. Exhibit 17 is the letter from DFR to Chair Foster dated July 12th, regarding solvency or the individual filing. And then Exhibit 18 is the same letter on the small group filing date of July 12th. Did I identify those correctly?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. And you've reviewed these letters and are familiar with them, correct?

MR. BACHNER: Yes, I have.

MR. KARNEDY: And are the letters

identical in substance with the exception of a reference to small group versus a reference to individual?

MR. BACHNER: Yes, they are.

MR. KARNEDY: So if you'd go to Exhibit 17, on the first page you'll see a heading, summary of opinion. Let me know when you're there.

MR. BACHNER: I'm there.

MR. KARNEDY: And would you read that sentence, please?

MR. BACHNER: Sure. "The proposed rate filed by MVP health plan would not negatively impact its solvency, and the company otherwise meets Vermont's financial licensing requirements for a foreign insurer."

MR. KARNEDY: And would you agree in your actuarial opinion as of the date of this letter, July 12th, 2024, that the rate increases proposed as of that date did not adversely impact the solvency of MVP Healthcare, Inc.?

MR. BACHNER: Yes. The rate increases as proposed would not impact MVP's solvency.

MR. KARNEDY: And since that time,

MVP's proposed rate has changed, increased to 15.89 percent individual and 12.81 small group as presented in evidence today, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: So in your opinion, MVP's proposed rates at this hearing, as amended by the hospital budgets, adversely impact the solvency of MVP Healthcare, Inc.?

MR. BACHNER: The rates, as proposed, would not impact MVP's solvency.

MR. KARNEDY: As proposed here in in the hearing with the updated hospital information, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Is there anything else you'd like to comment on as it relates to solvency? And please answer that question, and then I have another one for you.

MR. BACHNER: Okay. MVP would like to comment on the fact that both DFR and L&E have commented on Vermont's relatively small proportion of MVP Health Plan's total business. MVP recognizes that there is great uncertainty in the market, including the solvency of other insurers. That is public knowledge.

So MVP would like to note that while this filing does not necessarily impact MVP's solvency at this moment, things can change very quickly. And if MVP were to take on a significant portion of the individual or small group market, we would go to -- the business would become a much larger portion of our overall MVP Health Plan business and could, if the rates were inadequate, present problems for MVP's long-term solvency.

MR. KARNEDY: And this testimony you just provided about Exhibit 17 and solvency, that would apply equally to Exhibit 18 for the small group, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Bear with me. Hearing Officer Barber, I'm wondering, I'm about to pivot to the nonactuarial issues, whether you'd like to take a five-minute break now or whatever you deem appropriate?

HEARING OFFICER BARBER: Yeah. No. You read my mind. I think now would be a good time.

So Ms. Morales, if we could go off record. We're going to take a five-minute break,

and come back at 9:48.

(Recess at 9:43 a.m., until 9:51 a.m.)

HEARING OFFICER BARBER: Thank you. You can pick back up, Mr. Karnedy.

MR. KARNEDY: Thank you very much. Yes.

Eric, you're on mute. Can you unmute?

MR. BACHNER: Sure. Can you hear me okay?

MR. KARNEDY: Yeah. I can hear you fine. I know this is your first time. You're doing great. Doing great. So we're going to pivot now to nonactuarial issues please. Would you please go to Exhibit 16?

MR. BACHNER: I'm there.

MR. KARNEDY: Let me know when you're there.

MR. BACHNER: I am.

MR. KARNEDY: And this is your pre-filed testimony, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And if you would go to page 7, please, of that exhibit?

MR. BACHNER: I am there.

MR. KARNEDY: And there's a

question there, would you read question 21?

MR. BACHNER: Um-hum. Question 21 says, "What steps has MVP taken to lower costs and establish that its proposed rates promote affordability, access to care, and quality of care for Vermonters?"

MR. KARNEDY: So there's three items there that it's asking about, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And then in the answer, there's a list of items that goes up to 18, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And so all those items would respond to the question of promoting affordability, access to care and quality of care, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Okay. And then if you look at that list in turn, it makes references to other Q and A's, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: And those follow in your pre-filed, correct?

MR. BACHNER: That is true.

MR. KARNEDY: So I'd like to walk through some of these items with you and have you provide color and greater detail on the Q and A, all right?

MR. BACHNER: Okay.

MR. KARNEDY: Let's start with Q-22. Let me know when you're there.

MR. BACHNER: I am there.

MR. KARNEDY: So I want to expand this question slightly. How has telehealth affected access to health care and quality of care and affordability?

MR. BACHNER: Sure. So MVP has rolled out telehealth through our mobile app, Gia. We've seen a great increase in the utilization of telehealth services. I mean, as I say in my pre-filed testimony, it's gone up from 2020 to 2023, 143 percent. And if you think of 2020 as a baseline where many of us couldn't see our doctors for months, that's actually a fairly sizable increase off of what we'll say the middle of COVID levels.

Telehealth has greatly increased access to care and quality of care. I use the example of myself as a parent. It's very

unnerving when you wake up in the middle of the night and your child is spiking a fever. And my wife and I both look at each other and say, well, what do we do? Who do we call? You know, neither one of us are doctors. Do we go to the ER? How can we handle this? So using that example, telehealth has greatly increased both access to care and quality of care.

We've been able to access doctors. People can access doctors in the middle of the night, 24/7. They can access doctors even if they're in the most rural parts of Vermont, provided they have internet access. They're able to very quickly be able to access a provider and get them the care that they need. That care is also the care that is tailored to them. So that greatly increases the quality of care, right?

We can go to the Gia app and say, do I really need to go to my primary care for this? Do I need to go to the ER for this, that primary care that telehealth is able to work as a triage, effectively funneling care to the place where it is will be the best care for the member. It also greatly increases affordability.

We do think of some of the visits

are increasing cost in terms of people are utilizing telehealth and then saying, oh, well, I have to go to the ER anyway. But what we've seen is that that telehealth can and does reduce the amount of care that's utilized at places, which is more expensive. And that's tremendously important, not just for the ultimate premium rates, right? Every dollar that is not spent in claim expense is a dollar that reduces premium rates.

But it's also helpful for people with out-of-pocket expenses. So you think of somebody who has a deductible or somebody who has a very high ER copay. They want to avoid that ER visit at all costs, provided that they don't absolutely need to go. So this telehealth has greatly increased all three statutory criteria for MVP.

MR. KARNEDY: Thank you. Let's go to Q-23, please.

MR. BACHNER: Okay.

MR. KARNEDY: And again, I want to expand this slightly. How does MVP promote affordability, access, and quality care by encouraging strong relationships with PCPs?

MR. BACHNER: Sure. So MVP has really identified the primary care doctor as the person who is closest to the member. They know them the best. They have the best access to all of their medical records. They understand the unique needs of that person. So when we talk about trying to have strong relationships with the PCP, it greatly increases the member's quality of care.

They're not going to a doctor who doesn't know them has never seen them before. They're able to go to their PCP and say, look, I've had this condition for a long time, what should I do? That PCP, based on their medical history, might be able to say, well, maybe we could solve this with diet and exercise, or maybe you need to go see a specialist. Or maybe we can just solve this with physical therapy for an example.

So that PCP working as really the first line of defense in terms of a member's health is greatly, greatly increases the member's quality of care that they receive. It also greatly increases access. We've seen many PCPs who are able to work -- help a member navigate

through the health system. The member doesn't feel like they're alone. And certainly MVP helps with that. But we also have identified the primary care physician as the one who's able to better help members get through the system and find the exact care that they need.

The PCP also promotes affordability, because they help the member to triage in a similar way that the telehealth system does, right? If a member goes to the PCP and says, hey, we can manage this with a weight loss program or a diet change or nutrition, that's a win for the member because it reduces costs and it's a win for MVP because it reduces our medical expense, which ultimately will reduce the premium.

So MVP really feels strongly in terms of PCPs are an integral part of the care management process, and they help in all three lines of statutory criteria in order to improve the lives of our members.

MR. KARNEDY: Does MVP align their fees to increase access for PCPs -- to PCPs? Excuse me.

MR. BACHNER: Sure. So certainly

the fees are not aligned 100 percent. And that's due somewhat to the nature of specialists having to perform services that might be more complex or for members that might have more significant care needs. But MVP has worked over the past few years to increase and align our primary care fee schedules to reflect the fact that we value primary care doctors as an important part of the health care system.

MR. KARNEDY: Let's go to Q-26, please. 26.

MR. BACHNER: I'm there.

MR. KARNEDY: Would you please expand upon the question of MVP's case management programs, creating efficiencies to improve affordability, quality, and access to care?

MR. BACHNER: Sure. So you can really break our case management programs down into a couple of different buckets. The first bucket being management for chronic conditions. So you think about somebody who has asthma or COPD or diabetes, things that they're managing on their own. But they could utilize somebody to help better manage that condition.

And then we also think of the

other bucket would be like complex acute cases. So you think of like end-stage renal disease or certain types of cancer, one where it's really critical that somebody is helping the member to organize all of their care, to get them the right care at the right time and the care that they need.

So in terms of case management program, they increase affordability because they help the member to identify services that are specifically necessary in order to treat the conditions that they have. So in terms of chronic condition, we might say, hey, you may not need to go see this, this specialist for this condition, if it can be managed by MVP's weight management program or MVP's nutritional program that we can help you with.

On the other hand, the complex cases, right? Many times these members are going to see many different specialists, many different services. There's sort of options in terms of treatment. And we want the members to get the treatment that is right for them. That also is the lowest cost treatment that will provide quality outcomes for them.

So in terms of quality, we think of the member getting the best care that they need. And the case managers help with developing a plan alongside of these members to help them develop that care. So they're greatly increasing the member's quality of care. They're saying to the member, hey, look, this is the plan that we think is right for you. And they're getting the member's buy-in, and therefore, together they can help to drive ultimate health, which is the goal.

And then they help to provide access to care. I mean, as I said before, in terms of primary care physicians, but it's also true for our case managers. They're helping members navigate the system. They're helping members to say, oh, you need this service. Well, let's go to this physician down the street. Or if you can go, there's another physician a half an hour, 45 minutes away that might be cheaper, that might be better suited to help with your condition.

So MVP's case managers are really, say this sort of navigator that's helping members walk through whatever condition they're facing.

MR. KARNEDY: Thank you. Going to

Q-27. I want to expand it slightly. What steps does MVP take to make costs and contracts to approve affordability, quality, and access to care?

MR. BACHNER: Sure. So as I say in my prefinal testimony, MVP engages in a competitive bidding process whenever we're exploring the utilization of a new vendor. That vendor might be for IT services, or that vendor might be for, excuse me, case management services. We have this competitive bidding process, but a major part of that competitive bidding process is not just who is the lowest cost vendor. We have recognized that they might not be -- that may not provide the best outcomes for our members.

So part of that competitive bidding process doesn't just blend -- it doesn't just say who is the lowest cost, who will promote the most affordability, it also says who will get the job done the best, right. If we're installing a new ESRD case management program, right, will they truly increase the members quality of care that they receive? Will they be able to help the member increase their access to

the dialysis centers that they need?

So MVP is working through these cost-effective contract negotiations and competitive bidding process, but it's not just a race to the bottom, right, we're also taking into account quality and access to care in that decision making. I specifically said we might look at information technology IT vendors as a big part of that.

MVP internally has already worked on our lean initiatives where we said we want to try to cut out as much inefficiency as possible within the system, right. We've determined that inefficiencies cost the company money which ultimately leads to higher premium rates. Inefficiencies also can disrupt a member's care, right. If you think about a manual process that might be ranked with error, and nobody wants their health insurer to make an error either on their behalf or not on their behalf, it increases the uncertainty of the health insurance we provide. So MVP has taken -- undertaken these lean initiatives to try to remove inefficiencies out of processes to try to increase automation and stay away from manual processes.

So we recognize that health care is moving so rapidly in terms of information technology, and while we may have to spend slightly in our administrative expense in order to increase that, we ultimately view those investments as a win for the consumer, over the long term will lead to lower premium rates, will also lead to increases and access in quality of care.

MR. KARNEDY: Thank you. Would you please go to Exhibit 12, and let me know when you're there.

MR. BACHNER: I'm there.

MR. KARNEDY: So this was an objection -- a response to an objection letter from the Board, and item No. 1 on page 1 makes reference to a well-being reimbursement program. Do you see that?

MR. BACHNER: Yes.

MR. KARNEDY: Would you please tell the Board about that and how it provides affordability, quality, and access to care?

MR. BACHNER: Sure. So MVP's well-being reimbursement program is offered on all of our non-standard plans within a small

group in the individual marketplace. It's not offered on our standard plans due to some federal regulations, but on our non-standard plans, MVP has revamped the well-being reimbursement program over the past couple of years, and we now offer $600 per subscriber per year to be reimbursed. So the member will submit whether it's an online -- it's a paper claim. They can mail it to us, they can email it to us, we can receive it electronically. They say here's my receipt for the thing I purchased and they can get reimbursed for it.

MVP recognizes that health is not just the health care that you receive that MVP pays for directly, right, our health often times starts at our decision making, even before we've gone to the doctor. It's also heavy influenced by stressors in our life. It's heavily influenced by any number of what we call co-morbidities. And so MVP has increased the different categories that fall into this well-being reimbursement in order to account for that.

So I'll use the mind and spirit category for instance. MVP will reimburse for stress reduction classes or mindfulness apps.

We'll reimburse for things that we have identified while they may not be true healthcare claims costs, they are certainly integral in a member of managing their health and ultimately becoming healthier.

This well-being reimbursement program stays true to the fact that we want our members to be healthy, not necessarily to receive as much care as possible. Ultimately, if our members are healthier, their premium rates are lower and everybody wins. So we've undertaken this well-being reimbursement program, we've revamped it in order to include not just explicit things that you might think of in terms of your health but truly focusing on the entire person and their entire well-being.

MR. KARNEDY: Thank you very much. Would you please go back to Exhibit 16, your prefile testimony, and go to question 29. And let me know when you're there. Question 29.

MR. BACHNER: I'm there.

MR. KARNEDY: So this is a question about use of current technology to manage costs and improve affordability, access to care, and quality to care. Would you please

expand about this?

MR. BACHNER: Sure. So as I've spoken previously, we have our GM mobile app, which is our members primary way of accessing the telehealth for their MVP plan. It also contains a bunch of information in terms of who they can go see for doctors, managing their care, what their deductible co-insurance co-payments are. We have identified the fact that we're all moving towards this mobile society. I do very little on my computer anymore that's outside of work. Mostly everything is in terms of an app.

So MVP has rolled out this app that will help people access the care that they need and really help them to -- you know, we talked about access and quality and affordability, this makes it as easy as possible to access all of these different pieces of the healthcare system so that they may -- it may drive all of those categories.

MVP still has our website; however, we recognize that some people do still use the website. And in particular on our website, we have this shop for a plan tool, we have cost transparency tools. So these are

things where MVP has recognized that people want access, not just access in terms of providers but also access in terms of data, access in terms of understanding how much things are going to cost.

We're continuing to increase our ability and allowing members to look at those costs prior to receiving a service. There's no panacea so that will make it so that a member will know with hundred percent certainty what they're going to pay for when they go in to receive a service, but we're working towards that. And these cost transparency tools have really helped us to also drive members towards quality providers. So when you go into the cost transparency tool and you look up, for instance, an MRI, I need to get an MRI, you will see the cost of that MRI from many different providers who also see a quality stamp on some of those providers which will say MVP certifies that this provider is of supreme quality, and that is another data point that a member can take into account.

All of these tools are really helping the member to take initiative in terms of their care and help find the care that is right

for them.

MR. KARNEDY: Thank you. Moving on to Q-30. How does MVP increase affordability, access, and quality of care by helping lower the cost of premiums for subscribers? Could you explain that please.

MR. BACHNER: Sure. So MVP, there are really two areas particularly for individual insurance where MVP is working to increase affordability by lowering the cost of premiums. And both of those are statutorily required, they're apart of the federal Affordable Care Act, so certainly MVP is not unique or alone in helping to drive these, but we are a partner in trying to help reduce the cost of premiums as much as possible.

So the first one of those two tools is the cost-sharing reduction program. So cost-sharing reduction allows members who are of lower income to receive discounts on their services that they get so their lower deductibles, lower out of pocket maxes, lower co-pays, and coinsurances. That program was not funded after 2017 by the federal government, so MVP, along with partners at DIVA, DFR, the Green

Mountain Care Board, Blue Cross, have all developed a silver loading strategy which will help to make sure that the members receive the benefit of those cost-sharing reductions without having to take on the added cost of the federal government defunding them. So this has been driven through increases to the advance premium tax credit, which is the other piece of the puzzle here.

So the advance premium tax credits are once again premium tax credits that are given to lower income individuals. You can see up to 500 percent of the poverty level. And effectively what these premium tax credits do is they cap a member's premium rate as a percentage of their income and that's on a sliding scale, so lower income will pay a lower percentage of their income and premium.

And then it builds this tax credit. So it says you will not pay -- if you pick the specific plan that it's designed for, you will not pay more than this percentage of your income in terms of premium, but it also gives members choice. It also allows them, for instance, this year we'll see members up to 400

percent of the federal poverty level will be able to get a bronze plan design for free. So certainly, we don't want all of our members buying bronze plan designs with the high deductibles that come along with them, but if they're individuals who are younger and healthier and say I can withstand a higher deductible, I have a unique financial situation, they can, for instance, buy down to that bronze plan and get it for free. They can also buy up in terms of somebody who might need more complex care they can get a platinum plan or a gold plan for cheaper than what they otherwise would be able to.

So these increase affordability vary obviously, right, because we're reducing premiums, we're reducing out-of-pocket expenses for the members, but they also increase access to care and quality of care. So, you know, we seen the State has published health service where there is a non-zero percentage of people who are deferring care because they feel like they can't afford it, and MVP doesn't want to see that. It doesn't help the system at all. It doesn't help in terms of managing that person's care. That

person will ultimately likely have to incur greater claim costs down the road because they've deferred that care one time. So this is when we designed the system and maximized the way in which the system works, it helps not describe access to care, quality of care, it obviously drives affordability as well.

MR. KARNEDY: Thank you. Going to Q-31. Could you explain the implemented fixed perspective payments and how work on that is used to increase affordability, access, and quality of care?

MR. BACHNER: Sure. So MVP has partnered in some talks in developing Vermont's application for the CMS ahead model which will institute fixed prospective payments for Vermont hospitals. My understanding is that the state of Vermont was chosen for that head model, so MVP will continue to partner in those discussions. Fixed prospective payments for Vermont hospitals will move away from what is a so-called fee for service model of care where a hospital provides a service, they bill MVP for that service, and then they are paid for that service, and it will help align, for instance, conditions. So the hospital

might get paid for a certain condition. They might get paid a global budget for the members that they are expected to see within a given time frame. So it helps the hospitals to partner in with the insurance companies in reducing the amount of utilization that is inherent within the system. It helps a hospital to work within a given budget, have some financial skin in the game in order to decrease costs overall.

MR. KARNEDY: Thank you. Going to Q-3. What's the main driver of the cost of health insurance?

MR. BACHNER: Sure. So the main driver of the cost of health insurance, as I stated before, only 7 to 8 percent of our premium dollar is costs that are truly controlled by MVP and are truly to fund MVP's specific services; you think of our administrative services, you think of paying taxes, you think of funding our reserves. The other 92 to 93 cents of every dollar goes towards paying claims which include medical claims, it includes pharmacy claims.

Over 45 percent of healthcare costs are incurred through hospitals that are under the Green Mountain Care Board jurisdiction,

so these are significant portions of the premium rate. I would say the overwhelming portion of the premium is driven by medical costs.

MR. KARNEDY: Thank you. How do -- going to Q-35, excuse me. Q-35. I just want to broaden the question slightly. How do stack deductibles impact the affordability and access in quality of care of health insurance?

MR. BACHNER: Sure. So I will first describe what stacked or we call them embedded deductibles are. If you think of a normal health insurance plan, you think of I have a deductible. Well, usually the deductible listed is for a single contract. For a family contract, the deductible is some multiple of the single deductible. So most of our plans in Vermont are two times. So if you're single the deductible is 2,000, your family deductible is $4,000.

So those can be a significant barrier for families in particular, in particular families which have one member within the family who has complex health needs. They have to incur $4,000 worth of claims, in my example, before they receive any sort of coverage. So MVP has

identified this and has moved towards more embedded deductibles within our health plan, which an embedded deductible is we still have that family deductible overall, but each individual member would be capped at that single deductible. So what that would mean for my family in my example is the family's deductible is $4,000 but every individual member only incurs $2,000 worth of claims before they hit the second part of their coverage.

These stack deductibles, it is true that they do increase premiums slightly because the carrier is covering more of the health care than we otherwise would if it was just a what we call an aggregate deductible or a true family deductible, but it increases affordability on the member level.

So we have identified that there are families that are in these situations, right, where they have one member who has significant health needs, and we don't want again the cost to be a barrier to receiving care. So by developing these embedded deductibles, it may be overall an increase to the premium for the services, but for the individual families who need the care and who

are facing huge medical bills, we don't want them to not be able to afford that.

So while it decreases affordability on a macro level, it certainly increases affordability on a microlevel. And that obviously increases quality and access to care as well, right. We don't want a member to say I can't get this service or I can't get this procedure performed for my son or daughter because I can't afford it, that's not access to care, that's anti-access to care. And it doesn't promote quality because it will ultimately lead to worse outcomes down the road.

MR. KARNEDY: Thank you. If you go to Q-36 please. What drives the cost of MVP's medical plans, and how does that impact affordability, access, and quality of care?

MR. BACHNER: Sure. So first to just set out what the medical plans are, so these are federal guidelines. We have to make sure that our plan designs fit within a calculator that is published by the federal government, and they say that in general what is called a bronze plan would be 60 percent actuarial value, silver is 70, gold is 80, and platinum is 90. Now,

actuarial value is essentially how much of the claim cost is covered by the insurer versus covered by the member in terms of their out-of-pocket cost.

So a platinum plan, for example, 90 percent AV means that 90 cents of every claim dollar is taken on by the insurance company as incurred claim expense and the other 10 cents is paid by the member through deductibles, co-insurance, co-pay, and their out-of-pocket max, all the way down to a bronze plan where 60 percent is covered by the company, 40 percent is covered by the member.

So within these buckets, we have to fit very neatly within these actuarial value ranges. So just to use an example, our platinum plan has to fall between 88 percent AV and 92 percent AV. So they're significant limitations in terms of that the federal guidance and how we can structure our plans in order to provide for our members. There are plan designs that we could explore that would be more beneficial to our members, however, we can't do them because of these guidelines that are put in place. So that certainly impacts access to care and quality of

care if we can't get the members -- if we can't tailor the coverage to the members in some sense, then that will lead to adverse outcomes.

MR. KARNEDY: Thank you, Eric. Eric, would you go to Q-38 please. I think we've already talked about this, I just want to clean up the record. See the answer to 38, there's a paragraph number 2 or clause number 2 and it says increasing commercial process. Do you see that?

MR. BACHNER: Yes.

MR. KARNEDY: Should that word be prices?

MR. BACHNER: I would agree with that, yes.

MR. KARNEDY: Great. If you would then go please --bear with me -- to Q-40. Q-40 is what venues other than insurance rate review -- than the insurance rate review process are better suited to address affordability, access to care, and quality of care? Would you please answer that.

MR. BACHNER: Sure. So we've identified a couple of places where the statutory criteria might be better or might be more impacted. One of those is the product design

process. So as I just talked about our products are having to fall very neatly within these medal levels. But just to go over the timing of that, in late 2024 early --excuse me -- late 2023, early 2024, January, February, we have to come up with our plan designs for 2025. We have to develop them with this calculator in mind, then we have to submit those first to the Green Mountain Care Board for approval, particularly if we're trying to increase cost sharing on any one particular service above a threshold. We then have to file those with the Department of Financial Regulation. They have to be approved in terms of here are the types of services that are going to be covered, make sure everything is statutorily in order. We also have to file those with the federal government.

So by the time we get to our premium rates in May and now sitting here at the hearing in July, many of those product designs have already been designed, they've already been approved. All of this stuff have already been baked into the cake, as it were. So MVP really feels like doing any sort of product changes or cutting things or trying to talk about

affordability now, those discussions should be had in the product design process where we can better design products that will ultimately be beneficial to the members will increase the access to care, quality of care, and affordability.

The other one is the hospital budget system. I mean, as I said earlier, we don't know necessarily what the hospital budgets will be for 2025 prior to setting our rates and even prior to having the rates approved. MVP feels like the cost, the overall cost driver, as in terms of hospital care that are for the hospitals under the Green Mountain Board jurisdiction, managing the cost of that care is better suited for the hospital budget process. You know, we've identified the hospital budgets are approved, and unfortunately, because of how they're approved and the nature by which they're approved, those rate increase percentages often start as the floor of a negotiation rather than the ceiling, so it's difficult for MVP and there's limited amount of leverage to go and reduce claim costs below what has already been set by the Green Mountain Care Board during their

hospital budget process.

MR. KARNEDY: Thank you. And I have just a straight -- that was really helpful, but I have a straight question. You talked about the product design process. Is DIVA involved in that as well, or am I mistaken?

MR. BACHNER: Yes, in some sense, yes.

MR. KARNEDY: In what sense?

MR. BACHNER: They have to also approve the plan designs that are filed is my understanding.

MR. KARNEDY: Okay. Thank you. I'm going to Q-44. How does Vermont Health Connect define the term affordable?

MR. BACHNER: Sure. So if you go to the Vermont Health Connect website, they determine whether a plan is affordable based on how much of a person's income is required to pay for the lowest cost plan.

MR. KARNEDY: So does -- is it fair to say that that website the Vermont Health Connect looks at it on a case-by-case basis based on the individual or the family?

MR. BACHNER: That's correct.

MR. KARNEDY: And are there certain federal poverty levels that come into play?

MR. BACHNER: Yeah. So, you know, in determining what plan is affordable, that criteria has already largely been set by the federal government in terms of their premium cutoff points for their advance premium tax credits. So when, for instance, when we say whether a plan is affordable or not, that has already largely been taken out of our hands in terms of what is set by the federal government.

MR. KARNEDY: And then the state of Vermont has stepped in and also provide subsidies, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Then there's subsidies -- well, just generally speaking, Medicare and Medicaid help folks pay for their healthcare costs, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: I'm going to Q-49. Almost done. I appreciate your patience. This is about COVID-related services in 2025. Can you tell the Board about that?

MR. BACHNER: Sure. So assumptions that are specifically related to COVID within our 2025 rate filings, we do have to decrease our costs slightly for the unwinding of the public health emergency. So certain services that were previously covered in full by the insurance carrier are now covered by the member. The other big change is that back in the fall of 2023, insurers have been required to start paying for the ingredient costs for COVID vaccines, so it did make an assumption that the cost of a COVID vaccine for 2024 and 25 will increase from $40 to $140 to capture that ingredient cost.

So there are some moving pieces in terms of COVID that's still in our rate filing, however, these are ultimately relatively small in terms of the overall premium rate increase.

MR. KARNEDY: Thank you. So I'd like to step away from your pre-filed testimony and ask you about cost shipping. If you could explain that issue to the Board and give an example.

MR. BACHNER: Sure. I will do my best to try to explain it. So if you are a

hospital, you need a certain amount of revenue to perform all of the services that you need to do, right, so you think about having to pay your nurses and doctors, you think about having to increase your technology, pay for medical devices and implants, and those sort of things. That pool of money comes from many different sources. It comes from the commercial carriers who are paying claims, it comes from CMS in the Medicare program, and it comes from the State of Vermont and the Medicaid program.

So that revenue is coming from all different sources, and unfortunately, not all those sources have the same ability to negotiate their rates with the hospital or the hospital doesn't have the same ability to negotiate the rates with each of those different pieces. So CMS largely says here's what we're going to pay for a given service next year, Medicaid says here's what we're going to pay for a given service next year, and if the revenue achieved from those services is not sufficient to cover the cost of those services, then the hospital needs to get that money from somewhere, and it ultimately falls to the place where the one rates

being negotiated, and that is with the commercial rate payers.

So to give you a perfect example of this, there was a hospital this year, and in their proposed hospital budget, and I won't name the hospital here, they said that our commercial rate increase was going to be X, but since then, Medicaid has said that they will not pay anymore for service in 2025 than they did in 2024, their increase will be zero, therefore, we now need to request X plus 2 percent. I'm not sure of the exact numbers, but it's a statement that comes right out and points out this cost-ship which is basically if Medicare and Medicaid don't pay -- don't increase their payments with what the hospital incurs in terms of costs, they have to get that money from somewhere else, and it ultimately falls to the commercial insurers.

MR. KARNEDY: Thank you. Now I'd like to just shift to the last section which is to walk through the statutory criteria with you, you do each year.

MR. BACHNER: Okay.

MR. KARNEDY: So MVP's proposed rate is modified by your testimony and other

evidence for individuals of 15.89 and small group of 12.81 percent which includes the hospital budgets increases if approved by the Board. Are those two amounts actuarily sound and reasonable?

MR. BACHNER: They are.

MR. KARNEDY: So let's go through the particulars. And I'm referencing both filings when I ask you these questions, okay, Eric?

MR. BACHNER: Okay.

MR. KARNEDY: Based on the rate filing and other evidence in your testimony today, they all support a conclusion by the Board that MVP's rates meet the standard of affordability, correct?

MR. BACHNER: They do. That's correct.

MR. KARNEDY: Does the rate filing -- rate filings, excuse me, other evidence in your testimony today support a conclusion by the Board that the rates promote quality of care and access to health care?

MR. BACHNER: They do.

MR. KARNEDY: Do the rate filings, other evidence in your testimony today support a

conclusion by the Board that the MVP rates are not unjust, unfair, inequitable, misleading, or contrary to law?

MR. BACHNER: They do.

MR. KARNEDY: Are the rates reasonable based on the data that we have?

MR. BACHNER: Yes, they are reasonable.

MR. KARNEDY: Are the rates actuarily sound and fairly charged premium for services covered?

MR. BACHNER: Yes, they are actuarily sound.

MR. KARNEDY: Are the rates excessive, inadequate, or unfairly discriminatory?

MR. BACHNER: No, they are not.

MR. KARNEDY: Are the rates reasonable relative to the benefits that are offered?

MR. BACHNER: Yes, they are.

MR. KARNEDY: Do they provide for payment of claims, administrative expenses, taxes, regulatory fees, and have reasonable contingency or profit margins?

MR. BACHNER: They do.

MR. KARNEDY: So they are adequate?

MR. BACHNER: They are adequate.

MR. KARNEDY: Do the rates exceed the rate needed to provide for payment of claims, administrate expenses, taxes, regulatory fees, and reasonable contingency and profit margins?

MR. BACHNER: No, they do not.

MR. KARNEDY: So they're not excessive?

MR. BACHNER: Correct, they are not excessive.

MR. KARNEDY: Do the rates result in premium differences among insurers with similar risk categories which are not permissible under applicable law and do not reasonably correspond to differences and expected costs?

MR. BACHNER: They do not.

MR. KARNEDY: So they're not unfairly discriminatory?

MR. BACHNER: Correct, they are not unfairly discriminatory.

MR. KARNEDY: Thank you. So L&E is proposing, as the evidence shows, an increase

in the proposed rates that MVP proposed, right?

MR. BACHNER: That's correct.

MR. KARNEDY: And there's no actuary who's based on the evidence, what's in evidence as of this moment, there's no actuary supporting cuts in the MVP proposed rates this year, correct?

MR. BACHNER: That's correct.

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

MR. BACHNER: I would.

MR. KARNEDY: And as an actuary, would you agree you shouldn't silo the criteria?

MR. BACHNER: Yes, I would agree.

MR. KARNEDY: Any adjustment for rate increase, for whatever reason, all feed into the final number, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Is it important that the final number is actually sound and reasonable?

MR. BACHNER: Yes, it is important.

MR. KARNEDY: In this case, the

15.89 for individual and the 12.81 for small group, in your opinion, do those proposed rates provide -- are they sufficient for the Board to conclude that MVP has met its statutory criteria along with the evidence?

MR. BACHNER: Yes, I believe they're sufficient.

MR. KARNEDY: If the Board cuts the final number on non-actuarial grounds, is there a risk that rate would no longer be adequate?

MR. BACHNER: Yes, there is a risk the rate would no longer be adequate.

MR. KARNEDY: MVP has had losses over the past few years, correct?

MR. BACHNER: That's correct.

MR. KARNEDY: Are continued losses in Vermont's small group and individual products sustainable?

MR. BACHNER: No, they're not sustainable.

MR. KARNEDY: Do reasonable not-for-profit plans need to remain profitable in order to serve the communities they live in?

MR. BACHNER: Absolutely.

MR. KARNEDY: That's all the questions I have at this time.

HEARING OFFICER BARBER: Okay. Mr. Becker, do you need a minute or are you ready to?

MR. BECKER: I think I'm ready --

HEARING OFFICER BARBER: Okay. Then go ahead please.

MR. BECKER: -- witnesses. Yep. Yep. Okay.

MR. BECKER: So hi, Mr. Bachner, it's good to meet you.

MR. BACHNER: Hello.

MR. BECKER: So this is your first year testifying in one of these hearings it sounds like?

MR. BACHNER: Yes. I've been in attendance for a couple of them, but my first year testifying.

MR. BECKER: Okay. Well, this is only my second year doing these hearings myself, and I was only in attendance in one beyond that, so we're both still relatively new to these hearings at least, okay. I have quite a bit of ground I want to cover with you. Quite a bit of

it is technical, as you can imagine. I'm also going to try to run through some calculations with you, we'll see how that goes. I'll do my best to direct you to the relevant exhibits using, you know, the MVP binder that you have and the -- using the red Bate-stamped numbers at the bottom of the pages that you're familiar with.

But if you're ever not sure what I'm referring to or what I'm asking, please let me know.

MR. BACHNER: Okay.

MR. BECKER: Sound good?

MR. BACHNER: Sounds good.

MR. BECKER: All right. So to start, if I could have you turn to Exhibit 15, Bates page 10, page 10. Let me know when you get there.

MR. BACHNER: I am there.

MR. BECKER: Okay. So this document is MVP's 2023 supplemental health care exhibit; is that right?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And so just very generally, what kind of information is contained in this document?

MR. BACHNER: Sure. So I do understand this is -- I may have said MVP health care, this is MVP health plan specifically, so one of the companies that is under MVP healthcare jurisdiction. But this document contains for the year 2023 information on premiums, claims, some administrative expense, and the underwriting gain and loss, and some other information about the number of lives that are covered, and some other information.

MR. BECKER: Perfect. Thank you so much. So and the first 3 pages of these exhibits so that's New York, MVP's business in New York; is that accurate? If you look on the left --

MR. BACHNER: Yes.

MR. BECKER: -- left of the page. Yeah. Okay.

MR. BACHNER: Yep. That's correct. Yeah, the first three pages are for New York, correct.

MR. BECKER: Okay. And then next three pages, that's 13 through 15, are those specific to MVP's business in Vermont?

MR. BACHNER: Correct.

MR. BECKER: Okay. And then the final three pages, 16 through 18, these are MVP's entity-wide numbers, right, so that would be essentially New York and Vermont being added together?

MR. BACHNER: That's correct.

MR. BECKER: Okay. All right. So then if I could have you turn to page 17, and the vertical text on the left side of the page, what does that say?

MR. BACHNER: It says supplemental 216.2 grand total.

MR. BECKER: Okay. Grand total. So then this is the entity-wide data we were talking about the New York and the Vermont added together, right?

MR. BACHNER: That's correct.

MR. BECKER: Okay. So now row 13, could you tell me what number or sound in row 13, what the label is for row 13?

MR. BACHNER: Sure. Row 3 is net investment and other gains/loss.

MR. BECKER: Okay. So the numbers reported in this row are MVP's entity-wide investment gains or losses; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And so just so I understand, MVP as a company has investments like a person like you or I would have investments; is that accurate?

MR. BACHNER: That's accurate.

MR. BECKER: Okay. And some years MVP makes money on its investments and some years it might lose money on its investments; is that accurate?

MR. BACHNER: Yes, that's accurate.

MR. BECKER: Okay. So for 2023, if I could have you read the number from column 15 which is labeled total.

MR. BACHNER: Sure. So that number is 13,436,184.

MR. BECKER: Okay. So in 2023 MVP is reporting that it made 13.4 million on its investments' entity wide; is that correct?

MR. BACHNER: That's correct.

MR. BECKER: Okay. So MVP's business in Vermont, we've already heard some testimony about this, that it's not a very large share of MVP's business. Do you know the figure

off the top of your head of what percent of premiums come from Vermont, and if not, I can point you to an exhibit where it says.

MR. BACHNER: I think it was around 9 percent. That was quoted in L&E's memorandum.

MR. BECKER: That's correct, yep. So and here's one of the calculations I want to run through. So 9 percent of 13.4 million, I could tell you what I arrived at, or do you -- would you prefer to -- do you have a calculator; I don't know?

MR. BACHNER: I don't have a calculator. I mean, I estimate it, or if you'd like an exact number, I can do that.

MR. BECKER: So what I did is I did 9 percent of 13.4 million. I didn't do the whole number, I rounded it to 13.4, and what I got was 1.2 million. Does that sound --

MR. BACHNER: That sounds reasonable, yes.

MR. BECKER: Okay. All right. Now if I can have turn back to Exhibit 15, page 14, and the vertical text on the left side of the page that says -- what does that say here?

MR. BACHNER: Supplemental to 16.2, Vermont.

MR. BECKER: Okay. So if you go to row 13, column 15, what is the total amount of investment gains or losses listed for Vermont?

MR. BACHNER: That would be zero.

MR. BECKER: Okay. So could we assume then that the entire 13.4 million in investment gains and losses is allocated to New York in this exhibit? And we can go to -- I can direct you to page 11 where that number is found if you'd like to just verify that.

MR. BACHNER: No. Yes, I can see that. That is correct based on this file.

MR. BECKER: Okay. Okay. So back to page 14, the Vermont numbers, row 15, what is row 15?

MR. BACHNER: Row 15 is the net gain or loss.

MR. BECKER: Okay. So the figures in this row are what MVP reports to be their losses in Vermont in 2023, correct?

MR. BACHNER: That's correct.

MR. BECKER: And then the number in column 15 of row 15 is what?

MR. BACHNER: Negative 34,763,287.

MR. BECKER: Okay. So MVP is reporting losses in Vermont in 2023 of 34.7 million; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: Okay. Had you, and it's not the case, but had you proportionately allocated -- had MVP, not you. You probably didn't submit these financials, but had MVP proportionately allocated the investment gains to Vermont, so 1.2 million proportionately, what would MVP's losses in Vermont have been in 2023 then?

MR. KARNEDY: I'm going to object to the question. It just calls for speculation. He hasn't established that this witness prepared this document, and he's asking him to do math on the fly, so I would object to the question.

MR. BECKER: It certainly doesn't call for speculation, it calls for him to do some simple mathematics one number minus another. 34.7 million minus 1.2 million.

MR. KARNEDY: I stand by my objection.

HEARING OFFICER BARBER:

Objection overruled. I agree it doesn't call for speculation, so if you could provide that number, Mr. Bachner.

MR. BACHNER: Sure. So that number would be approximately $33.5 million loss.

MR. BECKER: Okay. It's still a large amount of losses, but it would have been, you know, just a little bit smaller. Okay. Now let's investigate those losses a little bit, and I -- you know, this exhibit, we can stay on this exhibit, and particularly, we can stay on page 14. If you could go to row 11, what's in row 11?

MR. BACHNER: So row 11 is the underwriting gain or loss.

MR. BECKER: Okay. And briefly, since pretty much all the figures in this row are losses, when you have an underwriting loss, does that mean you paid out more in claims than you collected in premiums?

MR. BACHNER: That's correct. Underwriting loss would include administrative expense, so it would be we paid out more in claims plus administrative expense than we collected in premium.

MR. BECKER: Okay. Thank you. So

column 1, that's the individual market, it's labeled individual market, correct? That's your individual group business here in Vermont?

MR. BACHNER: That's correct.

MR. BECKER: And what did you report for losses in the individual market?

MR. BACHNER: $3.2 million.

MR. BECKER: Okay. And column 2 is the small group; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: And what was reported as losses in the small group?

MR. BACHNER: $11.7 million approximately.

MR. BECKER: Okay. And in column 3, MVP reported some small-ish losses in the large group. Could you read the number there in column 3?

MR. BACHNER: Sure, it's approximately a $300,000 loss.

MR. BECKER: Okay. If I said to you that I added those numbers up and it was 15.2 million in losses, would you agree that that was the correct number?

MR. BACHNER: That looks

reasonable, yes.

MR. BECKER: Okay. So that's -- is that fair to say that that 15.2 million is less than half of the 34.7 million in total losses reported by MVP in Vermont in 2023?

MR. BACHNER: That's fair.

MR. BECKER: Okay. Here's where things might go off the rails, but let's give it a try. Can we calculate what the losses might be on a PMPM basis? So we do have the member months at the bottom of this table. In columns 1, 2, and 3, we have the member months listed for those three groups we just went through, right?

MR. BACHNER: Yes.

MR. BECKER: And if I told you I did the math and I ended up the 130,000 and the 192,000, and 18,000 and came up with 341,166 member months, does that sound about accurate?

MR. BACHNER: That sounds correct.

MR. BECKER: Okay. And so if we took the 15.2 million in reported losses in the individual small group and large group and divided that, are you able to tell us what that is on a PMPM basis, or should I give you my calculation?

MR. BACHNER: You can give me your calculation or I can pull up a calculator, but.

MR. BECKER: $44.55 per member per month.

MR. BACHNER: Okay. That sounds reasonable.

MR. BECKER: Okay. Now if we could go -- still on the same page, still in -- well, we're going to go over to column 12, and I'm going to ask you to tell me what is in column 12 first of all. What is column 12 labeled?

MR. BACHNER: Column 12 is our Medicare advantage business which includes Medicare advantage Part C and also Medicare Part D stand-alone coverage.

MR. BECKER: Okay. And what are the underwriting losses reported in row 11 in your Medicare advantage Part C line of business and Part D?

MR. BACHNER: Approximately, $19.6 million.

MR. BECKER: Okay. And is it accurate so we -- to say that that's 4.4 million more roughly, that 19.6 million is 4.4 million more than the losses we identify in the

individual small group and large group?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And could we attempt to do the PMPM calculation again? So we have the 19.6 million in losses, and down at the bottom of the column, is that 67,051 member months?

MR. BACHNER: Yes, that's correct.

MR. BECKER: And if we were to divide those two numbers, the PMPM, if I were to tell you that was $292.31, does that sound about right to you?

MR. BACHNER: That one I would have to check. I'm not that good in my mental math, so. Am I allowed to confirm that?

MR. BECKER: I mean, if you have a calculator handy. Mr. Barber?

HEARING OFFICER BARBER: Yes, if you have a calculator handy. I think he's asking for a calculation, and I'm not sure that Mr. Bachner's statements are evidence. So yeah, if you have a calculator, if you could pull it out please.

MR. BACHNER: Sure. I'm getting to approximately $292 on a PMPM basis.

Okay. So which of these columns on this page does the GMCV have oversight of?

MR. BACHNER: So the Green Mountain Care Board has oversight of columns 1 through 3.

MR. BECKER: Okay. So that's $44.55 PMPM losses on the GMCV regulated products; is that accurate?

MR. BACHNER: Yes.

MR. BECKER: And 292 approximately you said PMPM losses on the non-GMCV regulated products; is that accurate?

MR. BACHNER: Yes.

MR. BECKER: Okay. I'm going to shift gears here for a little bit. If you could turn to Exhibit 16.

MR. BACHNER: Okay.

MR. BECKER: So this is your pre-filed testimony; is that right?

MR. BACHNER: That's correct.

MR. BECKER: You just spent some time going over quite a few of these questions with your attorney. I'm not going to -- in fact, I was keeping track. There's not a lot of overlap here, which is a good thing. So quite a

bit of this pre-filed testimony, is it fair to say is contained beginning on page 7 under this heading 3, non-actuarial criteria; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And a lot of the way, if you were to flip through here, the questions are worded, they speak to promoting affordability or increasing affordability or improving affordability. Is that the legal standard as you understand it?

MR. KARNEDY: Objection. The document that he's referencing and the paragraphs he's referencing don't just reference affordability. We went through that testimony at great length, so I would object to the question is framed.

MR. BECKER: I could reframe the question.

MR. KARNEDY: Thank you.

MR. BECKER: What is the witness -- Mr. Bachner, what do you understand to be the non-actuarial review criteria here in Vermont?

MR. BACHNER: My understanding

would be that it's to promote affordability, access to care, and quality of care, do the rates promote those things.

MR. BECKER: Okay. I just -- for the record, I mean, I would note that the actual statutory standard is whether the rate is affordable and then promotes access to care and promotes quality care, just for the record.

Does MVP have any internal metrics or benchmarks to gauge whether a proposed rate is affordable?

MR. BACHNER: I think the answer to that would have to be no, we don't have anything that directly determines whether or not a rate is affordable.

MR. BECKER: Okay. And as an actuary, do you feel competent, and I'm using that in the legal sense, to testify about whether a rate is affordable?

MR. KARNEDY: I'm going to object. It calls for a legal conclusion, he's not a lawyer.

MR. BECKER: I believe we heard testimony about your qualifications as an actuary earlier. Are actuaries trained to judge

affordability?

MR. BACHNER: I would say --

MR. KARNEDY: Just so we're clear on the record, so you're withdrawing the question and asking a different question, Charles? I don't want to --

MR. BECKER: Yeah, I think that's what I did, Mr. Karnedy, yes.

MR. KARNEDY: Thanks.

MR. BACHNER: Specifically, no, there's no actuarial training for determining whether a rate is affordable.

MR. BECKER: Okay. All right. So I am going to go through, as I said, a few of your responses. There is not a lot overlap what we've gone over previously, so and it's -- yeah, so let's get started. If you could turn to page 13 which is has question 27 on the page. Are you there?

MR. BACHNER: Yes.

MR. BECKER: And question 27 reads, "What steps does MVP take to manage costs and contracts to improve affordability"; is that is right?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And you said beginning on line 12, MVP negotiates rates that reflect appropriate reimbursement levels across all provider types and MVP's network. Is that what your testimony was?

MR. BACHNER: That's correct.

MR. BECKER: Okay. Quickly, if I could have you turn to Exhibit 1, which is your actuarial memorandum, specifically page 5 of Exhibit 1.

MR. BACHNER: Okay.

MR. BECKER: And I'm not using the Bates numbers appropriately here. Oh, uh-oh. If I could take a second here. I actually mean I would refer you to page -- it's page 5 of the actuarial memorandum, Bate stamped page 37, I'm sorry.

MR. BACHNER: Okay. I am there.

MR. BECKER: Okay. So under the heading medical trend factors, the first – the second paragraph, could you read the first sentence there beginning for Vermont providers?

MR. BACHNER: I don't see a medical trend factors on Bates page 13. Is it Bates page 11, page 3 of the memorandum?

MR. BECKER: My fault. I told you I was going to use the Bate numbers and then I didn't do it. So we're on Exhibit 1, Bates page 37. 37, I'm sorry.

MR. BACHNER: Okay. I'm there now. Thank you.

MR. BECKER: All right. You found medical trend factors in the middle -- around the middle of the page?

MR. BACHNER: Yes, that's correct.

MR. BECKER: Okay. Could you read that sentence beginning "for Vermont providers"?

MR. BACHNER: "For Vermont providers whose contractual reimbursement changes are governed by the Green Mountain Care Board, MVP is reflecting the Green Mountain Care Board's most recently approved budget of changes as the unit cost trend for 2024. We are using approved" -- excuse me - "2024 increases" --

MR. BECKER: No.

MR. BACHNER: Sorry.

MR. BECKER: Yeah, I'm sorry. That's perfect. I just wanted you to read that first sentence. A lot of work for not very much because I'm going to have you flip now to Exhibit

24. Sorry for having you flip around here.

MR. BACHNER: Okay. I'm there.

MR. BECKER: And on page 2, so these are charts showing your derivation of medical cost trend by facility; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: And while most of the information on this page is confidential, the notes column is not confidential; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: Looking at this page, what is the most common note you see?

MR. BACHNER: The most common note I see would be the Green mountain Care Board rate effective 10/1/2023.

MR. BECKER: Okay. So taking into consideration this information here and what you read from your actuarial memorandum on page 5, would it be reasonable to conclude that MVP is largely not able to negotiate rates for GMCV regulated entities below the GMCV ordered rate cap?

MR. BACHNER: I'm not involved in our contracting directly, but that's my

understanding from discussions with our network team.

MR. BECKER: And I think I heard you testify earlier that the hospital budget rates are perceived as a floor not a ceiling. Did you say that just a little bit ago?

MR. BACHNER: That's generally true, correct.

MR. BECKER: Okay. Thank you. Again we're going to shift gears here again back to your pre-filed testimony which is Exhibit 16. If I could have you turn to Q-30 which is on page 16.

MR. BACHNER: Okay.

MR. BECKER: Okay. So Q-30 here reads, "How does MVP increase affordability by helping lower the cost of premiums for subscribers"; is that right?

MR. BACHNER: That's correct.

MR. BECKER: And this is one you actually did go over earlier with your attorney; do you remember?

MR. BACHNER: Yes.

MR. BECKER: Okay. And I just want to preface this here by saying I -- okay.

Strike that. I'm going to strike the preference and just go into my questions. Is it fair for me to say here that to summarize your response as MVP helps its members to get PTC and enroll them in cost-sharing reduction plans when they are liable; is that in essence what the response is here?

MR. BACHNER: I would say that the response is partially that and partially that we participate in these programs which enables members to obtain those things.

MR. BECKER: Are you able to not participate in the programs?

MR. BACHNER: I don't think so, but that is a --

MR. BECKER: Okay. All right.

MR. BACHNER: We are still doing it.

MR. BECKER: Yep. Is it fair to point out too that the PTC, the premium tax credits, and the cost-sharing reductions only exists in the individual market; is that accurate?

MR. BACHNER: That is true.

MR. BECKER: And in the small

group market, employers and employees share the full cost burden of any premiums and premium increases; is that a fair statement?

MR. BACHNER: That's correct.

MR. BECKER: Okay. Back to the substance of response, there were a few things in this response that I found confusing and so I want to ask you about them and hopefully we can clarify them. And actually, I think it's going to make the record clearer here. The figure 500 percent FPL comes up three times in this response, and it's not immediately clear to me why. So, for example, on line 20 of page 16, it says, "MVP reduces out-of-pocket costs for enrollees and earning from 100 percent to 500 percent of the federal poverty level through cost-sharing reductions." Do you know the FPL level that the cost-sharing reduction level plans end at?

MR. BACHNER: Yeah, I believe that should say 300 percent.

MR. BECKER: Okay.

MR. BACHNER: Specifically related to the cost-sharing reductions.

MR. BECKER: Okay. If I pointed

out that the CSR plans go up to 250 FPL and that Vermont premium assistance goes up to 300 percent, I think that might be what you're referring to as well. Does that sound familiar? Does that sound right to you?

MR. BACHNER: Yes.

MR. BECKER: Okay. All right. And the next reference -- so that clears up that one, so 500 should be 300, that's fair. The next reference to 500 FPL is line 2 on page 17 which reads, "Furthermore, individuals earning at or below 500 percent of the federal poverty level qualify for APTC." Did I read that read that sentence correctly?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And the way I read that, it sounds like 500 percent is a cutoff or a cliff for PTC; is that accurate?

MR. BACHNER: That would be accurate. That would be my understanding.

MR. BECKER: I'm tempted to want to do some more market with you because -- and this is a good thing for MVP. I mean, the PTC goes higher, and it's based on the benchmark plan. We know that premium tax credits are based

on the benchmark, correct?

MR. BACHNER: Yeah, it's based on the second lowest cost, the silver plan, correct.

MR. BECKER: Exactly, which in 2023 was -- do you happen to know roughly what the benchmark cost in 2023?

MR. BACHNER: Not off the top of my head, no.

MR. BECKER: Okay. If I told you it was around $900, would that sound accurate?

MR. BACHNER: I would have to take your word for it, I'm not sure.

MR. BECKER: Okay. Again, this is just for the sake of trying to clarify the record. And it -- I'm not -- this is not a got you for MVP. I mean it's -- the PTC goes higher, which is beneficial for your members. And if I told you it was close to 850 percent FPL for -- for this year until the -- the premium subsidies potentially expire, would you agree that that sounds fair.

MR. BACHNER: I'm not 100 percent certain, I -- I will take your word for it.

MR. BECKER: Okay. All right. Okay I'm going to move on to my final section of

questions, and thank you for bearing with me. If you could turn to page 14 of your pre-file, which has on it question 28.

MR. BACHNER: Sure.

MR. BECKER: So this question is "How does MVP managing prescription drug utilization improve affordability, access, and quality of care?" Did I read that accurately?

MR. BACHNER: That's correct.

MR. BECKER: Okay. Could I have you read the third sentence in your response. So that's starting on line 8 with the words cost containment?

MR. BACHNER: Yes. "Cost containment estimates in the MVP filings are based on our PBMs proven track record."

MR. BECKER: Okay thank you. Now if you could turn to Exhibit 19, and specifically page 9 of Exhibit 19? Are you there?

MR. BACHNER: Yes.

MR. BECKER: Okay. So first do you recognize this exhibit?

MR. BACHNER: I do.

MR. BECKER: Okay. And it's L&E's memorandum about your -- MVP's 2025 individual

rate filing?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And then the top of the page here, there is a chart entitled Historical Allowed RX Trends; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: And in your testimony today, I heard you say that L&E -- I think you phrased it, undertook a study comparing your PPMs projections of RX trend to MVP's actual utilization, or actual trend. Is that -- was that your testimony earlier?

MR. BACHNER: That's correct.

MR. BECKER: All right. And this table that's on page 9, is this the -- the study that L&E undertook?

MR. BACHNER: These are the results of the --

MR. BECKER: That's what this table is?

MR. BACHNER: -- study.

MR. BECKER: The results of it, okay.

MR. BACHNER: Yes.

MR. BECKER: I also believe I -- I

heard you say earlier in your -- in your testimony that, historically, when setting your RX trend in these fillings that MVP has relied on the trend provided by your PBM. Is that accurate?

MR. BACHNER: Yes.

MR. BECKER: And I think you said that you relied on your PBM's trend data with the understanding that they understand the market better than we do; I think you said something along those lines, is that accurate?

MR. BACHNER: Yes that's -- that's correct.

MR. BECKER: Okay. And that reliance on your PBM's trend is consistent in a way with your pre-file testimony; would you agree that your PBM has a proven track record? Would you agree?

MR. BACHNER: That's correct.

MR. BECKER: Okay. So if I'm interpreting this chart correctly, in the 4th column, it shows that your PBM has actually consistently under-projected MVP's RX trend; is that accurate?

MR. BACHNER: That is a fair

statement.

MR. BECKER: Okay. And when we talk about an under-projection, does that mean your prescription drug costs were actually higher than your PBM predicted?

MR. BACHNER: That is true.

MR. BECKER: Okay. And so the best guess at RX trend that your PBM provided you, in the four years listed here on this chart, was an under-projection of 7.6 percent. That was their best guess; is that fair?

MR. BACHNER: That's correct. The lowest number in this table is an under-projection of 7.6 percent.

MR. BECKER: Okay. Meaning that in that best guess year, MVP's prescription drug claims were 7.6 percent higher then what your PBM projected, is that correct?

MR. BACHNER: That's correct.

MR. BECKER: All right. And overall on a four-year average, how much higher was MVP's actual RX trend then what your PBM predicted?

MR. BACHNER: It would be approximately 10.6 percent, as shown on this

table.

MR. BECKER: Okay, thank you. And as a result of these under-projections, L&E is actually recommending that MVP not rely solely on CVS Caremark's provided trend, but that it blend -- the PBM-provided trend with the four-year average of actual RX trend.

Is that what L&E's recommending here?

MR. BACHNER: Well that's my understanding of their recommendation.

MR. BECKER: Okay. And as a result of that recommendation, the RX trends in this filing go up significantly from 7.4 percent, to 13.1 percent in the individual market; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: And then the small group market -- that number is just slightly different; it goes from 7.3 percent to 13.0 percent in small group. Is that accurate?

MR. BACHNER: I would have to look at the --

MR. BECKER: Oh yeah, I'm sorry. It's Exhibit 20, page --

MR. BACHNER: 7.3 instead of --

MR. BECKER: -- 7.

MR. BACHNER: -- of 13 percent.

MR. BECKER: Okay. Thank you. Which increases the overall rates of the effect of that, and I think we've heard testimony about this before today; it increases the overall rate 1.2 percent in the individual market. Is that right?

MR. BACHNER: That's correct.

MR. BECKER: And was it 1.4 percent in the individual market based MVP's calculations?

MR. BACHNER: I believe so, yes.

MR. BECKER: Do you know how much additional premium is represented by 1.2 percent, and 1.4 percent?

MR. BACHNER: Based on Exhibit 27 for 2024, we have $250 million in allowed premium, roughly, that's projected. So that would be -- and one percent of that would be approximately two and a half million.

So it would be somewhere in the neighborhood of three and a half million dollars.

MR. BECKER: Okay. So -- thank

you. L&E recommends that you not rely on your PBM's trend data alone, and asks you for -- asks you to ask for roughly 3.5 million dollars more in premiums to cover prescription drug claims is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: Okay. Which you agree with? I mean MVP has modified their rates to incorporate L&E's recommendation, is -- is that accurate?

MR. BACHNER: Yes.

MR. BECKER: Okay. But when you filed the rates, you were perfectly comfortable relying on PBM -- on your PBM's track record, and -- and to rely on their trend, the trend that they provided. Is -- is that accurate -- when you filed the rates?

MR. BACHNER: Yes I would -- I would say that both are reasonable estimates of pharmacy trend.

MR. BECKER: Okay. And those original trends, when you filed the rates, and you -- you submitted the rate filing, you thought that original trend produced actuarially sound rates; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: Okay. I'm going to take you to Exhibit 12 now. And to page 2 of Exhibit 12. So do you recognize this exhibit as your response -- as MVP's responses to questions from my office?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And do these responses look familiar to you?

MR. BACHNER: Yes.

MR. BECKER: Did you personally draft them?

MR. BACHNER: I did, with the --

MR. BECKER: Okay.

MR. BACHNER: -- with the support of our pharmacy team.

MR. BECKER: Okay. So just looking at question 5, and just taking the first subpart, subpart A, and it asks "Prior to renewing with CVS Caremark, did MVP audit CVS Caremark's performance under the prior contract. If so, describe all aspects of the audit."

Did I read that correctly?

MR. BACHNER: That's correct.

MR. BECKER: Okay. And could I

have you read your response to that subpart? It's the first two sentences of the response.

MR. BACHNER: That response is marked confidential. I don't know if we need to --

MR. BECKER: It is --

MR. BACHNER: -- note that.

MR. BECKER: -- you might have an outdated version of the binder because --

MR. BACHNER: Oh I -- I might, yeah.

MR. BECKER: Mr. Karnedy, could you refer that the response to question 5 is not confidential?

MR. KARNEDY: I can confirm that my copy of it doesn't have a red box around it. But I want to be careful, Charles. So I think you're correct, but Eric, what are you looking at. And when I say that, are you concerned about those first two sentences having something confidential that we've just made an error in marking this.

MR. BACHNER: I think I'm -- I'm relying on the binder that you sent me a week or so ago. So if there was a determination made on

the confidentially of this document since then, I might be relying on an outdated copy.

So I think --

MR. KARNEDY: I think we're --

MR. BACHNER: -- I am, mostly.

MR. KARNEDY: -- based on that, and thank you Charles, I think you're fine.

MR. BACHNER: Okay.

MR. KARNEDY: Continue to answer the question.

MR. BACHNER: Sure. So I'm sorry, you wanted me to read the first two sentences?

MR. BECKER: That's correct, yup.

MR. BACHNER: Okay. "MVP does audit its PBM. MVP has audited claims and rebates as part of the audit process."

MR. BECKER: Okay. So you were asked to describe all aspects of the audit, do you feel that this was -- do you -- do you -- in your opinion, was this a -- a full and complete response to the question?

MR. BACHNER: I would have to say yes.

MR. BECKER: Okay.

MR. BACHNER: This is our -- this is our response.

MR. BECKER: Okay. So the sum total of your -- your audit was that you audited the claims and rebates; that's your testimony?

MR. BACHNER: That's correct.

MR. BECKER: Okay. So you did not audit these charged by your PBM to assure they aligned with the contract?

MR. BACHNER: I did not perform the audit, so I can't speak to whether or not that specifically was per -- was done as -- as part of the audit.

MR. BECKER: Okay. So your response was that you audited the claims and rebates, and your testimony here today was that that's your full and complete response; and you're not able to speak to any more specifics because you were not a participant in the audit?

MR. BACHNER: That is a fair statement.

MR. BECKER: So you wouldn't then also be able to -- and it would probably be confidential, to tell us how much MVP has recouped from CVS Caremark as a result of its

audits, is that fair?

MR. BACHNER: That's also correct, I would not be able to provide that answer.

MR. BECKER: Okay. We go through a similar exercise with sub-part B of the question, which asks whether MVP has performed any market comparison checks prior to renewing with CVS Caremark, and if so to thoroughly describe the process; including the timelines, evaluation criteria, and bench marks.

Could I ask you to read your response to sub-part B which are the 3rd and 4th sentences in your answer?

MR. BACHNER: "We also perform periodic market comparisons to ensure we have competitive PBM pricing terms. This process includes hiring a consultant who will compare the key aspects of services and pricing to the market, similar sized plans, and lines of business."

MR. BECKER: So it sounds here like you hired a consultant to do the market comparison checks?

MR. BACHNER: That's correct.

MR. BECKER: So probably then,

similar to your -- the -- the audit, where you were not a direct participant, are you not able to speak to any additional details about the market comparison checks?

MR. BACHNER: That's correct. I'm not able to speak to any additional details.

MR. BECKER: Okay. Could I have you turn back to Exhibit -- page 3 of Exhibit 12? Oh, yeah, okay. We're on the same exhibit, page 3; next page.

MR. BACHNER: Sure.

MR. BECKER: Okay. We asked you about a new drug pricing model offered by your PBM called True Cost. And I explained at the beginning of the hearing that I -- we have included a non-stipulated exhibit.

I'm not going to ask you anything about that non-stipulated exhibit, I'm just going to ask you one simple question, and it's that if MVP members are not paying the True Cost of drugs now, what are they paying?

MR. KARNEDY: I'm just going to object -- object to the form of the question, just because it's referencing True Cost with a capital T and a capital C, and I would ask you

just to clarify what you're actually asking the witness.

MR. BECKER: So what I'm asking the witness -- I'm sorry -- I'm sorry, Mr. Barber.

HEARING OFFICER BARBER: No you were -- go ahead, so I didn't mean to cut you off.

MR. BECKER: Okay. All right.

The question is if MVP members are not paying the actual acquisition cost, plus a dispensing fee of the drug, which I understand to be the case, what are they paying?

MR. BACHNER: I would have to answer that I don't know that. I would have to get back to you on that. I'm not a -- I'm not at the -- I'm not a pharmacist, and I don't have expertise in that area.

MR. BECKER: All right, that's fair enough. We're going to go back to -- and this is my final set of questions here; where almost through it. Still on the same topic of PBMs.

Turning back to Exhibit 16, page 14, and back again to you response to question

28.

MR. BACHNER: Okay.

MR. BECKER: Are you there?

MR. BACHNER: Yes.

MR. BECKER: Could you read the second sentence in your response, beginning on line 6; the very end of line 6?

MR. BACHNER: "MVP has contracted with the same highly regarded and competitive PBM for several years to obtain the best prices on prescription pharmaceuticals."

MR. BECKER: Okay thank you. You were asked earlier today whether actuaries choose their words carefully, and you agreed; is that accurate?

MR. BACHNER: That's correct.

MR. BECKER: Okay. As an actuary for a health insurer, is it a part of your job responsibilities to keep up on current events in the -- in your industry?

MR. BACHNER: Yes. The ones that directly relate to my job as a -- as a health insurance actuary working in the commercial space.

MR. BECKER: Okay. Are you

aware -- I mean did you see in the news that last week the Vermont Attorney General filed a civil complaint against CVS Caremark, alleging that PBMs drive up drug prices and harm insurers and their consumers?

MR. BACHNER: I was not aware of that.

MR. BECKER: Okay. Did you see in the press any reporting, or did you read the report that was just issued by the Federal Trade Commission that was entitled Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies?

MR. BACHNER: I did not.

MR. BECKER: Okay. All right. Thank you very much, that's the end of my questions.

HEARING OFFICER BARBER: Okay. So we'll move to board questions next, but does anybody need five minutes; bio break or anything?

I see a couple people nodding their heads, so why don't we take a couple minutes. We'll come back at 11:25. So if we could go off record, and I'll see everyone back here then, thanks.

(Recess at 11:18 a.m., until 11:26 a.m.)

HEARING OFFICER BARBER: And we'll start with board questions with Board Member Walsh.

Tom, you're on mute.

MR. WALSH: Thank you, Mr. Barber.

And good morning, Mr. Bachner, thanks for your testimony so far. I'd like to start with a couple questions about medical trend. The first one, we could refer to the binder. It's in Exhibit 1, page 11.

There's a comment, under the utilization trend, about the analysis -- the findings of the analysis being too volatile to use. And I was wondering if you could just explain that a little bit more, please?

MR. BACHNER: Sure. So we take our claim data over a long period of time, and we attempt to adjust for things like demographic changes, changes in benefits, all different variables within the market.

And then we plug that data into a statistical analysis software that will spit out -- basically does a time series modeling

about what we expect future trends to look like.

And within that time series, there are variables of confidence and -- and variables of -- of variability. So it will spit out a best estimate trend number, but then it will also have a range around that.

And so when the range is sufficiently -- sufficiently large, then we can say that the data is volatile, and it would be -- while we could pick a point estimate, it could readily fall with -- into a large range of possible values.

MR. WALSH: And if we could -- thank you for clarifying it. If we were to look into the trend figure a bit further, what is the trend composed of?

MR. BACHNER: Sure. So currently we run our trend for casting models at three different levels; we run them by service category, so it would be inpatient, outpatient, and physician.

So inpatient, we run it at -- I believe it's days per 1,000, and outpatient and physician would be visits per 1,000.

And we do carve out certain

services from that. Things like vaccines or durable medical equipment; things that are not necessarily visits, and try to focus on the -- the core visits within each of those service categories.

MR. WALSH: In my -- my -- this is your first time with us, this my third time through this, so I'm still learning as well.

My understanding of the trend is that the trend is built over a long period of time, and then tries to forecast -- or looks at the price-per-unit and the number of units, and then the coding associated with each unit.

Is that -- do I understand that correctly?

MR. BACHNER: So specifically related to our trends, we -- this trend here focuses on utilization, so it would just be the number of services performed.

And our unit costs trends would be the cost-per-unit for a given unit. MVP has not historically done any sort of trend for intensity, which I think is what you're describing; sort of the third -- the third rail of trend where the cost-per-service is not

necessarily increasing, but the -- and the number of service is not necessarily increasing, but the average cost-per-service is going up over time.

MR. WALSH: Okay. That's not been a part of MVP's approach in the past?

MR. BACHNER: That's correct. We're certainly --

MR. WALSH: Okay.

MR. BACHNER: -- continuing to, you know, evolve our -- our medical trend forecasting, but that's not historically been a -- a part of it.

MR. WALSH: Okay thank you. Of the cost and the utilization trends, which has been the largest driver in premium prices over the past several years?

MR. BACHNER: So in terms of our premium increases, generally unit-cost trends are higher than utilization trends. So we see the cost of services going up faster than the utilization trends.

MR. WALSH: Okay.

MR. BACHNER: Now as to what's actually been experienced, I can't say for certain which one is higher.

MR. WALSH: Okay. So in MVP's analytic approach, it's -- it's not your approach to try to apportion which is driving a greater percentage than the other?

MR. BACHNER: That's correct. We view medical trend holistically as one number that's made up of utilization and unit-cost components.

MR. WALSH: Okay. Okay. Do you do that analysis at the hospital level, or is it only at a region level?

MR. BACHNER: It's only at a regional level, and specifically a -- a line-of-business level. We found that utilization trends at the hospital level are too -- even more volatile than the -- the utilization trends at a market level.

MR. WALSH: Okay.

MR. BACHNER: So it would be difficult to say one hospital's going up more than another.

MR. WALSH: Okay. Okay. That's helpful. You had mentioned in part of your testimony -- I didn't get the specific page number, but there was discussion of GMCB

regulated entities, and non-regulated entities.

And I believe the number that I -- that I heard was that GMCB regulated entities account for approximately 45 percent?

MR. BACHNER: That -- yes, that would be correct. They account for --

MR. WALSH: Okay.

MR. BACHNER: -- 45 percent of the total medical cost.

MR. WALSH: Of the claims.

MR. BACHNER: Correct.

MR. WALSH: Do you know -- are the -- are the utilization and cost trends behaving similarly in the GMCB regulated book of business, and the nonregulated book of business?

MR. BACHNER: I do not know off the top of my head. I would have to get back to you on that one.

MR. WALSH: Okay. That'd be helpful.

I'd like to switch to the risk adjustment transfer --

MR. BACHNER: Sure.

MR. WALSH: -- for a moment. If -- if another carrier in the state, or if

members left another carrier in the state and came into MVP, how would that be addressed -- or what are the issues that concern you if that were to happen?

MR. BACHNER: Sure. So I guess it depends on if we're talking about a few members, or, functionally, all of the members.

If a few members move -- and we see members move every year between carriers, there is uncertainty in terms of the risk adjustment, because we don't necessarily have -- the risk assessment's based on claims -- diagnosis codes for a given time period.

So if we don't have claims for that member historically, we can't say well, this member should have this diagnosis, but they actually don't.

Or this member hasn't been -- hasn't yet been diagnosed with a condition because they haven't seen their primary care doctor in a given year.

So there's usually a -- a lag in terms of risk adjustment for the first year that a member joins a carrier.

There would be -- if -- if all of

the members were to move, let's say, to one carrier or the other, that would be very difficult from a risk adjustment perspective, because it's -- the risk adjustment's designed to be a zero-sum game.

So it's designed to move money from some insurers to other insurers to level the playing field. If one carrier becomes the market, then the market is truly representative of all of the claims in that one carrier. There's nobody to deal with adverse claim impacts, and adverse risk adjustment impacts.

Does that answer your question?

MR. WALSH: Yeah that's helpful. It's -- you're -- it's helping me understand some of the uncertainty you face.

And so when a few members switch their claims from the prior affiliate -- the prior affiliation, those claims don't come over. You don't know what -- what their healthcare needs are going to be?

MR. BACHNER: That's correct, yeah. The risk-adjustment model is specifically based on diagnosis that are on claims within the given year.

So right now the risk-adjustment results that were just released were for 2023. So claims that had -- or diagnosis codes from members that were on claims in 2023.

So if a member goes to their doctor -- if the member is new to MVP in 2023, for example, they go to the doctor and they get properly diagnosed with a condition, then everything's all good.

But if the problem becomes if a doctor, for whatever reason, doesn't code that diagnosis, or hasn't coded it -- coded it a couple of years ago, but didn't code it this year. If a member is ours for a longer time period, we're allowed to do things like chart review; which is where we can go and actually pull the member's medical chart and access claims from the prior year to say hey, this member had diabetes, as an example.

Can we go to the -- to the provider then say do you think this member still does have it, and then we can get that on the claim.

So for a new member, we lose out on the ability to look back at our own historic

data and make a determination about a member's condition.

MR. WALSH: And in your experience, are members who -- who switch, is there a pattern? Do they tend to be healthier or less healthy?

MR. BACHNER: They tend to be healthier, all else being equal. And that has less to do with market dynamics, and more to do with members who are sicker are generally receiving care. And unless they have a really bad care experience, they generally want to receive the same care. So they want there to be minimal disruptions.

So to use an example, if somebody's receiving a chemotherapy drug, and they know that MVP is covering it, well they're less likely to move and have to try to go through, you know, prior authorization, or whatever it needs to be, to switch to a different carrier.

MR. WALSH: Thank you. Also in your earlier testimony, you discussed the UVM letter from last Friday requesting an increase in their -- in their budget, and the calculation

had -- then -- if that increase were granted, that would necessitate .4 percent increase in your rate request; is that correct?

MR. BACHNER: That's correct.

MR. WALSH: Okay. I would imagine that -- that such a -- that's a very -- that's the largest organization in the state. So if -- if a similar request had come from a much smaller facility, what would that have -- do to that .4 number? Would it go up or down?

MR. BACHNER: Yeah. So it would go down. I'm looking at one of our exhibits right now, Exhibit 24, where we -- we list out the percentage of claims that are each of the facilities, and to use -- actually that number has been deemed confidential, so I don't want to use it.

But in general, I would say yes; it would go down if a hospital with less utilization asked for a rate increase.

MR. WALSH: Okay. Thank you.

MR. BACHNER: And I'm happy to provide more color in the executive session if we need to, but --

MR. WALSH: Okay. Nope, I asked

that earlier. Finally you -- you discussed with your attorney the topic of cost shifting?

MR. BACHNER: Yes.

MR. WALSH: Is your understanding of that that as a hospital has a larger proportion of patients with Medicare and Medicaid, their commercial prices would need to be higher?

MR. BACHNER: Assuming that the Medicare and Medicaid fee-schedule increases are not adequate to cover the cost of providing care for those Medicare and Medicaid members, then yes.

MR. WALSH: Okay. And are you familiar with the meta-analysis done to look at that question?

MR. BACHNER: I'm not particularly familiar with that, no.

MR. WALSH: Are you familiar with the CBO analysis from 2022 looking at that question?

MR. BACHNER: I am not.

MR. WALSH: Are you familiar with the RAND 5.0 series of studies that also looked at that question?

MR. BACHNER: I believe we responded to one of the Green Mountain Care Board questions surrounding that, so I'm vaguely familiar with it; but I'm certainly not an -- an expert on it.

MR. WALSH: Okay. Are you familiar with the Yale hospital pricing projects examination of the relationship between Medicare and Medicaid prices and commercial prices?

MR. BACHNER: I am not.

MR. WALSH: Are you familiar with the National Associate of State Health policy, their analysis of the relationship between Medicare and Medicaid reimbursement and hospital prices?

MR. BACHNER: I am not.

MR. WALSH: Okay. Each of those has found the correlation between Medicare and medi -- the proportion of patients with Medicare and Medicaid at a hospital and commercial prices to be very low; less than .2.

The CBO report in 2022, their finding was that as the proportion of patients with Medicare and Medicaid went up one percent, commercial prices on average went up .1 percent.

So that association that our hospitals in Vermont and many others rely on is -- is simplistic and makes quick sense; but is wrong. The number that you -- the numbers that you talked about with cost shifting is not to do with price, it's Medicare and Medicaid reimbursement rates compared to the hospital price, not the hospital cost.

And because the hospital can set its price, the higher it sets the price, the greater the loss appears to be.

I don't know that that would affect your rate request at all, but I think it's a very important thing that we all try to understand together, and that the gap that is called the cost shift is actually the difference between Medicare and Medicaid reimbursement, and a hospital's price.

And because they set their price, if they have more market power, that gap will appear to be bigger.

Those are all my questions and comments.

HEARING OFFICER BARBER: Thank you, Tom.

Board Member Murman?

MR. MURMAN: Yeah thanks. Sometimes my audio's funny. I'm good right? Thanks. Okay.

One of things that you discussed in your non-actuarial testimony pre-filed in today is your telemedicine program.

Often there's discussion of the healthcare system being fragmented, and that patients receive care in different places that don't communicate with each other.

With your example that you gave of a young child with a fever receiving telemedicine care, do you have any concerns about that related to the fragmentation of the system?

MR. BACHNER: Certainly there can be times when -- when telemedicine can increase fragmentation, which I think is what you're specifically asking about.

But we also find there are tremendous benefits in being able to access care in a timely fashion, and understand and triage care necessarily.

So I think -- I would agree in theory that there are -- that telemedicine can,

potentially, increase fragmentation in the healthcare system.

MR. MURMAN: Okay. But you're suggesting it's offset by the benefit of access and timely care?

MR. BACHNER: That would be correct.

MR. MURMAN: Okay. Different topic, regarding what Tom was just discussing with the cost shift, which I kind of think about as the concept for hospital need revenue from commercial insurance to offset losses from public payers is often how it's described.

Is there any role of a commercial insurance company to try to reduce the magnitude of this impact onto their rate payers?

MR. BACHNER: There's the -- the role that we have specifically within that is to negotiate the best rates that we can for our insurance.

So if there's a -- a role that we can play in terms of understanding and impacting that overall revenue for the hospital, I don't know that we can directly impact it.

MR. MURMAN: Do you think there's

a -- a one-to-one obligation of a commercial insurer to pay all the difference that the -- that the government payers revenue is under those commercial price -- underneath the prices set by the hospitals?

MR. BACHNER: I don't think we have an obligation in terms of the marketplace, but there is significant pressure, and there's significant leverage brought to the table in terms of those things which make it difficult for insurers to negotiate.

MR. MURMAN: What are those elements of pressure and leverage?

MR. BACHNER: Sure. So I'm certainly not an expert in medical contracting, I defer to our contracting team on that. But if you think about a situation where a -- a negotiation becomes so bitter or so bad that one -- one entity wants to leave the table, and no longer wants -- you know, a hospital no longer wants to be in MVP's network or vice-versa.

Understanding that the hospital is the one who's primarily doing the care presents a significant burden to MVP, and in terms of what happens when that hospital leaves the network.

So members are -- are more likely to stick with their hospital rather than stick with their insurance company. And they're more likely to side with their hospital rather than their insurance company in terms of -- of care.

So, you know, there's -- there's significant leverage being -- I would say significant negative leverage being brought to the table when an event like that may happen.

MR. MURMAN: So it's said sometimes in our meetings, and I don't know if you're aware of this, that Vermont is different because the Green Mountain Care Board regulates the hospitals, and sets those hospital increases; and therefore thinking about market power doesn't apply in Vermont.

Do you think market power has an impact on negotiations with your Vermont hospitals?

MR. BACHNER: Again, not a -- not a contracting expert, but I do think that market power always has a role in negotiations between hospitals and insurance companies.

MR. MURMAN: Okay. You had mentioned that you viewed -- that the hospitals

view the Green Mountain Care Board defined rate increases as a floor, and not a ceiling.

Do you ever negotiate prices paid to hospitals above the floor?

MR. BACHNER: Not that I'm aware of, but I'm not privy to all of our contract negotiations.

MR. MURMAN: Okay. So would you say there's -- there's no space between the floor and the ceiling; is that what you're saying?

MR. BACHNER: In general, yes; that appears to be the case.

MR. MURMAN: Okay. There's been a bunch of discussion about -- healthcare costs rising over time a good bit today. Would you agree that healthcare costs are rising over time? I think you testified to that earlier?

MR. BACHNER: That's correct.

MR. MURMAN: Okay. And would you agree that healthcare costs are rising faster than other measures of inflation, such as in wage growth?

MR. BACHNER: That's correct.

MR. MURMAN: Okay. Can you -- you -- I think you said that medical costs are

one of the factors that's leading to this rising health care costs over time. Can you expand on some of the specifics of these medical costs that you think are leading to rising healthcare costs over time?

MR. BACHNER: Sure. So I mean just looking at our -- our data, right? Some of the possible drivers -- and I won't say that all of them are actually existing, and all of them are -- and to what extent they exist.

But certainly the number of services that are utilized, particular when we operate in largely a fee-for-service environment; more services being performed generally will lead to higher costs across the system.

That goes for pharmacy as well. More -- more drugs that are being used would also increase cost to the system.

You know, we can also take a look at -- at services that are more intense. So -- and I won't suggest this is happening at all times, and in all places, but times where level 3 ER visits become lever 4 ER visits, become level 5 ER visits.

You know, whether that's actually

the case or not, there are some places where services can start to go up over time, not simply because more services are being done, but because they are more intense.

You know a lot of it too is -- is we have -- and this not a -- necessarily an actuarial answer that's related to MVP in particular, but we have, as a society, placed a premium on expanding care; expanding the lives of people, expanding the livelihood of people who are dealing with certain conditions.

And so that comes with a cost. We -- we have greatly increased, for instance, the number of treatments that go along with cancers to extend people's lives and extend the quality of life.

So we have placed a premium on that as a society, and I do think that, you know, the cost is associated with that.

MR. MURMAN: Okay. And one major area that comes up with us that you didn't mention is prices. Do you see prices for healthcare services rising over time?

MR. BACHNER: Yes. We do see prices for healthcare services rising over time.

And that's, you know, a function of both where the Green Mountain Care Board's budgets come in, but also our negotiation with -- with payers.

MR. MURMAN: Okay. I want to talk a little bit about administrative costs. What percentage of the premium are made up, say, on either the small -- let me just take the small group plan. What percent of the premium of the small group plan are made up by administrative costs?

MR. BACHNER: Sure. I'd have to look at our exhibit for that. So if you don't mind me going to -- actually probably the best place to go is the L&E Exhibit --

MR. MURMAN: Okay.

MR. BACHNER: -- or the L&E memorandum, which is, I believe --

MR. KARNEDY: Exhibit 20.

MR. BACHNER: Thank you, Gary.

So Exhibit 20, page 12, lays it out that is 6.3 percent of premium for 2025.

MR. MURMAN: Okay. And do you know roughly if that's been stable over time?

MR. BACHNER: I think that's actually decreased over time. I can't speak to

exact specifics, but in general, our admin increases increased by less than the cost of medical and pharmacy claims.

So if you think of -- as the pharmacy claims are going up by more of then the -- the administrative expense every year, then the administrative expense becomes less as a percentage of premium over time.

MR. MURMAN: Okay. And then this describes the -- the -- this table breaks out the expenses of -- of the various administrative costs of healthcare. But each of these things, like you were suggesting, would -- would increase at a lower rate than healthcare costs overall, right?

MR. BACHNER: That's generally the -- that's generally been the case, correct.

MR. MURMAN: Okay. I guess I -- my impression was that the overall MLS -- the MLR ratio, the medical loss ratio, was about 90 percent for the medical side, and 10 percent on the administrative side over time. Is that roughly what you've experienced?

MR. BACHNER: Yes. Somewhere in that -- I mean I think we quoted this year in my

memorandum that somewhere in the seven to eight percent range. But historically rounding, it's been about 10 percent versus 90 percent of claims.

MR. MURMAN: Okay. So I don't have exact numbers on this, and I'm just kind of curious, which is why I'm trying to delve into this topic a little bit, that -- it dawned on me when I was reading through this yesterday, and this isn't complete through the years.

But looking back a little bit at the small group premiums and the membership, and looking at the -- the administrative costs overtime, I didn't see the -- the percent of administrative costs.

But if they were at this -- I found 5.8 percent I think is the number we used earlier today. If that 5.8 percent number was fixed over the last several years, when actually looking at what the administrative cost growth for a member, they should be from 2019 to 2023; it actually appears to go up by, like, about 56 percent.

But I guess you're saying that that 5. -- that that 5.8 percent growth has

decreased. I'd think I'd want some analysis into seeing how much your actual -- your actual administrative costs have grown, because 56 percent sure looks like a heck of a lot more than inflation or wage growth during that time frame.

MR. BACHNER: I'm sure we can pull that analysis together for you.

MR. MURMAN: Regarding the MVP healthcare structure. So MVP healthcare is the overarching company to the nonprofit MVP health plan that we're discussing today.

MR. BACHNER: That's correct.

MR. MURMAN: Is MVP healthcare a -- a for profit or nonprofit company?

MR. BACHNER: I don't know the answer to that off -- off the top of my head. I'd have to confer with our financial team.

MR. MURMAN: Okay. Then I have one other question. It appeared to me that you submit -- that MVP submitted Exhibit 29, is that correct?

MR. BACHNER: We had originally submitted it, but I believed it was --

MR. MURMAN: The nonstipulated list, 29.

MR. KARNEDY: That's not entered.

HEARING OFFICER BARBER: That's one of the documents that was not admitted. There was some motion --

MR. MURMAN: Okay.

HEARING OFFICER BARBER: -- about this before the hearing.

MR. MURMAN: Okay. Okay. All right. Okay. I'm going to stop there, thank you.

HEARING OFFICER BARBER: Board Member Lunge?

MS. LUNGE: Thank you.

Good -- I guess I can still say good morning if we have four minutes left. My first question is in your direct testimony about Exhibit 27, you indicated that the 2024 estimates, there was a range of expected outcomes; am I remembering that correctly?

MR. BACHNER: That's correct.

MS. LUNGE: Would you be able to provide us with that range?

MR. BACHNER: We could provide a potential range, but I'm not sure that we would have the ability -- I mean I'm an actuary, my job

is to predict the future, but I don't have a full crystal ball.

So we could certainly provide a -- a -- if you're asking for a range, I think that's something that we could provide.

MS. LUNGE: I was just curious because you had indicated that it was within a range, but that made me wonder what is the range.

So I think if you -- if that's something that you could give us a general sense of plus or minus what the range would be, that would be interesting.

MR. BACHNER: Sure.

HEARING OFFICER BARBER: Robin what exhibit was that? I missed it.

MS. LUNGE: It is Exhibit 27.

HEARING OFFICER BARBER: Okay.

MS. LUNGE: The historical rate summary. Yup. And specifically I think the testimony was that the 2024 numbers -- I think particularly around the impact on the losses, was the estimate -- was estimate -- was an estimate. If I'm remembering correctly.

HEARING OFFICER BARBER: Thanks, I just wanted -- I just, for my notes, just wanted

to clarify.

MS. LUNGE: Yup. Yeah sure.

I had a couple questions about the price transparency tool. Do you know how many people use the price transparency tool on your website?

MR. BACHNER: I -- I don't, unless we quote it in our pre-file testimony; I don't know it off the top of my head.

MS. LUNGE: I did not see it in the pre-file testimony. Is it possible to just get a snapshot of the order of magnitude? I'm just curious whether we're talking 10 people or 100,000 people.

MR. BACHNER: It is likely less than 100,000 people, but yes, we can get a specific number.

MS. LUNGE: Thanks. And could you -- and you may or may not know this given that this is not an actuarial question, but what is the quality stamp based on?

MR. BACHNER: I believe that it's based on NCQA certification, but I would have to double check; I'm not 100 percent certain on that.

MS. LUNGE: Okay, thank you. In your pre-file testimony you talk the product design process as where -- one place to think about affordability. And I was wondering if you could expand on that a little bit?

MR. BACHNER: Sure.

MS. LUNGE: In what way -- what are you suggesting happen with the product designs?

MR. BACHNER: Sure. Well part of my testimony was to say that by the time we get to the rate filing and are done with the product design process that it's -- our hands are largely tied in terms of what our benefits are going to be.

MS. LUNGE: Yup.

MR. BACHNER: And then the rate is largely a function of what those plan designs look like.

So we would recommend any sort of plan design options that are, you know, new and innovative, and would drive members to utilize care in a different way, or would tailor care towards a certain member.

And obviously we understand, just

like anybody else, that there are frameworks by which you have to provide certain services, and you have to have cost sharing that fits into those specific plans.

So one of the big ones is that we've also filed a new gold, nonstandard plan this year in retired, one of our old ones that has a little bit of a unique plan design. It's something that we haven't really done too much of yet, and so we're hoping that we can -- that plan will be tailored to individuals who specifically would like to utilize a plan like that.

MS. LUNGE: Okay. And I believe you participate in a plan design -- the plan design process, don't you? Your company?

MR. BACHNER: That's correct, yes.

MS. LUNGE: Okay. Thank you.

So in looking at Exhibit 15, in the pre -- in the -- hold on, let me get to Exhibit 15.

So with Mr. Becker, you talked -- you talked about your annual statement, particularly pages -- page 14, about the Vermont business. And there was a discussion earlier around the Vermont alliances business, and the

underwriting gains and losses, including individual, small group, large group, and Medicare advantage.

Could you crosswalk the numbers for the individual and small group market for 2023 in this exhibit, to the numbers of losses in Exhibit 27 for the individual and small group market for 2023? They do not appear to be the same, and I would have expected them to at least be closer.

So can you explain to me the difference --

MR. BACHNER: Sure.

MS. LUNGE: -- between those two?

MR. BACHNER: I can explain to you the difference. And I'm not sure if I can fully crosswalk all of the dollars, but I can tell you what has occurred between the filing --

MS. LUNGE: Perfect.

MR. BACHNER: -- of this statutory filing and -- and this document. So the first one would be that this document, Exhibit 27, has more runout. So statutory filings we have to assume some level of IBNR, incurred but not reported reserves, at the end of the year that

goes into our statutory filing.

And those claims always are not exact, those are just estimates. So to the extent there might be claims that have restated favorably or unfavorably, I would have to get back to you on specifics in terms of how the actual claims have come out, relative to our expectations. That would be one area where we would see a significant driver.

Another one is that not every -- the Exhibit 27 would be on a gap basis. So generally -- general accounting practice -- generally accepted accounting practices basis, whereas the statutory filings have slightly different rules in terms of what specifically is claim expense, what specifically is admin, what specifically counts in -- in which bucket.

So I can't say whether or not that's specifically impacting the underwriting gain or loss, but it is an area where they could be different.

Finally the -- you can see here if you go down to the bottom table, we assumed $8.1 million dollar payment for individual, and $5.8 million in terms of risk adjustment. The Exhibit

27 would reflect any changes to that from what we booked at year end.

So to the extent that we understand that our risk adjustment position is different than those might be different. So -- there's also, you know -- there's -- there's other items that are accrued for at the end of the year that are not reflected in here. That's the overarching item would be that.

Our financial statements are a moment in time as of yearend, 2023. And Exhibit 27 would be a moment in time as of June of -- or early July of 2024.

MS. LUNGE: Got it. Okay thank you, that was very helpful. The remaining questions that I have are for executive session.

MR. BACHNER: Okay.

HEARING OFFICER BARBER: All right. Board Member Holmes?

MS. HOLMES: Hi great, thank you so much.

I -- some of my questions have been asked and answered, some I will reserve for executive session, but I do have a couple.

If it's possible, could you turn

to Exhibit 16, page 13? This will be question 27 of your pre-file testimony.

MR. BACHNER: Okay.

MS. HOLMES: Great. So in question 27, which asks, "What steps does MVP take to manage costs and contracts to improve affordability?", your answer there is, "MVP negotiates rates that reflect appropriate reimbursement levels across all provider types in MVP's network." Yes?

MR. BACHNER: That's correct.

MS. HOLMES: Okay. Could you tell me specifically how MVP determines whether a reimbursement rate is appropriate?

MR. BACHNER: I don't have specific answers to that question, I would have to take that back to our contracting team.

MS. HOLMES: Okay. That would be very helpful. Okay. We know that you use words very carefully, right. So it would be helpful to understand what is appropriate, and how it's defined.

On Exhibit 15, if you would go to that exhibit.

MR. BACHNER: Okay.

MS. HOLMES: And this is the response form MVP as it relates to the RAND Round 5 study. And the response there references that "MVP notes that these findings are consistent with comparison across our commercial block of business. Vermont providers have consistently higher costs as compared to our New York providers on both facility and physician, including drug prices for physician purchased drugs, and the Vermont commercial drug reimbursement is significantly above New York, in some cases 50 to 100 percent more."

So I have a couple of questions here, but one -- actually, and maybe you're going to have to bring this back to your contracting team; it would be helpful to understand why it would be appropriate to pay Vermont providers significantly more than New York providers for the same services?

MR. BACHNER: Yeah. I would -- I would have to take that back.

MS. HOLMES: Okay. Well I would appreciate an answer to that.

And similarly, it would be very helpful to understand what is happening with

physician purchased drugs? I'm assuming that's what you're referencing there -- or MVP is referencing in terms of Vermont commercial drug reimbursement?

Is it hospital-based drugs, is it -- so I would under -- do you have an answer to that, or is that something you would have to take back.

MR. BACHNER: It -- I could get specifics, but my understanding is that it's primarily hospital-based drugs.

So our negotiated contracts with hospitals produce pharmacy costs that are significantly higher than Vermont relative to New York.

MS. HOLMES: Okay. So I would -- it would be helpful to me to understand which hospitals in particular, and also, again, I guess I would ask the same question; why it's appropriate to agree to a reimbursement that's significantly higher in Vermont than in New York.

And I would say, I have heard testimony, you know, about floors and ceilings in negotiations with hospitals once the GMCB has provided hospital guidance -- or a hospital

budget order.

And I just want to -- I want you -- I would love to hear if you are aware of our specific language that we put in hospital budget orders.

And I'll just read this one component of our hospital budget order. It says the commercial rate increase cap in paragraph B, referenced in our hospital budget order, is a maximum, and is subject to negotiation between hospital X and commercial insurers.

Hospital X shall not represent that maximum commercial rate increase approved by the GMCB in paragraph B, or the expected commercial MPR based on that rate increase, as the amount set or guaranteed by the GMCB in the hospital's negotiations with insurers.

So that's language that we use, that we put in every hospital budget order specifically to guard against that floor-ceiling issue that has been raised. So I would also appreciate -- I understand you're not on the contracting team, but I would appreciate a response from the contracting team to why that language hasn't seemed to work.

MR. BACHNER: Yeah, I certainly --

MS. HOLMES: Is that something you can do or if you have an answer to now, but.

MR. BACHNER: We can take that back to our contracting team, but I -- I want to clean up my testimony to say that we're certainly not accusing any hospital of coming to the negotiating table and saying this is the only rate that we will accept. It's just functionally how things are playing out, but I would have to get specifics from our contracting team in terms of efforts for negotiating.

MS. HOLMES: Okay. I would very much appreciate that. And then I wondered if you, with all of the hospital and insurance price transparency data that is readily available on websites as a result of some federal regulation changes in the past few years, would you be able to share any analysis that MVP has done, comparing the MVP negotiated rates with Vermont hospitals and frankly, New Hampshire border hospitals with the negotiated rates observed in those, you know, price transparency websites of the larger out of state and I mean out of state national. You're all -- to some degree, MVP is

out of state based in New York, but I mean, here the Aetnas, the Humanas, the, you know, I mean, the United Health Cares, the Cignas, all of those larger insurance companies. Is that an analysis that you have done?

MR. BACHNER: We have not done anything national as far as I'm aware, and I don't think we've done anything in terms of New Hampshire. We have done stuff in Vermont, particularly related to the University of Vermont Health Network. I could potentially share the results of that study, but I'd have to go back to our network trend analytics team for that.

MS. HOLMES: That would be very helpful, and it would be very helpful to see just in the context of, you know, national carriers how do MVP's reimbursement -- you know, negotiated reimbursement rates compare. So if there's an opportunity to do that analysis and share it, it would be very helpful to us.

MR. BACHNER: Okay.

MS. HOLMES: Thank you. My -- my next question is, and I know there's been several scenarios that have been proposed by the Board in terms of looking at the premium impact of various

hospital rates, and I'm wondering -- I don't think I saw it, but please forgive me if I missed it, but did you do an analysis of if the -- the -- basically, if rather than actual hospital submissions were implemented, but actually the budget guidance was implemented where we capped commercial rate growth at 3.4 percent, is that an analysis that you have in your scenarios that I've missed?

MR. BACHNER: We have not done that as a scenario. That was not requested by L&E, but we certainly could do that calculation quickly and -- and return it to you.

MS. HOLMES: That would be extremely helpful. I would appreciate that. I guess my last final question really is you had testified earlier how strongly MVP feels about primary care providers, how they're central to the patient medical experience, and access to a primary care provider is an essential component of care management efforts to promote affordability, and I guess my question is, do you -- does MVP keep track of the members that have no assigned primary care provider in -- in their membership pool? Do you -- yeah, I'll ask

that first question.

MR. BACHNER: Sure.

MS. HOLMES: Do you keep track of people who don't have a PCP?

MR. BACHNER: So depending on our, our company, whether it's MVP Health Plan or MVP Health Services Corp., we have different attribution methodologies that are either based on whether a member chooses a PCP, whether they're forced to choose a PCP by virtue of being in a plan, or we sometimes will attribute based on claim data for the past twelve months. So there's various attribution methodologies. I can't speak for certain for this line of business, but we do generally have PCP attribution in our data.

MS. HOLMES: Okay. So I would -- it would be helpful to find out what proportion of -- in this line of business, of members do not have a PCP or have not visited a PCP, you know, if you have it in a year, a given year, just trying to understand what kinds of efforts are made and what kinds of a proportion of people are not actually accessing such a central component of that patient medical experience?

MR. BACHNER: Sure. We can provide that, and I think it would be helpful to provide that as two buckets where a member has not utilized the PCP, but also utilized other medical services as opposed to somebody who truly just has not utilized the PCP. I think if I'm reading through your question, I don't necessarily want to say someone who is healthy is not utilizing their PCP, and that's a bad thing. If they don't have any reason to, then we certainly would not want them to go, but for things like wellness visits and things, we could -- we could look at that.

MS. HOLMES: That would be helpful. That's all my questions. Thank you.

MR. BACHNER: Thank you.

HEARING OFFICER BARBER: Chair Foster.

MR. FOSTER: It appears from Exhibit 19 that your PBM has been fairly off in anticipating pharmacy trend. Why do you rely on the PBM if it's consistently wrong?

MR. BACHNER: They have more significant knowledge than we do of the future-looking pharmacy trends. So certainly

their knowledge is not -- as you've noted, has been off the past few years, but they have more knowledge than we would, which would also enable us to support it. So we have to again justify our rates to both L&E and to the Green Mountain Care Board. So for us to say we have no idea, we're just going to pick a pharmacy trend, we at least have credible -- credible data in terms of relying on our PBM.

MR. FOSTER: And is the pharmacy trend that your PBM furnished you and submitted to the Board, you submitted to the Board MVP, is it reliable?

MR. BACHNER: We view it as generally reliable.

MR. FOSTER: And do you think it's reasonable?

MR. BACHNER: I would say that it is reasonable.

MR. FOSTER: The Medicare Advantage product, is it forecast to continue to lose money?

MR. BACHNER: I don't have specifics in front of me, but that's my general understanding.

MR. FOSTER: If the Medicare Advantage product was not losing money, would your rate submissions to the Board be different?

MR. BACHNER: No.

MR. FOSTER: Is there any impact of the Medicare Advantage losses in what you're requesting to the Care Board in connection with the QHP rates?

MR. BACHNER: There is not.

MR. FOSTER: I'm sorry. My internet might have broke up. What was the answer?

MR. BACHNER: There is not. There is no connection between the -- the two.

MR. FOSTER: Do any other parties share in losses from the Medicare Advantage product that you offer?

MR. BACHNER: I would have to take that back to our finance team.

MR. FOSTER: Are there any other parties that benefit from the Medicare Advantage product that you offer?

MR. BACHNER: Once again, I'd have to take that back to our finance team.

MR. FOSTER: The third one is, are

there any other parties that contribute to the costs or work in connection with the Medicare Advantage product that MVP offers?

MR. BACHNER: Again, I would have to take that back to our farm -- to our finance team.

MR. FOSTER: Okay. In the last year, has MVP experienced any unanticipated claims surge?

MR. BACHNER: Not that we've -- that's been observable and attributed to any one particular event.

MR. FOSTER: What about just whether or not you're getting more claims than you had forecast?

MR. BACHNER: I think that's generally the case, just based on our -- our premium rate submissions, 2023 was below what we would have forecasted. I think it's too early to tell in terms of 2024 data. The 2024 data at first glance does not appear to be above our trends.

MR. FOSTER: And are you seeing any increase in the QHP claims in patient acuity?

MR. BACHNER: We are not, but I --

it would be too early to tell.

MR. FOSTER: Okay. And in the claims, are you seeing any increase in the average length of stay?

MR. BACHNER: I don't have that specific data point.

MR. FOSTER: You testified earlier about the -- you know, generally, the New York hospitals are less expensive for you for the services that are provided as compared to the Vermont hospitals, yet the New York hospitals receive lower rate increases from MVP than the Vermont hospitals. Can you explain that, why that is?

MR. BACHNER: Do you mean -- when you mean rate increases, do you mean premium rate increases in terms of small group and individual rate increases?

MR. FOSTER: The negotiated rates with those hospitals, the -- the change in charge increases for those hospitals being larger for Vermont despite a higher base expense in the New York hospitals?

MR. BACHNER: Yeah, I don't -- I don't know that that's necessarily true. I don't

know that we always have lower increases for New York hospitals than we do for Vermont hospitals.

MR. FOSTER: Let me ask you a different way. If -- when negotiating with Vermont hospitals, do you consider their -- I'll call it their base level of expense, and by that I mean what you're already paying them, whether they're high or low compared to other hospitals you contract with.

MR. BACHNER: I can't speak to certainties in terms of how our contracting team handles that. I'll leave it at that.

MR. FOSTER: Is there a contracting representative testifying today?

MR. BACHNER: There's not.

MR. FOSTER: The healthcare advocate, in their opening statement, made three recommendations, not sure if you -- did you catch that? Were you here for that?

MR. BACHNER: Yes.

MR. FOSTER: I wanted to go through each of those with you and hear your perspective as to whether or not they are sound or not, and why either way. So the first recommendation was for MVP to assume hospital --

I forget if there's costs or NPR increases were consistent with the Board's guidance.

MR. BACHNER: So our position, as I stated previously, would be that if the hospital rate increases are aligned in both, in terms of what's built into premium rates as well as what's built into the ultimate approved budgets, then MVP would be amenable to that.

MR. FOSTER: The second one was to assume a 0.1 percent medical utilization trend.

MR. BACHNER: So L&E did note in their filing that 0.1 percent would be an acceptable utilization trend. We did somewhat disagree with that in terms of their justification and their disagreement with us in terms of the impact of COVID. They also noted elsewhere that if a lower than -- lower-than proposed and recommended utilization trend was used, then a higher-than current CTR or risk margin would be justified. So I would not say that we would -- we would not approve or not accept as reasonable a lower utilization trend without also a corresponding increase to the risk margin.

MR. FOSTER: I see. Okay. And

you think the 0.1 percent medical utilization trend is within the range of reasonableness?

MR. BACHNER: It is below the -- the trend that has historically been seen in this block of business, and I believe it's below L&E's what we relied on, which is a historical range of utilization trends that I believe is between one and four percent. So we would not necessarily agree that it would be reasonable.

MR. FOSTER: And would you -- would you agree or disagree that it's within the range of reasonableness?

MR. BACHNER: Based on the -- the one to four percent range provided by L&E in prior studies, I would say that that's not within the range of reasonableness.

MR. FOSTER: And then the third one that the health care advocate recommended was using the 7.4 percent RX trend that the -- your PBM had provided. Do you think that's reasonable?

MR. BACHNER: So we agree to L&E's recommendation. We do think that our trend would be reasonable. They also have a reasonable trend. The risk would be that if the claim costs

continue at a level above what CVS -- excuse me, our PBM has projected, then we would be left short and future rate increases would have to increase for that. So you know, if the -- if the data, if the trends come in higher than what we expected in our 2025 premium rates, when we go to use 2025 data to price, then that would have to increase our premium rates.

MR. FOSTER: One of the fundamental problems, it seems to me, in our health care system is that the amount you, the insurance companies, have to pay is too great, like there is a minimal amount that we can save Vermonters on the insurance side of the equation, the costs that you have to pay, the claims you have to pay, they are what they are, and they're high. Is there anything -- you spoke a little bit about some of the techniques and methods that MVP is using to lower that component, is there any way we can or you can track and be accountable for whether or not those actually work? And I understand that part of it is the Care Board is regulating cost containment on the hospital side, but what do you do at MVP to make sure you're doing the best you can to lower that

component?

MR. BACHNER: Yeah. So I'm not aware of anything that's done at MVP to track -- I'll use prior authorization as an example -- to track prior authorizations other than the number that are approved versus denied. What impact that those have on future claim costs, I think would be a complex issue that I know MVP is not doing anything currently to track. Whether or not that's something that could be done reliably, I can't speak to. So I don't know specifics in terms of how -- what -- what could be done to further hold insurance companies accountable for tactics like that.

MR. FOSTER: Is there anything MVP can do to promote care being moved out of expensive hospitals to less expensive hospitals, or from less expensive hospitals to community providers?

MR. BACHNER: I will say that there are strategies, you know, our -- our wellness benefit is one where it seems trivial, but you know, every service that we can move out of a hospital because somebody took the initiative and started taking care of their

health a lot -- a long time before that condition occurred is something that can help. Certainly, MVP is utilizing other tools in terms of our, you know, cost transparency tools and those sort of things to be able to say the -- we're putting it on the member to be able to have an active part in their care, but in terms of MVP telling a member, you have to go use this facility rather than this facility, I think that's generally limited in terms of our ability to do that. You know, ultimately the member is the -- the care that is provided to a member is between the member and the doctor, and so to the extent that a doctor recommends that they go get this service, it's difficult for MVP and becoming increasingly more difficult for MVP to step in and say, wait, maybe that care is not the exact specific care that's needed.

MR. FOSTER: If MVP is losing such significant dollars on the QHP plan, why do you remain in the market?

MR. BACHNER: That's a question that's, I think, well above my pay grade, but I will say that we are evaluating all of our options, as we do every year in terms of long

term sustainability in the market, whether we feel like these -- these losses can be turned around and doing everything we can to try to turn those around and -- and be able to support our members for the long term.

MR. FOSTER: Thanks for your testimony today, and it was nice to meet you, and I appreciate your answers. Thank you.

HEARING OFFICER BARBER: So Mr. Karnedy, I think I'm going to give you an opportunity for redirect, but we're also kind of at a good breaking point for lunch. So would you like to break for lunch and come back to that, maybe get a chance to think about that for a minute, or are you ready to proceed with any redirect you might have?

MR. KARNEDY: Oh, I'm ready, and I want to do my redirect right now if I could.

HEARING OFFICER BARBER: Okay. Go ahead.

MR. KARNEDY: I have no redirect.

HEARING OFFICER BARBER: Okay. Okay. Then this is a good time to break for lunch. We should talk about the rest of the afternoon. It sounds like Board members, at

least, have some questions about confidential materials. We could go into executive session after lunch and then proceed with the DFR witness and L&E witness or we could kind of put it on at the end. Does anybody have a -- Mr. Becker, Mr. Karnedy, any preference on that?

MR. KARNEDY: I would obviously defer to you, Hearing Officer and the Board members. I do think that -- it may be with different witnesses testifying, afterwards, you would get a clearer picture of where -- what they say about various issues, so that you go into executive session at the end, and you can cover everything at once and have a full picture of it. That may be more efficient, would be my thought, but I'll defer.

HEARING OFFICER BARBER: That's a -- that's a good thought. So let's plan on that. Why don't we take thirty-minute lunch break, reconvene at 1:00. And Mr. Lussier, are you sure you're with us?

MR. LUSSIER: I am. Yep.

HEARING OFFICER BARBER: Is that work for you to come back at 1 and start with your testimony?

MR. LUSSIER: Yeah, that -- that'll work for me.

MR. FOSTER: Okay. Ms. Morales, can we go off record?

(Recess at 12:31 p.m., until 1:03 p.m.)

HEARING OFFICER BARBER: Okay. Thank you. So next we're going to hear from Jesse Lussier, Department of Financial Regulation. Jesse, are you ready to take the oath?

MR. LUSSIER: I am. Can you hear me okay?

HEARING OFFICER BARBER: Yep.

MR. LUSSIER: Okay.

Whereupon,

JESSE LUSSIER,

a witness called for examination by counsel for the Board, was duly sworn, and was examined and testified as follows:

HEARING OFFICER BARBER: Okay. Then please go ahead.

MR. LUSSIER: Hello, everyone. Board, Mr. Barber, and Mr. Karnedy, and do we have the HC, Mr. Becker on? Good afternoon to all of you. For the record, my name is Jesse

Lussier. That's J-E-S-S-E, L-U-S-S-I-E-R. I'm an insurance examiner for the Department of Financial Regulation. Our role in the hearing is to offer a solvency opinion. We have two letters, one for the individual business and one for the small group business. They're effectively the same, except for in the final paragraph the -- the rates as they apply to each filing.

I will just read some parts of the opinion. I'll start with the summary on page 1, and for reference, those are Exhibits 16 and 7 -- I'm sorry -- 17 and 18, and I'm on the first one, Exhibit 17. The summary of the opinion on page 1, 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. When we go down to the second to last paragraph on page 2 titled MVHP Solvency Opinion, there's a few bullets I'll just quickly address.

As most folks are aware, insurance is a state-based regulation, and those states that the company is domiciled in are the company's primary solvency regulator, and in

MVP's case, the primary solvency regulator is the New York Department of Financial Services. We, the DFR, has not learned of any immediate solvency concerns from New York at this time.

We also normally talk about the -- and we have talked about or I have heard the percentage of business that Vermont represents for MVP. It is a smaller piece of business compared to their total business, but as DFR has said in the past, and we included again in this solvency letter, even though Vermont operations pose less risk to solvency compared to the overall New York business, the adequacy of rates and contribution to reserves are still necessary for all lines of business, and as echoed by other people generally, we would -- we would see all individual lines written so that they stand on their own. Each -- each line should have an adequate rate and cover all the costs that an insurer incurs.

And then finally, I will read the impact on the filing on solvency, which is the final paragraph. "In its filing, MVPHP has requested that the Board approve an overall average rate increase of 11.68 percent, based on

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

The small group reads the same, except that it states the original filed rate of 9.34 percent. I've been listening to the rate hearing today, and I've reviewed the actuarial information as well as the other exhibits. It appears that there have been adjustments to the rate, and I think Exhibit 26 -- let me pull that up -- outlines those changes, and from what I understand, and please correct me if I'm wrong, for the most part, L&E and MVP have agreed on those changes. I know there's some final adjustments that are to be made based on budgets, but assuming that that holds true that L&E and MVP still agree at the final -- at the final rate, then -- then those changes would not -- the changes to the rates would not change our final impact on the filing on solvency.

And I think with that, I will turn it back over to you, Mr. Barber.

HEARING OFFICER BARBER: Thank

you. Mr. Karnedy, do you have questions for Jesse? You're on mute.

MR. KARNEDY: So sorry. My partner, Ryan Long, will handle the examination.

MR. LONG: Good afternoon, Mr. Lussier.

MR. LUSSIER: Good afternoon.

MR. LONG: Frankly, I think you answered about two-thirds of my questions, so I'll keep it brief. I got to scroll down because, like I said --

MR. LUSSIER: I was hoping that would be the case.

MR. LONG: Yeah. Could you please go to Exhibit 19, and that's L&E's report, the individual filing, and turn to page 19 of that document.

MR. LUSSIER: Uh-huh. And I am there.

MR. LONG: And I see five bullets. Do you see those?

MR. LUSSIER: Yep.

MR. LONG: And keep a finger on that page if you could, or -- or bookmark and have a look at the -- the small group version of

the report at page 17, and if you could just confirm for me the bullets are the same in both reports.

MR. LUSSIER: Yes. That -- that looks correct.

MR. LONG: And I believe you already said this, but you heard some testimony today that MVP generally agrees with all five of those recommendations; is that correct?

MR. LUSSIER: That's my understanding.

MR. LONG: Okay. And you also heard that -- from Mr. Bachner that the rates as proposed today incorporate L&E's recommendations, correct?

MR. LUSSIER: Correct.

MR. LONG: And just to be clear, did you -- did you hear Mr. Bachner testify that with all of the adjustments from, I think the date of your letter, July 12th to today, the rate for individual is 15.9 percent, and the rate we're asking for, for small group is 12.8 percent, correct?

MR. LUSSIER: Yes, and that's reflective in Exhibit 26 plus the other

adjustment that they talked about, which was about 0.4 percent.

MR. LONG: And I believe you had just testified that that really doesn't change DFR's opinion and that the rates are adequate to protect carriers solvency; is that correct?

MR. LUSSIER: Yeah, under the assumption that the final sign-off is agreed between L&E and MVP.

MR. LONG: And just referring to -- to your DFR letters, that last paragraph, that's that contingency you're talking about, correct?

MR. LUSSIER: Yeah. Yes.

MR. LONG: Just above that paragraph, I'm looking at Exhibit 17, page 2, that third bulleted point. If you read through the last sentence in that third bulleted point, I believe you may have read it, but just refresh for me.

MR. LUSSIER: "Nonetheless, adequacy of rates and contribution to reserves are necessary for all health insurers to main strength of capital that keeps pace with claims trends and in turn protects policyholders."

MR. LONG: Thank you. I think you may have heard Mr. Bachner refer to risk margin instead of CTR in his testimony this year. In the past, we generally referred to risk margin as CTR. So I'll represent to you that where I'm asking about risk margin, I'm using that interchangeably with CTR, understood?

MR. LUSSIER: Yep.

MR. LONG: Could we go back to Exhibit 19 and turn to page 16?

MR. LUSSIER: Okay.

MR. LONG: Orient you. I'm looking at the section 12 changes in contribution to reserves, and then I'd like to go to page 17, and could you read the very last sentence on page 17?

MR. LUSSIER: The very last sentence on page 17.

MR. LONG: That's --

MR. LUSSIER: "L&E strongly emphasizes that reducing the CTR assumption from the filed 1.5 percent presents significant risk of inadequate premium rates that are not actuarially sound."

MR. LONG: And as you sit here

today, do you agree with L&E or do you have an opinion?

MR. LUSSIER: I'm not an actuary, but I would agree that -- that reducing the rate would generally increase the risk that rates would be inadequate.

MR. LONG: Has DFR analyzed whether the rates would still be adequate if, for example, the Board reduced MVP's proposed risk margin?

MR. LUSSIER: We have not.

MR. LONG: Okay. So -- so DFR has not provided in this rate review an opinion on adequacy of, for example, the rates with a 0.5 percent reduction to risk margin; is that right?

MR. LUSSIER: Yeah, that's correct. We have not done any kind of actuarial calculations.

MR. LONG: And so DFR is not offering an opinion on whether a rate with that reduction would protect carrier solvency, correct?

MR. LUSSIER: Correct.

MR. LONG: And given L&E's report and the testimony you've heard so far about the

most recent adjustments to the rates discussed by Mr. Bachner, does that contingency that we discussed at the bottom of your report still stand or has that been cleared up?

MR. LUSSIER: I'm sorry. Could you -- could you repeat the question?

MR. LONG: I'll try. So given what we've heard today in L&E's report, you have a contingency in your opinion based on the opinion of the GMC, the actuary. Now, has that contingency in your mind been satisfied?

MR. LUSSIER: From -- from what I've been hearing during the course of the hearing, we -- it sounds like L&E and MVP have mostly agreed on the rates. Effectively, they've agreed on them, and with the caveat that there's a few other minor adjustments, and I'm assuming it sounds like L&E would agree with those as well. So assuming that they agree with those, then -- then yeah, that would satisfy the contingency.

MR. LONG: Okay. So I have nothing further. I would just reserve and potentially recall at the end in case something comes up in the L&E testimony that we need to

discuss, but nothing further from me at this time.

HEARING OFFICER BARBER: Jesse, are you able to stick around for the rest of the day?

MR. LUSSIER: I -- I think so. I should be able to, yes. If I have to leave, I'll send you a message if that's okay.

HEARING OFFICER BARBER: Okay. Mr. Becker, do you have questions for Mr. Lussier?

MR. BECKER: Mr. Barber, no, we do not have any questions for Mr. Lussier except that we would likewise reserve in case some additional questioning comes up after L&E testifies.

HEARING OFFICER BARBER: Okay. Board Member Walsh, anything? Board Member Murman, do you have any questions?

MR. MURMAN: Yeah. I just want to clarify. You testified that a -- the rate as filed would not risk the insurer solvency, correct?

MR. LUSSIER: The yes, and when I say the --

MR. MURMAN: Adjust -- adjusted file?

MR. LUSSIER: Correct. Yeah. Okay. And did -- and you have not done an analysis that if a rate was approved that was below this rate, the impact of that on the insurer's solvency, right?

MR. LUSSIER: Correct. We have not done any kind of actuarial analysis.

MR. MURMAN: Okay. But you did do an analysis previously that the submitted rate would not impact the insurer's solvency, correct?

MR. LUSSIER: We rely on L&E to -- to issue their report and the reasonableness of -- of the rates, and then we look at, you know, if there's any discussion between L&E and MVP on the changes. So again, assuming that MVP and L&E are in agreement that the rates are adequate and reasonable, then -- then we would kind of defer to L&E's opinion on that.

MR. MURMAN: Okay. So you would defer to L&E's opinion that the rate is adequate and reasonable, but not comment on their solvency?

MR. LUSSIER: The assumption that

is an adequate rate will cover -- will cover the costs, and you know, if in a perfect world the rate would be -- be exact and that the 1.5 percent CTR would -- would go to MVP. So under -- under that kind of assumption then that wouldn't negatively affect their solvency. Does that -- does that answer your question?

MR. MURMAN: Well, it answers that. Yeah. So that the rate -- so the rate that is submitted wouldn't negatively impact their solvency, but -- but I don't think we know of a range of a rate potentially below the rate submitted, that would potentially lead to a negative impact on solvency.

MR. LUSSIER: Yeah, yeah. Because the -- the rates are not, I think as -- as Eric said, there's no crystal ball here, so it's -- it's, you know, the best estimates that -- that folks can provide, and normally when you have two actuaries agreeing on it, that lends us more credibility that the rates are adequate and that there will be the -- the minor contribution to reserves that has been posted.

MR. MURMAN: Okay. I don't have any further questions. Thanks, Jesse.

MR. LUSSIER: Yep.

HEARING OFFICER BARBER: Board Member Lunge, any questions?

MS. LUNGE: I'm all set.

HEARING OFFICER BARBER: Board Member Holmes?

MS. HOLMES: No, I'm set. Thank you.

HEARING OFFICER BARBER: Chair Foster?

MR. FOSTER: No questions.

HEARING OFFICER BARBER: Mr. Long. Any -- any -- anything you need to clear up before we let Mr. Lussier go?

MR. LONG: We talked a little bit about that contingency with the GMC, the actuary. Does that contingency flow both ways? So if the -- if L&E recommends increases to the rate, you would take that into account into giving your opinion on solvency?

MR. LUSSIER: I think so, yeah, but generally speaking, we're more focused on whether rates will be inadequate, but -- but sure, if yeah, if there was a -- if -- if, I guess, if the rates were deemed to be -- if they

were too high, then -- then yeah, we would -- we would, I assume, note that.

MR. LONG: And just -- just to be clear, if L&E looks at the rates and says -- says you need to adjust certain aspects of that upward, that that would go towards your opinion on adequacy? You would tend to defer to them; is that correct?

MR. LUSSIER: Yeah. Correct. Yep.

MR. LONG: Thank you. Nothing further.

HEARING OFFICER BARBER: Okay. You're excused, Mr. Lussier. If you could be available later, and yeah, if you need to hop out for something, please just text me.

MR. LUSSIER: Okay.

HEARING OFFICER BARBER: So we'll work through that.

MR. LUSSIER: Okay. Sounds good. Thank you.

HEARING OFFICER BARBER: Thanks. The next witness, I believe, is Jacqueline Lee from Lewis and Ellis. Jackie, are you with us?

MS. LEE: Yes. Yes, I am here.

Hi, Mike.

HEARING OFFICER BARBER: Hi. Let me just give me a minute to --

MS. LEE: Enable screen?

HEARING OFFICER BARBER: Yeah. Put you on the screen here.

MS. LEE: Sounds great.

HEARING OFFICER BARBER: Okay. I'm going to swear you in at this point.

Whereupon,

JACQUELINE LEE,

a witness called for examination by counsel for the Board, was duly sworn, and was examined and testified as follows:

HEARING OFFICER BARBER: Thank you, and Ms. Beliveau, please go ahead.

MS. BELIVEAU: Good afternoon, Jackie. How are you?

MS. LEE: Good.

MS. BELIVEAU: And you can hear me okay?

MS. LEE: I can, thank you.

MS. BELIVEAU: Great. So can you state your name for the record?

MS. LEE: Jacqueline Lee.

MS. BELIVEAU: And where do you work?

MS. LEE: I work at Lewis and Ellis.

MS. BELIVEAU: And what is your position at Lewis and Ellis?

MS. LEE: I'm a vice president and principal.

MS. BELIVEAU: Okay. If you could please turn to Exhibit 21 in the binder.

MS. LEE: Okay. I am there.

MS. BELIVEAU: And do you recognize Exhibit 21?

MS. LEE: Yes. This is my pre-filed testimony that I provided on July 12th.

MS. BELIVEAU: Can you briefly describe the information contained in the document?

MS. LEE: Sure. It gives some background about me, about Lewis and Ellis, our experience in Vermont, as well as how we go about assessing the various assumptions and conclusions within the rate filing. Looking through to see if that covers it, and yeah, just the general process we go through in reviewing a rate filing.

MS. BELIVEAU: Is the information in this document accurate and correct to the best of your knowledge?

MS. LEE: Yes, it is.

MS. BELIVEAU: And is there any information in this document that you'd like to change or clarify at this time?

MS. LEE: No.

MS. BELIVEAU: And do you wish to adopt this pre-filed testimony as part of your testimony today?

MS. LEE: Yes, I will.

MS. BELIVEAU: Can you please explain your role in L&E's review of MVP's individual and small group filings?

MS. LEE: Yes. We have a team that reviews each filing. We set it up so that we have consistency year over year. So Traci Hughes has assisted me for several years on the MVP filing. Allison Young began reviewing a year or two ago, and so these are all credentialed actuaries that are looking at the filing. They take first passes, have helped develop the questions that we will end up sending to MVP. I oversee all of those questions and responses, and

then we -- as a team that includes the Blue Cross team of Kevin Ruggeberg and Jared -- Jason Doherty, we meet once a week to talk about the various issues, to ensure that we're remaining consistent in our methodology and just thinking about all the issues, because some issues are market-wide, while -- where others are individual, and just ensuring that we have extra peer review as well across all filings.

MS. BELIVEAU: Okay. And how do you submit your recommendations to the Board?

MS. LEE: We submit a report on day 60. Day 60, this year, was also July 12th. So we issued a report. We issued one for each filing. So that's why we have two, an individual report and a small group report.

MS. BELIVEAU: Right. And the report for the 2025 individual rate filing is Exhibit 19?

MS. LEE: Yes, it is.

MS. BELIVEAU: And the report for the 2025 small group rate filing is Exhibit 20?

MS. LEE: That's correct.

MS. BELIVEAU: So bearing those two reports in mind, do you have any changes you

wish to make to either report at this time?

MS. LEE: I do not have any changes I wish to make further to the reports.

MS. BELIVEAU: Can you explain your standard of review in both filings?

MS. LEE: Yes. We use our actuarial standards of practice as the basis for our reviews. There is a ASOP that covers how rate filings are supposed to be put together. We also use -- the Board has a standard that is reflected in our report, which is Exhibit 19. On page 4 at the top, we -- we look at the aspects of that standard of review that include not excessive, not inadequate, and not unfairly discriminatory. And again, those items are defined within our -- our ASOPs, as well as within my pre-filed testimony, but those are the brackets we tend to review all assumptions and rates surrounding.

MS. BELIVEAU: Great. And do you review for affordability in either filing?

MS. LEE: We do not.

MS. BELIVEAU: Using your methodology and standard of review, did you make any recommendations to modify this proposed

filing?

MS. LEE: Yes, we did. Those are included and have been referenced multiple times today. On Exhibit 19, page 19, we made five recommendations. The same recommendations are made for small group on Exhibit 20.

MS. BELIVEAU: And would you like to briefly describe those?

MS. LEE: Sure, sure. We made two recommendations about unit cost. One was surrounding the inclusion of Brattleboro Retreat. That was overlooked on the initial filing. We also made a recommendation, and this is a recommendation we've made nearly every year, that given the timing of hospital budgets that those submissions that come in kind of right at our filing time for our report, that those are reviewed and considered in light of what might ultimately be approved. We also made a recommendation for pharmacy trend that's been discussed briefly this morning already, but we are recommending an increase to the pharmacy trend given our review because we feel it is more of an appropriate assumption than the assumption originally in the filing.

House Bill 766 is an increase as well, because it was a new requirement put on the carriers that was signed into law kind of in the middle of the rate review season. So that needed to be incorporated because it will be effective within the 2025 time period, and then finally, risk adjustment transfers. Every year, we perform an independent calculation using actual information that CMS will be receiving. Each year, that has been very accurate. There was a delay in the submission of these reports due to some of the issues with change in healthcare and reporting, and so we did not have the reports prior to our Day 60 report. However, those did come out on Monday, and we have verified that our calculations are in alignment with the CMS report, and we made the recommendation that that be updated as a starting point for MVP.

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

MS. LEE: Yes. We have a -- an estimate in our report, but I'm going to reference Exhibit 22. Exhibit 22 is MVP's

verification of that calculation. So for the individual filing, the initial submission was seven point -- or sorry, 11.7, and according to the calculation, it should now be based on these recommendations, 14.9 percent, which is a little bit different than what our report states. The small group is the same. It is a 9.3 with a initial -- with a change to 11.5, which is slightly different than what we put in our report, and so we believe these, the 14.9 for individual and the 11.5, are more accurate calculations, but are based on the same recommendations that we placed forth in our report.

MS. BELIVEAU: And do you find the 14.9 percent increase reasonable in the individual filing?

MS. LEE: Yes.

MS. BELIVEAU: Can you let us know why you find it reasonable?

MS. LEE: Yes, as stated before, our standard of review includes not excessive, not inadequate, and not unfairly discriminatory, and based on our review, the 14.9 falls within that standard.

MS. BELIVEAU: And do you find the 11.5 percent increase reasonable in the small group filing?

MS. LEE: Yes, I do.

MS. BELIVEAU: And can you again discuss why you find it reasonable?

MS. LEE: Yes. It's for the same reasons. We did the same review and -- and assessed up against our standard of review and came to the same conclusion for the 11.5.

MS. BELIVEAU: Have you reviewed the other pre-filed testimony in this proceeding?

MS. BELIVEAU: Yes.

MS. LEE: Have you listened to the testimony today so far?

MS. BELIVEAU: Yes, I have.

MS. LEE: So after reading the carrier's pre-filed testimony and all of the materials that have been submitted so far in the filing, and then listening to today's testimony, is there anything you wish to add or change to the five recommendations for the individual and small group filings that we have covered so far?

MS. LEE: No.

MS. BELIVEAU: And if your

recommendations as of today are implemented, do you believe that rates would be excessive?

MS. LEE: No.

MS. BELIVEAU: Do you believe they'd be inadequate?

MS. LEE: No.

MS. BELIVEAU: And do you believe they would be unfairly discriminatory?

MS. LEE: No.

MS. BELIVEAU: I have no further questions at this time.

HEARING OFFICER BARBER: Questions from MVP?

MR. KARNEDY: Yes. Thank you very much. Hi, Ms. Lee, how are you today?

MS. LEE: I'm good. How are you? Good to see you.

MR. KARNEDY: Nice to see you as well. So I want to walk through a couple of things. First, I just want to start with you looked at Exhibit 19 and Exhibit 20. Those are the two memorandums from -- from L&E: 19 is for individual; and 20 is for small group, correct?

MS. LEE: Yes.

MR. KARNEDY: So as in prior years

I'm going to ask you questions, and the questions would relate to both. We may just be looking at 19, but please, please correct me, but I'm going to presume that your responses relate to both filings. We're on the same page?

MS. LEE: Yes. Yes. I'm on the same page. Thank you.

MR. KARNEDY: Thank you. So starting with concerns you expressed about losses. If you go to Exhibit 19, please, in your binder, and it's pages 16 to 17.

MS. LEE: Yes, I'm -- I'm on those pages.

MR. KARNEDY: Thank you. So first you heard me asking questions of Eric, regarding the use of the term "risk margin". I just want to talk about that term first, just so we get apples to apples. So the risk margin here in your report in the table is 1.5 percent, correct?

MS. LEE: Yes.

MR. KARNEDY: And I'm at page 16, that table, the first table, and then you reference again the risk margin of 1.5 in the third paragraph, correct?

MS. LEE: Yes.

MR. KARNEDY: And then if you go to the next page, there's a table, and then there's a sentence below the table on page 17; do you see that?

MS. LEE: Yes.

MR. KARNEDY: And it says MVP's filed base CTR of 1.5. My question is, does that 1.5 -- is that referencing the risk margin of 1.5 on the table on page 16?

MS. LEE: Yes, it is.

MR. KARNEDY: Thank you. And the bad debt, that .3 percent, that's separate and apart, correct?

MS. LEE: Yes.

MR. KARNEDY: And the table above that paragraph on page 17 where it shows where MVP falls, those would be risk margins, correct?

MS. LEE: Well, it's actually --

MR. KARNEDY: Well, let's --

MS. LEE: -- called profit in the profit and risk in the URRT, which is the actual number where that is coming from, but yes.

MR. KARNEDY: Okay. Thank you. That number is the same number, and we'll just -- you and I will avoid the words that we -- that

you reference on page 16 next to risk margin, correct, the 1.5?

MS. LEE: Yes. Yes, that's correct.

MR. KARNEDY: Thank you. Okay. Back to page 16, and now that we have our words straight, I want to ask you some substantive questions. You'll see on page 16 at the bottom, the last paragraph references the reasonableness check. Do you see that?

MS. LEE: Yes.

MR. KARNEDY: And that's something that L&E has done for the past few years, correct?

MS. LEE: That's correct.

MR. KARNEDY: And just briefly, tell us what that's about.

MS. LEE: So CMS requires this part of filings for any qualified health plan that is operating on the exchange that they file a URRT, which is a unified rate review template. So most states and filings will have this template. They aggregate that into a public use file, and as I said a moment ago, there are different data elements, and so we have pulled

the profit and risk data element for all the filings that are submitted to CMS. And so 377 carriers were -- or URRTs were -- well, I guess carriers -- let me stick with carriers. 377 carriers provided data for 2024.

MR. KARNEDY: And that would be nationwide, correct?

MS. LEE: It is nationwide. There are some states that are state-based exchanges that may not include their data, and so there's some nuances, but it is a good portion of nationwide, and we use it very frequently in our work to just get an overall assessment of the individual and small group market.

MR. KARNEDY: Would you read the last two sentences of that last paragraph on page 16, please?

MS. LEE: Sure. "The filed CTR varied from -17 percent to +8 percent, but most often fell between 0 percent and 5 percent. The premium weighted average CTR for all carriers was filed as 3.0 percent."

MR. KARNEDY: Thank you. And then would you go, please, to the next page, page 17, and if you could explain the percentile and the

table and what it shows where MVP falls as it relates to risk margin?

MS. LEE: The graph at the top is a, you know, pictorial version of the data that we get from the -- the public use file or the PUF, and what it is trying to outline is of the 377 carriers, how many fell within the buckets that are listed at the bottom. So for instance, it looks like there's about fifty-one who fall between 2.5 percent and 3 percent, which is why we said that the rough average is around 3 percent because there's a good chunk that's within, but mathematically we did that differently based on premium weighted, but basically, it is trying to showcase where if you pick a number, so 1.5, which is where MVP is, you can see how many carriers fall below it and how many carriers fall above it and what's -- where they sit on a percentile basis, and for the 1.5 it is around the 20th percentile.

MR. KARNEDY: So that's on the low end?

MS. LEE: That is on the low end.

MR. KARNEDY: Okay. And I don't know if you would recall, but that's even better

than last year when this was done, and MVP was at the twenty-third percentile. First, do you remember what I said; and second, do you agree with me?

MS. LEE: I do remember what you said. I would have assumed that it was twenty-three, and yes, this is a less of -- they have a less percentile, so they're kind of even lower than they were last year if they were at twenty-three.

MR. KARNEDY: I'd ask you to go to Exhibit 48 in your binder, please.

MS. LEE: Yes. I have exhibit --

MR. KARNEDY: Let me know when you're there.

MS. LEE: Sorry, I have Exhibit 48.

MR. KARNEDY: I'm just going to identify it. This is L&E's individual rate filing. It's an excerpt of it from last year. So if you look at page 1, you see that says July the 5th, 2023. Do you see that?

MS. LEE: Yes.

MR. KARNEDY: And then if you look the last two pages, they reference page 17 and

18, and this is the section 12 on changes in contribution to reserves; do you see that?

MS. LEE: Yes.

MR. KARNEDY: And do you -- I'm not going to hold you to every word in this, but do you recall this from last year, this filing?

MS. LEE: Yes, I do.

MR. KARNEDY: Okay. So if you would go to page 18, please, and would you please read the first sentence below the historical RBC ratio, the paragraph below, first sentence?

MS. LEE: "It is slightly concerning", that sentence?

MR. KARNEDY: Yes, please.

MS. LEE: Okay. "It is slightly concerning that MVP has experienced an overall negative profit in the last few years, and there was a significant decrease in RBC in 2021."

MR. KARNEDY: Thank you. Next, I want you to go to Exhibit 19.

MS. LEE: Okay.

MR. KARNEDY: Excuse me? I grabbed the wrong. Exhibit 19, and I want to look at the -- the same section. So this at page 17, and read that first sentence, please.

MS. LEE: "It is concerning that MVP has experienced consistent material losses in the last few years. However, MVP's RBC has been steadily increasing in recent years."

MR. KARNEDY: So I want to ask you first, about a year ago, you said it is slightly concerning and then referenced losses and profits. This year, you're saying it is concerning. So can you understand -- or could you explain that, and have -- have your opinions changed and do you have greater concern and why?

MS. LEE: I would say my opinion has changed slightly in that it has become more apparent that these losses are continuing to happen, and it seems to be moving into a place where it feels unsustainable. The fact that last year, I probably could have modified that sentence, given the RBC was actually declining at that time, but it just feels like there are aspects of this filing as it relates to the pharmacy trend, where there has just been historic underprojections that this is becoming a consistent issue and is obviously impacting the profitability of this block.

MR. KARNEDY: Thank you. And then

if you go back, I'm sorry to go back and forth, but go back to Exhibit 48.

MS. LEE: Yes.

MR. KARNEDY: And we'll go to that paragraph again. And would you please read the last sentence in that paragraph?

MS. LEE: That same paragraph?

MR. KARNEDY: It's "given this information", that sentence, please.

MS. LEE: "Given this information, L&E believes that a CTR between 0.5 percent to 3 percent would be considered reasonable."

MR. KARNEDY: So that last year you provided a range around the 1.5, both below and above, correct?

MS. LEE: Correct.

MR. KARNEDY: So let's go to this year. It's Exhibit 19. Go to that same paragraph and please read the last sentence there.

MS. LEE: "L&E strongly emphasizes that reducing the CTR assumption from the filed 1.5 percent presents significant risk of inadequate premium rates that are not actuarially sound."

MR. KARNEDY: That's strong language coming from an actuary, would you say?

MS. LEE: I would agree.

MR. KARNEDY: So why the change in language? I know you -- you touched on that a moment ago, but could you explain, please, why the change of language?

MS. LEE: Again, I think it goes back to a holistic review of a lot of the assumptions that have been -- that as we were reviewing the assumptions, I think the most alarming being the pharmacy trend and continuing to rely upon the PBM. I think that the increase, the change that we increased it helps with -- with that because to me, it puts in at least a good faith effort to go beyond what the PBM has been recommending. However, there have been even more losses than that, and I think that while I didn't see it prior to the report, I do believe that -- I believe it's Exhibit 27, while I have some questions about some of the numbers, I think the story remains that there have been significant losses on this book of business for the last -- I guess it's five years -- and it's just continuing, and a lot of -- a large while --

a large part of it, you know, as demonstrated here, has been Board cuts. There have also been equally that the rates have just not been adequate over the years, just from what MVP had requested. So in light of that, I feel that we needed to be stronger in our language, recognizing that it is a small percentage, but as -- as noted, it would be really good for the market as a whole and MVP if this would be sustainable on its own.

MR. KARNEDY: And you referenced Exhibit 27, what you just expressed, that opinion, that includes -- and I know the numbers aren't exact, but that would include estimates in 2024 where there appeared to be some -- some profit for that year. You're looking at the trend; is that fair?

MS. LEE: That's fair. I'm not really looking at individual years. I think it's more about the amounts, and then, like I said, in coupling that with the fact that we've had serious concerns about the assumptions setting in the past as well and then seeing the pharmacy -- there was no change in the methodology of the pharmacy trend assumption setting, just wanting

to ensure that we, again, try to get MVP to have an adequate premium, which has just appeared to not be the case for the past several years, and again, independently looking at this filing, it didn't feel like it was.

MR. KARNEDY: Okay. And going back to Exhibit 48 last year, see the CTR. I'll say risk margin. You said it could be reasonable between .5 and 3. That could be considered reasonable. This year, you're saying, don't cut it. That would -- that would -- you strongly emphasize that presents significant risk, correct?

MS. LEE: Correct. I believe it is a risk to reduce the CTR risk margin below the 1.5 this year.

MR. KARNEDY: Thank you. Okay. Let's go back to Exhibit 19, the last paragraph before the RBC ratio table -- excuse me -- after the RBC ratio table. Sorry. And would you please read the third, fourth, and fifth sentences, and the third sentence to help you get your bearings starts with "Vermont business accounts".

MS. LEE: Exhibit 19?

MR. KARNEDY: Yes. Exhibit 19.

MS. LEE: 17.

MR. KARNEDY: Page 17, and it is the -- under the historical RBC ratio, there's a long paragraph that starts --

MS. LEE: Yes.

MR. KARNEDY: -- "it is concerning".

MS. LEE: Yes. So however --

MR. KARNEDY: So I would ask --

MS. LEE: -- however --

MR. KARNEDY: Yeah.

MS. LEE: Start with "however"?

MR. KARNEDY: Yeah. Let me get you the right spot. I appreciate it. Yes. "However", go ahead.

MS. LEE: Okay. "However, actuarially sound rates are sustainable without other subsidization. L&E notes that it is not sustainable to have long term losses, and therefore a higher CTR could be justified." Keep going? Keep going, Gary?

MR. KARNEDY: I'm sorry, I was thinking.

MS. LEE: Oh, okay.

MR. KARNEDY: I'm slower than you. Let's talk about those two sentences. What are you -- what are you saying there? Can you explain it to the Board?

MS. LEE: Yes. I think Eric also covered this as well, quite well, is that each product that you are offering in a market is supposed -- from an actuarial perspective, should stand on its own. There are times, especially early in a startup where you expect to have losses, but the ultimate goal is to achieve profitability and have that profitability be able to rely within its own product and not have other products be profitable, so that you can see a loss in the product itself. So to have a goal to make the profitable -- like, if this was their only book of business, they would be profitable because it stands on its own.

MR. KARNEDY: So you -- you heard some questioning by counsel for the health care advocate of Eric looking at the -- the larger company, MVP's financials and questions of -- of profits. Would you agree with me that as an actuary, you're looking at that product line, and that's what your focus is on in terms of

actuarially reasonable rates?

MS. LEE: Yes, we are focused on the product that has been filed.

MR. KARNEDY: I forget which sentence I had you read, so bear with me. I'm going to read the sentence to you. "L&E notes that it is not sustainable to have long term losses, and therefore a higher CTR could be just justified." What do you mean, it's not sustainable to have long term losses?

MS. LEE: Again, if you have this as your only product line, you can't just have losses indefinitely. At some point, typically, businesses assess whether or not they should continue to offer a particular product, and so it is not -- it -- a company cannot continue to remain in business when it's not making money, and if it has a product that is causing this, changes need to be made, whether that is they need to increase the premium, decrease the benefits, or simply stop offering it.

MR. KARNEDY: Thank you. The next sentence: "Given that a lower utilization trend assumption could also be justified, as discussed previously in this report, L&E is not

recommending a higher CTR." Is your point there that if you set aside the utilization trend, if you didn't consider that, you would be recommending a higher CTR?

MS. LEE: It is likely we would have recommended a higher CTR. Yes.

MR. KARNEDY: And all this testimony you've given about long-term losses and sustainability, all the more important when there's only two carriers in the particular market, correct?

MS. LEE: Yes. I mean, that's not part of our overall review, but it does hurt the market if, you know, say there were to be one that happened, and a lot of markets early on in the ACA after it established, and it was not good for consumers.

MR. KARNEDY: Thank you. So --

MR. FOSTER: So can I -- can I -- can I interrupt just for a second, just being mindful of time. We spent a lot of time reading the pre-filed testimony from Ms. Lee. I just want to make sure you're focusing where you think it's most useful for the Board to get the information. Some of this seems pretty basic to

me, so we might want to just be thoughtful of the time.

MR. KARNEDY: I -- Chair, appreciate everything you said, except I couldn't hear what you said. Some of it seems pretty -- are you saying repetitive? I didn't hear what you said. It cut out.

MR. FOSTER: Repetitive, repetitive, and I think it came through in the report quite a bit, a lot of this. We get this. So it might be good to just focus on the -- the key material if you think there's something that's really important for us.

MR. KARNEDY: Okay. Thank you. Let me readjust for a second, then. My head will be down for a moment.

MR. FOSTER: Sure. Thank you.

MR. KARNEDY: So I'm going to skip a lot of this. I think that you generally agree with -- I guess I can't testify, but you agree with the testimony you've heard about various things in the calculations. I want to get to the hospital budgets. You heard testimony on the hospital budgets. I know in prior years, you've been flying to Vermont, and there hasn't been

time to review matters before we went to hearing, but did you hear the testimony on the hospital budgets and the inclusion of UVM, which we just got on Friday, which would bring the rate to 15.89 for individual and 12.81 for small group? First, did you hear the testimony?

MS. LEE: Yes, I did.

MR. KARNEDY: And do you -- are you able to, as you sit here today, agree with those figures?

MS. LEE: I think you're referring to the figures on 26, Exhibit 26.

MR. KARNEDY: Let me go there. So let's -- let's walk through this just so the record is clear, and I think this will be helpful for the Board. 26, the figures were the updated budget figures, which you heard testimony on, but -- but when we prepared this exhibit, we hadn't heard that UVM was changing their proposed budget, and so we, in live testimony, changed those last two figures based on -- and this is all in evidence -- based on UVM's revised budget proposal, and those went up slightly to 15.89 for individual and 12.81 for small group. So my question is, do you agree with that? I don't

want to put you on the spot if you haven't reviewed it.

MS. LEE: I will. I feel comfortable saying we have reviewed the updated budgets that are listed on 26, which are the 15.5 and -- and the 12.39. We have generally always agreed with the calculations, so I'm not really questioning the UVM. I think that that is probably appropriate given the size of UVM and what they requested. So I think I feel comfortable agreeing that those are the numbers as calculated, for calculation purposes, not necessarily what they will ultimately be.

MR. KARNEDY: So let's get to that, and I'm going to just move it along, in light of the -- the Chair's request. So you saw that -- well, you probably wrote the questions where you asked for different scenarios, and you heard that testimony. There was an A and a B and a C. And --

MS. LEE: That's correct.

MR. KARNEDY: -- and so MVP had filed rates based on last year's increases, and then those three scenarios were if you accepted the hospital budgets, if those were approved,

that's A, and B was no increases, and then C was ten percent. Do you recall those questions and those responses?

MS. LEE: Yes.

MR. KARNEDY: Okay. So would you agree with me, I think you heard Mr. Bachner testify that whatever the Board ultimately decides, you as an actuary would prefer that the rate that's approved here is as close -- the hospital budget data input is as close to -- as possible as to what is ultimately decided by the Board; is that fair?

MS. LEE: Yes. Yes. It would be nice that they would be close.

MR. KARNEDY: And finally, on administrative costs, there were tables. I'm going to try to cut to the chase. There were tables in your actuarial memorandums that showed that MVP, its administrative costs, were as a percentage of premium quite impressive; wouldn't you say?

MS. LEE: Yes.

MR. KARNEDY: The one percent tile as a percentage of premium, correct?

MS. LEE: That's correct. It is

low compared to that same PUF that we talked about earlier.

MR. KARNEDY: Thank you very much.

MS. LEE: Thank you.

HEARING OFFICER BARBER: Mr. Becker?

MR. BECKER: Hi. Hi. Thank you. Hi, Ms. Lee, how are you?

MS. LEE: I'm good. How are you?

MR. BECKER: I'm doing well. I didn't have a lot of questions to begin with, and then hearing the concerns about pacing, I've been attempting to rework what I've had as -- as you -- as Mr. Karnedy's been asking you questions, so this hopefully should go pretty quickly. Let's -- okay. So -- and this first thing, I'm going to ask about it, but it might not even be material. So Exhibit 19, this is your memo about the individual rate filing, MVP's individual rate filing, and then page 3 of the memo, there's a table at the top of the page, 2025 proposed individual rate changes?

MS. LEE: Yes.

MR. BECKER: I mean, to me, I look at these numbers here in this table and just the

numbers look very high to me. I wonder if these numbers are in error or if I'm not understanding the table correctly, because I don't think we have $1200 a month bronze plans yet here in Vermont. Do we, or am I misunderstanding the table?

MS. LEE: So that is the average premium. So it is going to include other tiers so that - that is representative of, like, the percentage of families that you have as well. So it's not just the single. It's going to be just if you have sixty percent of families.

MR. BECKER: I misunderstood. Yeah. Okay.

MS. LEE: Yes.

MR. BECKER: All right. Perfect. Thank you so much. All right. Down at the bottom of the page, there's a table about silver alignment, and what this shows is that hypothetically, for a family of four making $60,000 a year, next year, that family will be able to buy a $0 gold plan in the individual market at significant savings. Am I interpreting that chart correctly?

MS. LEE: Yes. That's correct.

MR. BECKER: Okay. And also, maybe this is an inferential leap from this chart, but that the, the, the gold plans will be cheaper than silver plans next year in the on exchange individual market; is that accurate?

MS. LEE: Yeah, I can't verify that every data cell will be, but yes, that is a general consequence that's positive of silver loading, is that gold plans become cheaper than silver. So there's not a incentive to have a silver plan. You would then move to gold, and then you have less cost-sharing.

MR. BECKER: Perfect. Thank you. Just to verify, I think we all know the answer. Silver alignment has no impact on premiums in the small group; is that accurate?

MS. LEE: That's correct.

MR. BECKER: Okay. Thank you. If you could turn to page 6 of Exhibit 19.

MS. LEE: I'm on page 6.

MR. BECKER: Okay. So this is where medical unit cost trend is discussed. Here in that box on the right, it appears that MVP, for the individual market, uses 4.1 percent as the cost trend, medical unit cost trend, for the

individual market; is that an accurate statement?

MS. LEE: For the GMC regulated hospitals, they use 4.1. Yes.

MR. BECKER: And in the small group market is that number 3.7 percent? It's on page 5 of your small group memo.

MS. LEE: Yes, it is 3.7.

MR. BECKER: 3.7 percent. The hospital budget guidance this year that the GMCB be -- issues, and I might not get the phrasing exactly correct, but I -- as I interpret the impact or the -- the import of the guidance is that the hospitals were requested to keep their net patient revenue and/or their -- their -- their costs, their prices to no more than a 3.4 percent increase. That was the guidance that they were provided. If we plugged 3.4 percent as the GMCB regulated facilities trends into both of these filings, would that have the effect, can you say, of lowering the rate overall?

MS. LEE: I believe that the hospital budgets, as they came in, as they were submitted were higher than that amount, which is what the -- those boxes were developed based on. If they were capped, then I believe that number

would be lower, which means those numbers would go down.

MR. BECKER: Okay. And I'm sure, you know, it wouldn't be a huge amount, right, but it might lower the rate?

MS. LEE: Correct. It -- keeping in mind that also part of that table which I've abandoned on my binder, but there's only about half is subject to the --

MR. BECKER: Yeah.

MS. LEE: -- the regulation and the -- and the hospital budgets, so only half would be impacted by that change.

MR. BECKER: Exactly right. Thank you. Yep. So on page 7, that's where we start talking about medical utilization trend. We've had a lot of discussion about this already. If I could just sort of quickly summarize and you tell me if anything I say here is wrong. For the past few years, MVP's been using a one percent medical utilization trend, and they picked that number from a range that you all provided to them because their historical data wasn't producing accurate results for them, and so they went with that one percent that -- that you all had

recommended, and now, it sounds like this year MVP has -- not MVP, L&E has determined that, you know, actually their utilization data is appropriate for them to be using and that at the 50th percentile of -- of their utilization data, a 0.1 percent utilization trend would be a reasonable and appropriate number for them to have selected. Did I get that basically right?

MS. LEE: But yes, I would just add that the market study that we did was from, I believe, 2019, and we have not agreed with the use of it for quite some time, given that it's dated. So that's another reason why we -- we don't really reference it because we don't deem that's an appropriate methodology at this point.

MR. BECKER: Okay. So you identify a number that would have been reasonable 0.1 percent. You don't recommend cutting the rate from their one percent that they use in developing their rate to 0.1, because of concerns about CTR, right?

MS. LEE: Correct.

MR. BECKER: And we've spent a lot of time already talking about what those concerns are. I'm not going to try to go over them all

again, but we probably should flip to page 17 of your memo.

MS. LEE: Okay.

MR. BECKER: Yeah. And let me just take a second here because like I said, I'm reworking everything I had. I haven't heard anyone today even suggest reducing the CTR assumption of 1.5 percent. I haven't had -- have you heard anyone suggest that?

MS. LEE: No.

MR. BECKER: I guess, so if the 1.5 percent CTR was maintained as -- as is. Are any of your concerns at all alleviated about plugging in that 0.1 percent, that medical utilization trend that you thought was reasonable and appropriate?

MS. LEE: I think the only concern that I would have is that it does, as we state, put a higher risk that they would be inadequate. Aiming for the 50th percentile is an approach, but obviously you can mitigate by being at a higher percentile. So if you went for, you know, a half a percent, that would alleviate it even more, but I would say, I think that, you know, we have used 50th percentile. That's roughly what

we did for the pharmacy trend. We did an average that's along the same lines. So that -- that is why we -- we plugged -- we use that number, but I do want to continue, I think where we kept, you know, as a team and -- and me personally kept referencing, which hasn't been referenced very much on page 16, which is the ATE or actual to expected of the risk margin. That's where I continue to go back to. So it puts at a greater risk of continuing a pattern of negative actuals the lower that we set the utilization trend.

MR. BECKER: Okay. No, that's -- that's fair enough, I suppose, and I mean, it's a good segue. I mean, Mr. Karnedy did reference briefly, Exhibit 27, which does show, I believe, for 2024 potential gains or -- in the order of $6 million in the individual market, and I -- I get that you're looking at a -- a trend instead of just a single year in isolation, and probably if I asked you if that six million in potential gains alleviated your concerns, I bet they wouldn't alleviate them all that much.

MS. LEE: I mean, I had not seen this exhibit until it was provided within this document, at least that was not what I had seen.

Rates are based on 2023 experience.

MR. BECKER: Uh-huh.

MS. LEE: So we don't -- we don't get 2024. We don't -- we will ask some questions, but even during our conversations back and forth, you only have a few months that are really reliable. I like to see that we're moving in the right direction, finally. That is helpful to see, and so I think this was beneficial, but it -- it has been a pattern that they lose a lot of money.

MR. BECKER: Okay. Let's move on. This is the last thing I want to talk to you about quickly to the RX trend, which begins on page 8 of your filing. Let's see. Again, I mean, I think we've -- we've had a lot of testimony on this today and maybe what I'll try to do instead of going through my list of questions is to summarize what I think we've heard today, and you can tell me what -- if I got anything wrong. So historically, CVS, MVP has relied on the prescription utilization trends or prescription cost trends, cost and utilization trends from their pharmacy benefit manager to develop a trend in which they input into these

rate filings. What's been discovered, it sounds like, based on an analysis that L&E performed, is that the trend data from their pharmacy benefit manager hasn't been particularly accurate through the years, and now you're -- evidently hasn't been particularly accurate through the years, and now you're saying in this filing in your memo that it's no longer reasonable for them to be relying solely on their -- on their PBM provided trend data? How did I do with that?

MS. LEE: Yeah. I don't think it's really relevant. This isn't new. I can't remember what we recommended last year, but I think that we have recommended changes to the pharmacy trend frequently. So this is not new.

MR. BECKER: Well, this is what I mean. It's actually what I wanted to ask you about, and it's my final question, and I -- and I almost feel bad that I didn't think to ask Mr. Karnedy to include your full memorandum from -- from last year instead of just those selected pages, because I was going to ask you whether or not in prior years you found it reasonable and appropriate for MVP to rely on their RX trend data, and maybe if I could make an ask for

post-hearing follow up information, which we don't tend to do a lot of, is would it be appropriate for me to ask for us to go through and look at how often has MVP -- has L&E said it's reasonable and appropriate for them to use that PBM provided number?

MS. LEE: I will say confidently that we have never taken the we're using the PBM and said, okay, they know best and moved on. We have always done a very similar analysis. Several times, it has defended the PBM's number or come close or striking distance. I don't disagree with anything that Eric said about PBMs knowing the industry better. That is generally the case. When I do my pricing, I look to the PBM for their help because they -- new drugs are coming on market all the time. Drugs are moving from brand to generic. This particular situation, and you know, we always like to look at Vermont only, and look at your experience. We really like to use our own because Vermont can be different, and you're just off all the time here. So I just think given the historic -- it need -- this -- we need to stop, and then again, coupled with the losses, this is a place where they have

lost a lot of money is in their pharmacy drugs.

MR. BECKER: It's probably an unfair question, and if you give me a look, I'll withdraw it the second I ask it, and it will be my last question. If you saw trends provided by your PBM that were so consistently wrong, would you stick with them? Would you re-sign a contract with that PBM?

MS. LEE: Laura, should I answer that question?

MS. BELIVEAU: Do you feel you have the background? Have you had that experience in your other professional work? Can you give an accurate professional opinion?

MS. LEE: What -- I can answer it in a way that may not answer your question, but I don't think that trend projection is all the value that a PBM brings to an organization. I would be looking at, like, the audit question. While it was vague and small, I'm more concerned about my reimbursement rates and my rebate guarantees and minimums with my PBM, not necessarily can they project trends? That's obviously very helpful, and in other markets, sometimes you're required to use what your PBM is

doing. So I'd take a hard look at it, but to me that is not -- this should not be a measure of reflection on how good a PBM would -- is performing for you.

MR. BECKER: I appreciate the response. Thank you. Oh, that's all I had. If that wasn't clear.

MS. LEE: Thank you.

MR. BECKER: Yeah.

HEARING OFFICER BARBER: Now, Board Member Walsh, do you have questions for Ms. Lee? Board Member Murman?

MR. MURMAN: Sorry. My camera's off there. I didn't realize it. I have just a few questions, and one of them, I think Mr. Becker touched on, but I wanted to clarify, because when I looked at these premiums on page 3 of -- of tab 19 that were remarkably high, especially in the gold and platinum, all of them, but you're saying that those premiums could be -- they're not individual premiums?

MS. LEE: Yes.

MR. MURMAN: Okay. Because when I compared them to the submission we reviewed the other day, they were substantially higher, but

that probably relates to a different mix of individuals --

MS. LEE: Correct.

MR. MURMAN: -- and families that are in these.

MS. LEE: Yes. Yes. So that -- that just says that you have a good portion of families that enroll in the QHP market, or at least some --

MR. MURMAN: Okay.

MS. LEE: -- because it's higher than a single.

MR. MURMAN: You commented on this submission 48, I believe, from last year about MVP's overall negative profitability and RBC, and you also commented on, you know, at some point, a insurance company may look to end a particular product line because of their losses, and the other thing that's come up today is the sustained or the apparent losses in the Medicare Advantage plan from MVP. So I'm trying to understand the relative impact of the Medicare Advantage losses in Vermont to the -- to the QHP market in Vermont and their impact to the overall RBC and thus the -- the solvency of -- of the company. Do you

have any -- have you looked into the Medicare Advantage losses at all with regards to their solvency?

MS. LEE: I have not. I will say that the RBC formula does necessitate a higher RBC requirement for part D. So that's the pharmacy arm of it. That would be -- the only difference is they do deem that -- "they", being the NAIC group that put together RBC did deem that a more risky business, but outside of that, I haven't looked at it. As far as -- I just know that it does have an impact on the RBC, and given that we've been kind of looking back and forth between last year's memo and this one, you know, clearly the losses in Vermont are not really impacting because they're going directionally different based on still continued losses, and so that has to do with their -- their just general capital position and the amount -- their kind of claims ratio in each of the individual lines, and there is a greater emphasis and risk placed on like the part D version of -- portion of the RBC ratio, if you look at the calculation.

MR. MURMAN: Okay. That's all I have. Thanks.

MS. LEE: Thanks.

HEARING OFFICER BARBER: Board Member Lunge.

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

MS. LEE: Thanks, Robin.

HEARING OFFICER BARBER: Board Member Holmes?

MS. HOLMES: I'm all set. Thank you.

HEARING OFFICER BARBER: Chair Foster, any questions?

MR. FOSTER: No questions. Thank you.

HEARING OFFICER BARBER: Ms. Beliveau, any redirect?

MS. BELIVEAU: No redirect at this time. Thanks.

MS. LEE: Thank you.

HEARING OFFICER BARBER: Okay. Thank you, Ms. Lee. So I think we're to the point where it makes sense to go through the motions to go into a nonpublic session and pick up with questions that folks had on confidential materials for Mr. Bachner. Any -- well, so

the -- the -- if you recall from Monday, there are provisions in the open meeting law that allow you to go into executive session to discuss certain things, but there's a broader provision in the rate review statute, actually, which is more useful. So it says that notwithstanding the open meeting law, the Board may examine and discuss confidential information outside a public hearing or meeting, and so that provision really allows you to, I think, ask questions about the confidential material, as well as the subjects that that material pertains to, which is also confidential. So trade secrets being the primary subject. So -- so would anybody like to make a motion to go into an executive or nonpublic session, to ask questions about the confidential material in the binders and other confidential information?

MS. LUNGE: I will move that we go into executive session under the rate review statutory provisions in order to discuss confidential material.

MS. HOLMES: I will second.

HEARING OFFICER BARBER: Any questions or discussion? Okay. All those in

favor, please say aye.

IN UNISON: Aye.

HEARING OFFICER BARBER: Okay. So before we move over, I just want to warn everybody that we really do need to stick to confidential material, and if -- if you have any questions about -- about that, what is confidential, what is not, please don't be shy. We can talk about that and make sure that this really sticks to what needs to be kept confidential, and as far as who needs to go over to the executive session line, obviously, MVP's attorneys, Mr. Bachner, anyone else from MVP, anyone from the healthcare advocate, Board members and staff. I believe, Mr. Lussier, if you're still on, you're -- you're welcome to come, and we'll do kind of a roll call at the beginning to make sure that we have everyone we need and no one we don't.

So with that. I think we can go off record, Ms. Morales, and we can see everybody -- actually, why don't we take -- take a five-minute bio break and see everyone there at 2:25.

(Recess at 2:21 p.m., until 3:08 p.m.)

HEARING OFFICER BARBER: Thank you. Mr. Becker, do you have witnesses you'd like to call?

MR. BECKER: Other than Mr. Fisher, no, and I wouldn't be calling him to do a direct examination, but to do as we traditionally do, to allow him an opportunity to speak.

HEARING OFFICER BARBER: That's fine, Mr. Fisher. You ready to take the oath?

MR. FISHER: I am.

Whereupon,

MICHAEL FISHER,

a witness called for examination by counsel for the Board, was duly sworn, and was examined and testified as follows:

HEARING OFFICER BARBER: All right. Please go ahead.

MR. FISHER: So thank you, Board members and MVP and members of the public for sticking around for another long day. I think reading the room and reading the dynamic, I'll be I'll be super brief, and yes, I'm happy to take a few questions from Mr. Karnedy to the best of my ability. I think the -- the comments that I made on Monday, to the extent that they were market-

wide comments -- I'm not going to repeat them here, but I think their comments about the overall process and I think they apply and -- but there's one thing I didn't say on Monday that I had planned to, but I'll just spend a minute on here is just a recognition of the comment process.

And you know, we, at the HCA, take the -- we see ourselves, we see part of our statutory duty is to support and facilitate public comments, make sure Vermonters voices are heard, and we work hard at it. For a long, long time, we've struggled with this dynamic that it is rate review that comes first. It is paying premiums that people focus on the most, and the average person, I'm sure, does not appreciate the relationship between hospital budgets, hospital commercial rates, and the insurance rates. So that challenge felt more acute to me this year. I just want to recognize the -- the challenge.

You know, we -- we can't go back to the public in a month and say, oh, comment again, and yet, the comment period for the rate review process is about the proposed rates, and so we don't have -- I don't have an easy answer

about it. I think that our thinking has moved some to asking people, at least in our request, this is about some -- our request is asking people to comment about the affordability of the system, and -- and to mention both hospital costs and -- and insurance costs, costs of running both sides of the equation. So I just wanted to speak really honestly and directly about that. It is my hope that as you enter into the next set of proceedings about hospital budgets that you'll see the pleas for, you know, managing the costs of -- of the system that came in through the insurance rate review process as applying just as much to the hospital budget process. So I wanted to make that that point.

I generally spend a minute reading a few. Charles Becker did that some in his opening statement, and so I think I won't though. I guess I would invite you -- I trust the Board members to spend the time needed to read all the public comments that come in. The ones I was going to focus on, and I would ask you to spend a little time focusing on as you look at them, is the ones from the small business community. As has been noted a number of times, and I'll say it

again, we have the most -- you know, due to your actions and others' actions, we have the most generous supports in the individual market that we've ever seen. Does that completely satisfy the affordability questions and concerns in the individual market? No. And -- and repeat, due to the fact that we only know it will be in place for one year, we have real concerns about the individual market going forward, but the small group is where the real challenge is, and -- and we have just a strong concern about affordability in the small group as ever.

So I think I will -- all right. I'm sorry. I have one more process comment I want to make. This is not the first year where there -- I believe there's been some concern or expression of concern about whether MVP has brought to the table the range of experts that are needed to be able to answer questions, the business questions or questions about negotiations with hospitals, and so I just think for future years, it's worth thinking clearly about that to make sure that MVP brings people to the table for both the HCA and for the Board to be able to ask the full range of questions.

I say that with a recognition that MVP bringing one witness means we're a couple hours earlier today, but I think it would improve the process if -- if we had expertise from MVP on the business side and the negotiating with hospital side as well. Thank you, Board members. Thank you, Mr. Hearing Officer, and happy to respond to any questions.

HEARING OFFICER BARBER: Mr. Karnedy, do you have any questions? You're on mute.

MR. KARNEDY: I have one brief line of questioning, which one of our lawyers has briefed, and they go on and on, but I think this will be brief. How are you, Mr. Fisher?

MR. FISHER: I am excellent.

MR. KARNEDY: Great. So I want to read from you a quote from your testimony for the 2023 rate filing. So this was back in July of 2022. It's relatively brief. "We have the conversation every year about what the term 'affordability' means from the HCA's perspective. The term literally means do people reasonably have enough money to buy the product? You have a great product that -- that costs, say, $5 and you

only have $3 in your pocket, it doesn't matter how much you have done to reduce your costs or even what a good value the product -- the product is, I still only have $3 in my pocket." Now I know that was two years ago, but what I just read is what you said, I'll represent. You still agree with that notion?

MR. FISHER: Yes. And I said something similar to that on Monday.

MR. KARNEDY: So would you agree with me that what is affordable to a given individual or family depends on their income and other life costs?

MR. FISHER: Yes. Affordability is directly related to -- to income.

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

HEARING OFFICER BARBER: Okay. I'll open it up to Board members if you have any questions for Mr. Fisher. Yeah, just go ahead. Okay. Thank you, Mr. Fisher.

MR. FISHER: Thank you.

HEARING OFFICER BARBER: Gary, do you have any -- you had mentioned potentially calling Mr. Lussier back? Is that something

you're wanting to do?

MR. KARNEDY: I'll defer to Attorney Long on that.

MR. LONG: No. We can -- we can let Jesse go today. Thank you, Hearing Officer Barber.

HEARING OFFICER BARBER: Thank you. Then I think we're ready to move to closing statements. Do you -- the parties need a couple minutes or are you ready to go?

MR. KARNEDY: I think I'm ready if Charles is ready.

MR. BECKER: I'm ready. Yep.

HEARING OFFICER BARBER: Why don't you go ahead, Gary?

MR. KARNEDY: Thank you very much. Thanks for everybody's time today, and I also appreciate very much the heads up from the Chair when he said, Gary, move it along a bit. So I appreciate that. We're trying to go through a lot of complicated things, but I also know that this isn't your first time at this rodeo, so I appreciate your patience.

L&E is recommending that MVP increase its overall rates from MVP's original

filed rates of 11.7 for an individual and 9.3 for small group. Jackie Lee testified that she would rely on MVP's calculations of L&E's proposed rate adjustments, which was a recommended impact initially of 14.9 for individuals and 11.5 for small group when adjusted for mathematical accuracy. That figure did not include the hospital budgets.

So today, we had -- we offered evidence on the hospital budgets. Ms. Lee heard that evidence, and as I understand it, would defer to MVP's calculations, and the rate increase when you include the revised budgets, including what was filed by UVM on July the 19th, it gets to a proposed rate of 15.89 for individual and 12.81 for small group. So both actuaries are in agreement on that. That, of course, is just one option for the Board to adopt as it relates to the hospital budgets. That calculation was based on adopting what the hospitals proposed. What the hospital proposed, that was item A in the scenarios that -- that the Board and L&E had asked us about.

The Board could use a different input for hospital budgets. It could use the

same increase as last year. It could use no increase. It could use a ten percent increase or some other amount, but whatever the Board chooses, you heard Mr. Bachner testify and Ms. Lee testify. Both actuaries agreed that what's decided in the proceeding here should be as close to the actual budget decision that's made later by the Board, consistency, so the carriers don't get caught short.

I hope that you'll find we provide a significant amount of evidence on affordability and other nonactuarial criteria through the pre-filed and live testimony of Eric Bachner, as well as the related testimony of Mr. Fisher that you just heard and other exhibits.

First, yes, the Board should continue to be vigilant in reviewing MVP's administrative costs and charges for health insurance that it provides. That said, Mr. Bachner provided you with both data and an opinion that the underlying health care costs are the primary driver of affordability. Second, the state and federal government have created subsidies and safety nets for individuals to address affordability, Vermont Health Connect,

Medicare, and Medicaid. The federal and state governments have already effectively determined what is affordable for each particular Vermonter. Third, the evidence suggests that the determination of affordability is best made in two other material venues. This is difficult for the Board, but the first venue is the product design, and you heard evidence on that. Affordability is considered and baked into the plan, designed earlier in the year by the Green Mountain Care Board and other stakeholders, including DVHA.

The second venue is the hospital budget process and hearing has a determination of affordability is largely about health costs, not health insurance. As a society, we placed a premium on health care in America, and there are costs associated with that. Affordability is also determined by the personal circumstances of a particular consumer. What is affordable to a given individual depends on their income and other life costs. These are all personal factors and what a person can afford just beyond MVP and its actuaries control.

Thank you very much for your time

today. I know you've got some difficult work ahead of you, but we appreciate your attention.

HEARING OFFICER BARBER: Go ahead, Mr. Becker.

MR. BECKER: Thank you. I'll be very brief. Quite simply, rate increases that now stand at 15.9 percent in the individual market and 12.8 percent in the small group market are too high. Vermonters can't afford premium hikes this high for the third consecutive year in a row, especially in the small group market, and while the individual market is protected from the premium increases for at least one more year, if the cliff at 400 percent of the FPL comes back next year, having baked in years of double digit increases, it goes without saying that the situation in the individual market will be dire, and that's just the premiums.

As my colleague Eric Schultheis often points out, for consumers there is the dual burden of premiums and deductibles. No, Vermonters can't afford these premium hikes, as they've made abundantly clear in public comments. To any Vermonters listening right now, please continue to express your views by submitting

written comment or by coming to the public comment forum scheduled for tomorrow night at 4 p.m. The HCA pointed to some potential cuts, areas for cuts today at the hearing. We will summarize those recommendations at least and potentially more, along with additional discussion about affordability and access in our post-hearing memorandum. Thank you very much.

HEARING OFFICER BARBER: Thank you, both. Thanks to all the witnesses today, too, and Board members, and I think I'm ready to turn it back to you, Chair Foster, to take public comment and adjourn the meeting.

MR. FOSTER: Thank you, Hearing Officer Barber for your work this week. I'll open up to public comment via the raise the Hand function. All right. Seeing none. Ms. Gutwin (ph.).

MS. GUTWIN: Yeah. I just want to compliment MVP for a couple of things. First of all, their telemedicine product is really helping a lot of people, what I hear. It -- it makes not only accessibility but affordability shine. It's just one of, I think, an asset not to be taken lightly. It's a real benefit, and the wellbeing

incentives, I also agree wholeheartedly. That is preventative care in its most affordable way. So I applaud them on that, and then the last thing I applaud them on the relationships with the nonregulated entities, I being one. I think they did an excellent job treating me. I felt, with due respect, as they would any provider, regulated or not. That's it. Thanks.

MR. FOSTER: And thanks for sharing that, Ms. Gutwin. I appreciate that. Any other comment? Okay. I want to thank counsel for both the HCA and for MVP, for ably assisting your clients in a good presentation today and providing us a lot of great information in the submissions. It's an immense amount of work, and we really appreciate the diligence you all put into preparing and putting on today's presentation and giving us all this to think about.

These are really tough times. I'm just going to say something that I think came out of Mike Fisher's, which was an observation, an obvious one, but there's just three bad options here, like, in this current state. If you reduce the insurers, there's real insolvency problems.

They're just -- there's a lot of evidence of testimony relating to that, and there's concerns about people leaving the market. If you don't do a reduction, it's extremely expensive, and you worry about people not having insurance or people incurring more medical debt or buying down, or actually a longer term problem of people not being here or not having their businesses here. And if you reduce the hospitals, you also have a problem of ensuring their solvency and/or people's access to care on that end. So this is a real tough year, and we really appreciate people sharing thoughts and perspectives to try and help us make those really tough decisions this year.

So thank you, everyone, and I will move that we adjourn today's hearing.

MS. HOLMES: Second.

MR. FOSTER: All in favor, say aye.

IN UNISON: Aye.

MR. FOSTER: Good afternoon, everyone. Thank you.

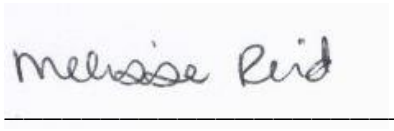
HEARING OFFICER BARBER: Thank you very much.

THE COURT REPORTER: Okay. The rate and review hearing is now closed. It is 3:27 p.m.

(Whereupon, the proceeding was adjourned at 3:27 p.m.)

C E R T I F I C A T E

I, Melissa Reid, certify that the foregoing transcript is a true and accurate record of the proceedings.



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Date: July 29, 2024