

STATE OF VERMONT  
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-008-16-RR

VERMONT HEALTH CONNECT RATE REVIEW HEARING  
(BLUE CROSS BLUE SHIELD OF VERMONT)

July 20, 2016  
9 a.m.

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89 Main Street  
Montpelier, Vermont

Hearing held before the Green Mountain Care Board, at the City Center, 89 Main Street, 2nd Floor, Montpelier, Vermont, on July 20, 2016, beginning at 9 a.m.

P R E S E N T

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1 MR. GOBEILLE: Good morning everyone.  
2 I'll call this meeting of the Green Mountain Care  
3 Board to order. The only item we have on the agenda  
4 today is the Blue Cross Blue Shield rate filing and  
5 the hearing.

6 And so at this point I'm going to turn  
7 it over to our Hearing Officer, Noel, if you want to  
8 take it from here.

9 MR. HUDSON: Okay, thanks Al. Good  
10 morning everyone. My name is Noel Hudson. I'm the  
11 designated Hearing Officer for the chair today. I am  
12 also part of the Green Mountain Board staff -- Green  
13 Mountain Care Board staff, but today I'll be the  
14 Hearing Officer.

15 It is July 20th, 2016. This is a  
16 hearing in the matter of Blue Cross Blue Shield of  
17 Vermont, Vermont Health Connect 2017 rate filing.  
18 This is Docket Number GMCB-008-16-RR. The  
19 application for this rate review is conducted under  
20 Section 4062 Title 8 and Sections 9375 and 9380 of  
21 Title 18 of the Vermont Statutes as well as the  
22 Board's Rate Review Regulation Rule 2.

23 We have a court reporter with us today,  
24 Kim Sears. And she will be producing a record and a  
25 transcript of this proceeding. And because that

1 record and transcript need to be very clear, please  
2 turn all cell phones off at this time. That way we  
3 can get a clear record. And all parties in  
4 attendance and people in the audience can hear  
5 everything that's going on.

6 The parties to this proceeding are Blue  
7 Cross Blue Shield of Vermont, the Vermont Office of  
8 the Health Care Advocate, and we have also appearing  
9 today though not as a party, the Department of  
10 Financial Regulation who will be giving some witness  
11 testimony on the question of solvency, and that's as  
12 designated by statute.

13 And the order of business today is we  
14 will do some bookkeeping, stipulated exhibits, and  
15 getting witnesses sworn in at first. Then we will  
16 hear testimony, opening statements from the parties,  
17 testimony from Blue Cross, testimony from DFR, and  
18 testimony from the Health Care Advocate.

19 MR. GOBEILLE: Can I interrupt?

20 MR. HUDSON: Sure.

21 (Phone playing music)

22 MR. GOBEILLE: Jaime, if you could call  
23 into this number that would be great, just to get the  
24 music to shut off. That way there is a participant.

25 Thank you. Sorry to bug you. But I did

1 kind of feel like I was part of a musical for a  
2 little while there while Noel was talking.

3 MR. HUDSON: Once we hear testimony  
4 from all the parties and the Board has had an  
5 opportunity to ask all the parties the questions that  
6 they have, we will have an opportunity to -- for  
7 public statements. And if anyone who is here, a  
8 member of the public, who wishes to make a statement,  
9 there is a public statement sign-up sheet in addition  
10 to the attendance sheet that we have located in the  
11 back. So if you would like to make a public comment,  
12 please make sure you get your name on that so that we  
13 have your name for the record. And please limit all  
14 public comments to a span of two minutes apiece.  
15 That would be much appreciated.

16 The public comments period in this  
17 matter will go through July 26, so we will also be  
18 taking public comments through that date via the  
19 Green Mountain Care Board rate review Web site if you  
20 wish to submit a public comment that way.

21 So without further ado, let us move on  
22 to swearing in the witnesses. We will do that all at  
23 once, and then we will get our stipulated exhibits  
24 in, and then we will move on to opening statements.

25 Could all witnesses who plan to appear

1 today please stand before our court reporter. And  
2 let me get their names in for the record too. The  
3 planned witnesses for this hearing are Ruth Greene  
4 and Paul Schultz of Blue Cross Blue Shield. Donna  
5 Novak of NovaRest who is the contract actuary for the  
6 Health Care Advocate. Ryan Chieffo, Assistant  
7 Director of Rates and Forms for the Department of  
8 Financial Regulation. And Dave Dillon, Lewis &  
9 Ellis.

10 (The five witnesses were sworn)

11 MR. HUDSON: Thank you everyone. At  
12 this point it would be appropriate to move on to  
13 taking the stipulated exhibits into the record.

14 MS. HUGHES: So we presented -- this  
15 does not sound like it's on, but we provided the  
16 Board -- maybe it is. Sorry.

17 We provided the Board as well as the  
18 Health Care Advocate's Office with binders that  
19 contained the exhibits that we stipulated to at a  
20 prehearing conference, I believe it was last week.

21 MR. HUDSON: Okay. And if we have that  
22 copy, we can forego the ceremonial handing over.  
23 That will be fine.

24 MS. HUGHES: Yes. We actually expected  
25 one to be on the table there. But apparently --

1 MS. HENKIN: We have an extra one here.  
2 We can put one up there.

3 MS. HUGHES: Okay.

4 MR. HUDSON: Does everyone have the  
5 binders places they need to be?

6 MS. HUGHES: This morning we provided  
7 everyone with a replacement page 131 so that the  
8 numbers could actually be read.

9 MR. HUDSON: Thank you. All right. So  
10 stipulations are entered. And everyone is sworn in.  
11 We can move on to opening statements.

12 (Exhibits BCBS 1-11, 16 and 18; HCA 14  
13 and 15, Board 13, and DFR 12 and 17 were admitted into the  
14 record.)

15 MS. HUGHES: Okay.

16 MR. HUDSON: Start with Blue Cross.

17 MS. HUGHES: Good morning. I'm Jackie  
18 Hughes with Blue Cross Blue Shield. I want to say we  
19 are pleased to be here once again to present our 2017  
20 Qualified Health Plan rate filing to the Board. This  
21 filing supports Blue Cross's continuing efforts to  
22 provide Vermonters with affordable Qualified Health  
23 Plans. It also is further supportive of our  
24 partnership with the State of Vermont to be an active  
25 participant in health care reform efforts.

1           We very much appreciate the timely and  
2 thorough review by both Lewis & Ellis and NovaRest,  
3 and you have their opinions in your binders.

4           This year, like the preceding three  
5 years, we are presenting rates that we have developed  
6 that are the most affordable rates while covering the  
7 cost of the care that is being delivered to  
8 Vermonters in Qualified Health Plans. Our goal today  
9 is to answer your questions. We do want to say that  
10 we are in agreement with the recommendation for  
11 modification by L&E which when rounded gives a  
12 weighted average of 8.2 for our request, an 8.2  
13 percent increase.

14           So with that, we are prepared to go  
15 forward.

16           MR. HUDSON: Okay. Thank you. And  
17 does HCA wish to make an opening statement?

18           MS. RICHARDSON: Yes. My name is Lila  
19 Richardson. I know the Board and other people here  
20 know me, but for the public members who are here, I  
21 wanted to clarify that I'm appearing on behalf of the  
22 office of the Health Care Advocate. The HCA appears  
23 as a party in the case to represent Vermont  
24 ratepayers who will be enrolling in the plans that  
25 Blue Cross Blue Shield of Vermont is offering on the

1 Vermont exchange marketplace beginning next year,  
2 January, 2017.

3 This rate filing is a very important  
4 one because it affects so many Vermonters. According  
5 to the documents filed in the case, Blue Cross Blue  
6 Shield is projecting approximately 77,500 Vermonters  
7 will be enrolled with the Qualified Health Plans that  
8 it offers under the exchange in 2017. And this  
9 represents a very large percentage of the total  
10 number of Vermonters who are enrolled in plans and  
11 exchange, and indeed, who are enrolled in plans in  
12 Vermont generally.

13 Our office has a goal of ensuring that  
14 Blue Cross Blue Shield of Vermont's rates are both  
15 reasonable and as affordable for ratepayers as  
16 possible. As Jackie Hughes just stated, Blue Cross  
17 Blue Shield is requesting an 8.2 percent increase for  
18 2017, and this includes a small rate increase over  
19 the originally filed proposal based on a change in  
20 methodology and information and risk adjustment. So  
21 the HCA's very concerned about affordability of  
22 premiums if the rate increase is approved as proposed  
23 and with the slight upward modification recommended  
24 by Lewis & Ellis.

25 The 8.2 percent increase far exceeds

1 the average national increase and other costs for the  
2 past year, and I would refer the Board to the  
3 Consumer Price Index which shows that the cost of all  
4 items listed on the CPI rose one percent in the  
5 12-month period that ended in June of 2016. And  
6 again, I wanted to review why affordability is so  
7 important. Lower income Vermonters do have subsidies  
8 to help pay for the cost of their premiums on the  
9 exchange, but other Vermonters must pay the full  
10 price for non-group coverage if they sign up on --  
11 for an exchange plan. And in addition, small  
12 employers purchasing on the exchange would have the  
13 full impact of any rate increase that the Board  
14 approves, and many employers would pass that cost  
15 increase on to their employees. Increases in  
16 employer-sponsored health insurance are not free to  
17 the employee. They are typically passed on to  
18 employees through increased employee contributions to  
19 insurance or in lost wages, or a combination of the  
20 two.

21 So to put the rate increase into  
22 context, personal income in Vermont only increased  
23 about 3.5 percent between 2013 and 2014 and about 3.1  
24 percent between 2014 and 2015. So clearly the  
25 requested rate increase is well in excess of these

1 modest increases in income for Vermonters. The Board  
2 has already received many public comments expressing  
3 concern about affordability, and I anticipate that  
4 during the rest of the comment period there will  
5 probably be additional comments.

6 I wanted to quote very briefly from one  
7 comment which sums up the concerns that Vermonters  
8 have about absorbing a rate increase of 8.2 percent.  
9 And this member of the public says: "Health care  
10 costs each month take up the largest percentage of my  
11 income, more than rent, food or transport. And an  
12 increase of eight percent would cause significant  
13 stress to our budget, quality of life, and therefore  
14 also our ability to remain healthy. I would be  
15 surprised to learn of many people who buy their  
16 health insurance through Vermont Health Connect who  
17 receive a pay increase this year of eight percent.  
18 Mine was about 2.5 percent."

19 So again, the office of the Health Care  
20 Advocate wants the Board, asks the Board to approve a  
21 rate increase that is affordable as possible for  
22 Vermonters. We have a major area of disagreement  
23 with the filing. We contend that the Blue Cross Blue  
24 Shield filing overstates the level of contribution of  
25 reserves it needs, and the request to reserve CTR of

1 two percent will be reduced.

2 We will have evidence from our actuary  
3 who has reviewed the filing about this particular  
4 issue. In summary, we are asking the Board to reduce  
5 the proposed rate in order to achieve rates that are  
6 as reasonable and as affordable as possible so that  
7 Vermonters will be able to purchase health plans on  
8 the exchange.

9 Thank you.

10 MR. HUDSON: Thank you. So at this  
11 point, we can move on to Blue Cross and the  
12 presentation of their witnesses.

13 MS. HUGHES: Thank you. We call Paul  
14 Schultz.

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1 PAUL SCHULTZ

2 Having been duly sworn, testified

3 as follows:

4 DIRECT EXAMINATION

5 BY MS. HUGHES:

6 Q. Mr. Schultz, can you state your full name for  
7 the record?

8 A. My name is Paul Schultz.

9 Q. And what is your position with Blue Cross?

10 A. I am the chief actuary at Blue Cross.

11 Q. And I would -- I would refer the Board to  
12 Exhibit 16 page 225 for his qualifications and background  
13 rather than go through each of them.

14 MR. HOGAN: Thank you.

15 BY MS. HUGHES:

16 Q. Are you familiar with the filing that is under  
17 consideration today?

18 A. Yes, I am. I supervised its preparation.

19 Q. Okay. And is that Exhibit 1 of the binder?

20 A. Yes, it is.

21 Q. And can you review for the Board how that  
22 filing was prepared?

23 A. Yes. Any rate filing consists of many parts.  
24 The largest of those parts is a projection of allowed  
25 claim costs. That is to say, the total cost of health

1 care for the Vermonters who were enrolled in Qualified  
2 Health Plans.

3           So to perform that projection we started with  
4 basic experience in 2015. That included the experience of  
5 over three quarters of a million member months of  
6 Vermonters enrolled in QHPs. We trended that experience  
7 forward. We made demographic adjustments to reflect the  
8 fact that we expect a somewhat different population in  
9 2017 than we had in 2015. We then applied a set of  
10 allowable adjustments to calculate paid claims, that is to  
11 say the portion of total claims that are paid by Blue  
12 Cross to providers as compensation for care that's  
13 provided to Vermonters.

14           Paid claims represent about 90 percent of the  
15 total premium. So to that we add administrative expenses.  
16 We used a similar process here. We started with 2015 data  
17 as a baseline for -- to project 2017 administrative  
18 expenses. We then reduced that baseline for a number of  
19 factors. One is anticipated enrollment growth and  
20 economies of scale that come from that. We removed  
21 certain one-time costs that occurred in 2015. And we also  
22 reduced the starting point to reflect the fact that more  
23 Vermonters will be able to enroll directly with Blue Cross  
24 Blue Shield in 2017 as opposed to going through Vermont  
25 Health Connect. So we made those reductions, and then

1 projected that amount forward to 2017 reflecting wage  
2 increases and inflation. That total is about 6.9 percent  
3 of the premium dollar which is a very competitive figure  
4 not only in Vermont but also nationally.

5 To this we then added state and federal taxes  
6 and fees. This year that represents only about one  
7 percent of the premium. That's lower than it has been  
8 recently, and the reason for that is that there is a  
9 one-year waiver of the federal insurer fee in 2017. That  
10 fee is about two and-a-half percent of premium, and we do  
11 expect that to come back in 2018. But it's waived for  
12 2017.

13 To that we then added contribution to  
14 reserves. We have requested a contribution to reserves of  
15 two percent which is the amount needed in the long term  
16 for us to maintain the level of solvency that has been  
17 deemed appropriate by our regulator. We also include a  
18 quarter percent for the cost of bad debt; in other words,  
19 uncollectible premiums.

20 Finally there is -- there is no profit in  
21 these rates. Blue Cross Blue Shield of Vermont is a local  
22 non-profit company.

23 Q. So as you were developing these rates, what  
24 were your objectives?

25 A. Our goal in developing these rates was to

1 create the most affordable and competitive rates possible  
2 while using assumptions that are reasonable both  
3 individually and in the aggregate, and using methodology  
4 that is within the bounds of what's required by state and  
5 federal law and regulation.

6 Q. And can you give us an overview of the various  
7 assumptions that you used in preparing the filing?

8 A. I can. So one very important assumption has  
9 to do with population morbidity. That is how will the  
10 2017 population differ from the population in 2015. And  
11 we made a number of adjustments in order to get from one  
12 to the other.

13 There were new members who were enrolled on  
14 our books in 2016 who were not in the 2015 base  
15 experience. So we made an adjustment to account for the  
16 demographic differences of those new members. Similarly,  
17 there were members in 2015 who were no longer on the roles  
18 in 2016 at the time we were preparing the filing. So we  
19 also adjusted experience to account for those members no  
20 longer being in Qualified Health Plans. The members who  
21 were continuing we needed to adjust for their change in  
22 demographics. That is, they're two years older in 2017  
23 than they were in 2015, so we included a factor for that.

24 We include the impact of plan selection on the  
25 overall cost of the risk pool. We include a factor for

1 the change in the definition of small groups. Vermont  
2 state law changed the definition of a small group to  
3 include groups of 51 to 100 starting in January of 2016.  
4 So the members of those groups were not in the base  
5 experience data in 2015. We therefore have to make an  
6 adjustment to reflect those members coming onto the plans  
7 throughout 2016.

8 Finally, Vermont is going through a  
9 recertification process in Medicaid. So as they go  
10 through that process, we have seen that some members are  
11 found to no longer qualify for Medicaid. They therefore  
12 need to seek their health insurance elsewhere, and we  
13 expect that a certain portion of that membership will be  
14 coming on to the QHPs and enrolling with Blue Cross. So  
15 we have an adjustment to our rates to reflect those  
16 members coming on as well.

17 Another significant assumption has to do with  
18 paid-to-allowed factors. And that consists of two things.  
19 One is a pricing actuarial value at a contract level along  
20 with a benefit richness adjustment. We had to project a  
21 risk adjustment transfer amount which Lila has referred to  
22 earlier. We also projected the fee associated with that  
23 program which is known to be 13 cents per member per  
24 month. Alongside that we had to also use certain  
25 assumptions to project administrative expenses and project

1 other taxes and fees.

2 I kind of saved the best one for last. Trend  
3 is the most important assumption of all of these. The way  
4 we look at trend is to separate it into two different  
5 components. One is utilization which we define as both  
6 the number of services that are received as well as the  
7 mix or the intensity of those services. The second  
8 component is unit cost which is quite simply the price of  
9 each service. So to estimate utilization trend what we do  
10 is to take a look at historical and emerging patterns, and  
11 we use that to develop a projection moving forward. Our  
12 projection is a modest one percent utilization trend for  
13 medical services and a half percent for pharmacy.

14 Unit cost we calculate in a somewhat more  
15 discrete manner. So we look at kind of four different  
16 categories of providers in Vermont. The largest of which  
17 are those hospitals and providers who are under the  
18 jurisdiction of the Green Mountain Care Board and the  
19 hospital budget process that you go through. That  
20 represents about 44 percent of total paid claims on QHPs.  
21 Beyond that we have other providers with whom we contract  
22 -- with whom Blue Cross Blue Shield of Vermont contracts  
23 but are not part of the hospital budget process. That  
24 might include some hospitals in New Hampshire, for  
25 example, or community physicians.

1           There are out-of-area providers who are  
2 accessed and contracted through the Blue Card Network. We  
3 have reciprocity with other Blues in other states so that  
4 members who are traveling out of state can still access  
5 care.

6           Finally, there are prescription drugs. So  
7 with those last three categories we also take a look at  
8 historical patterns and emerging data. We temper that  
9 with any understanding we have of ongoing contract  
10 negotiations, and we use that to project a unit cost trend  
11 moving forward. For the facilities who are part of the  
12 hospital budget process of the Green Mountain Care Board,  
13 we start with an assumption that the commercial rate  
14 increases that are part of that hospital budget process  
15 will be the same as they were in the most recent process  
16 in 2015. We then make adjustments from there as  
17 necessary.

18           Q.       So were those commercial rate increases  
19 directly applicable to the unit cost that you were just  
20 talking about?

21           A.       They are not. They are a starting point of  
22 negotiations between Blue Cross Blue Shield of Vermont and  
23 these hospitals. So while they are a starting point for  
24 the assumption, we then work with our provider contracting  
25 department to project what the ultimate outcome of those

1 -- of those contract negotiations may be. That's what we  
2 put in the filing. So there are certain adjustments that  
3 we make to reflect any differences from last year in this  
4 year's contracting process.

5 Q. So are those found on page 131 of the binder?

6 A. Yes. They are.

7 Q. Okay. And is that the page that we gave to  
8 everyone because it was unreadable?

9 A. That is the page that's hopefully a little bit  
10 more legible now.

11 Q. Okay. Can you tell us more about that page?

12 A. I can. So if you -- there is a lot of numbers  
13 on this page, but there are certain numbers that are  
14 highlighted in a red or a pink depending on which version  
15 you're looking at. Those are changes from the result of  
16 last year's contracting negotiations and hospital budget  
17 process.

18 So for example, we have made some adjustments.  
19 One is for Rutland Regional Medical Center. The Board  
20 approved a 3.7 percent rate reduction for Rutland Regional  
21 Medical Center as of May 1 of 2016. If you have  
22 particularly good eyesight, you can see on the page that  
23 we have reflected that 3.7 percent decrease in Rutland  
24 Regional's rates. We have also made certain adjustments  
25 for other contract negotiation efforts that were underway

1 at the time of the filing.

2 Q. Are you familiar with the recent hospital  
3 budget submissions that were submitted to the Board?

4 A. I am. I have reviewed a summary of the  
5 commercial rate increases that were contained in those  
6 submissions. That summary was created from information  
7 publicly available on the Green Mountain Care Board Web  
8 site.

9 Q. And what would those recent submissions for  
10 hospital budgets have on your unit cost trend assumptions?

11 A. If we assume that those commercial rate  
12 increases flow through to final contracts, the resulting  
13 unit costs would be slightly higher than what we submitted  
14 in our filed rates.

15 Q. So what contribution of reserve -- to reserve  
16 has Blue Cross requested?

17 A. We have requested a two percent contribution  
18 to reserves. That's the amount needed in the long term to  
19 maintain a level of solvency that was deemed appropriate  
20 by our regulator in the face of health care cost  
21 increases, membership increases, and potential adverse  
22 events.

23 Q. And as you calculated it, what contribution to  
24 reserve was required for the 2017 QHP business  
25 specifically in order to maintain Blue Cross's current

1 level of solvency in light of projected membership growth  
2 and the health care cost trend?

3 A. 3.8 percent.

4 Q. And can you describe to the Board how you  
5 calculated that 3.8 percent figure?

6 A. I can. So authorized control level risk-based  
7 capital is the denominator in the RBC calculation. ACL,  
8 authorized control level, is very closely proportional to  
9 the level of claims costs. Therefore, RBC is inversely  
10 proportional to the level of claim cost, that is to say as  
11 claim costs go up, RBC goes down, all else being equal.

12 So what we wanted to do was calculate the  
13 change in ACL that is brought about by an increase in  
14 health care claim costs for the QHP line of business. We  
15 did not include in the calculation the impact of any other  
16 of our lines of business. We are just looking at QHP.

17 Furthermore, we did not include the increase  
18 in claim costs for QHP that was driven by those groups of  
19 51 to 100 moving to QHP from a large group product with  
20 Blue Cross. So we already have reserves established for  
21 those groups as large groups. When they move to QHP there  
22 is no change in the level of reserves required. So we did  
23 not consider that as part of our calculation.

24 So looking only at the increase in claims  
25 costs for QHP exclusive of those 51 to 100 groups, we

1 calculated the resulting increase in authorized control  
2 level. So in order to maintain a constant RBC, as  
3 authorized control level goes up, surplus or reserves need  
4 to go up proportionally. There are two different sources  
5 of surplus that are available to us. One is investment  
6 income. So as part of the calculation we allocated a  
7 share of overall investment income to QHP. We did that  
8 based on premium equivalents. The rest of it then has to  
9 come from premiums. So that's the amount that we  
10 calculated as 3.8 percent of premiums would be needed to  
11 maintain RBC in light of these claims increases.

12 Q. And is what you just spoke about on Exhibit 7B  
13 of the filing?

14 A. It is. It's Exhibit 7B.

15 Q. So why would Blue Cross choose a long-term  
16 assumption of two percent rather than the short term 3.8  
17 percent requirement that you calculated?

18 A. First I wouldn't characterize the 3.8 percent  
19 as a requirement, rather I would see that as a minimum.  
20 There are more reasons than health care cost increases and  
21 membership increases. There are more reasons than that  
22 why we need reserves. But nonetheless, rather than filing  
23 that, we believe that it's more appropriate in order to  
24 avoid rate fluctuation, and in order to maintain fairness  
25 among policyholders, both across time and across different

1 products, to consistently file a long-term contribution to  
2 reserves that keeps us within the range of solvency that's  
3 been deemed appropriate by our regulator. That's why our  
4 solvency target is a range rather than a point estimate.  
5 So rather than filing the 3.8 percent, in the interests of  
6 avoiding rate fluctuation and to promote affordability, we  
7 filed instead the long-term rate which is two percent,  
8 that will keep us within the range of solvency that has  
9 been deemed appropriate and necessary by our regulator.

10 Q. So over the last five years what is Blue  
11 Cross's actual realized contribution to reserve for  
12 individual and small group business?

13 A. Negative 0.8 percent.

14 Q. And what was the expected contribution to  
15 reserve after regulatory action over the same time period?

16 A. Negative 0.4 percent.

17 Q. And what would you conclude about those  
18 results?

19 A. I would conclude two things. One is that  
20 rates were inadequate over that five-year period after  
21 regulatory action. Secondly, I would conclude that our  
22 assumptions before regulatory action have been very  
23 accurate given the close proximity of actual and expected  
24 results.

25 Q. So the overall requested average rate increase

1 is 8.2 percent; is that correct?

2 A. Correct. 8.2 percent.

3 Q. And can you detail for the Board the numerical  
4 components of that 8.2 percent?

5 A. I can. So the biggest element of that 8.2  
6 percent is the starting point for any kind of rate review  
7 process, and that is a comparison of actual versus  
8 expected claims. When we looked at actual 2015 claims we  
9 found that they were significantly higher than what we had  
10 expected 2015 claims to be within the 2016 rate filing.

11 Now we are not looking to recoup any of those  
12 losses, but in order to project a 2017 we have to start  
13 with the right baseline. We have to get to the right  
14 starting point. So that rebasing to the proper starting  
15 point causes an increase in premiums of 6.3 percent. And  
16 that consists of two pieces. First, the members who are  
17 actually enrolled in QHPs in 2015 had higher claims  
18 experience than expected and that led to a 5.4 percent  
19 premium increase. The balance of that is due to these  
20 groups of 51 to 100. What we found in looking at the data  
21 is that we did a pretty good job of estimating the number  
22 of such groups that would be joining the exchange in 2016.  
23 However, the cost -- the claims cost for those groups was  
24 considerably higher than what we had anticipated in the  
25 2016 filing. So because of that, even though these groups

1 are a relatively small portion of the population, they are  
2 generating almost a one percent increase in premiums  
3 because that claims experience was so much higher than  
4 expected.

5           So in addition to that, the next significant  
6 factor has to do with the increase in the amount that  
7 providers are paid. And that is bringing about a 3.7  
8 percent increase in premiums. As we have discussed in the  
9 past with this group, much of that -- and the reason that  
10 it's higher than inflation and general wage increases has  
11 to do with the cost shift, that is to say government  
12 payers, Medicare and Medicaid generally do not increase  
13 their prices at nearly the same level as what hospital  
14 budgets and budgets for other providers are coming in.  
15 That shortfall is made up through commercial rates and  
16 that includes QHP rates.

17           So that 3.7 percent unit cost increase was  
18 partially offset by a new contract that Blue Cross Blue  
19 Shield of Vermont negotiated with our pharmacy benefit  
20 manager that helped to lower the price of prescription  
21 drugs, particularly generics. That contract lowered  
22 premium rates by about a percent.

23           There were a number of other factors that were  
24 less weighty in terms of the increase. Our projection of  
25 administrative costs increases premium by about 0.9

1 percent. And that increase is primarily due to continued  
2 challenges in coordinating with Vermont Health Connect.  
3 Our contribution to reserves of two percent, even though  
4 that's significantly less than the amount that would have  
5 been required if we looked only at QHP which is for 2017  
6 and what would be required of that, it's still greater  
7 than the one percent that was approved by the Board last  
8 year. So therefore, that delta or one percent goes toward  
9 the premium increase.

10 Finally, there were a number of other  
11 assumptions, and the most important of those is the change  
12 in demographics. So we are assuming that 2017 members in  
13 Qualified Health Plans will be somewhat healthier than the  
14 2015 QHP membership.

15 All of those items put together, that one  
16 being the most meaningful, decrease the premium adjustment  
17 by 1.9 percent. Finally, there are some mandated changes  
18 either through the -- reflect from the Accountable Care  
19 Act -- Affordable Care Act that were either mandated by  
20 the federal law or through plan changes made at the state  
21 level and certain plan changes that we made on our plans  
22 as well. Those all combined to decrease premium this year  
23 by 0.8 percent. The largest of those again is the one-  
24 year waiver of the federal insurer fee. That in and of  
25 itself was a two and-a-half percent decrease to premium.

1 But altogether minus 0.8.

2 Q. So are you familiar with the recommendation of  
3 the Board's actuary Lewis & Ellis?

4 A. Yes, I am.

5 Q. And is that in Exhibit 13 of the binder?

6 A. It is Exhibit 13.

7 Q. And how many recommendations did Lewis & Ellis  
8 have on your rate filing?

9 A. They had one recommendation.

10 Q. And what was that recommendation?

11 A. They recommended an adjustment to the risk --  
12 the estimated risk adjustment transfer. So Lewis & Ellis  
13 was in a unique position when it comes to estimating that  
14 risk adjustment transfer.

15 When we prepared the filing we only had half  
16 the data. We know our own data; we don't know MVP's data.  
17 Also at the time of the filing we did not know the final  
18 2015 risk adjustment transfer. So using the somewhat  
19 limited information we had at our disposal, we projected a  
20 risk adjustment transfer of 1.27 million dollars to Blue  
21 Cross from MVP. On June 30 we learned the 2015 risk  
22 adjustment transfer amount, and that was a little less  
23 than six hundred thousand dollars, significantly lower  
24 than we had expected. We had expected a number closer to  
25 2.6 million dollars. So when we had that information

1 available to us we revised our estimate of the 2017 risk  
2 adjustment transfer to be a transfer from Blue Cross to  
3 MVP of 680 thousand dollars.

4 Now when Lewis & Ellis did their calculation  
5 not only did they know that final 2015 result, but they  
6 had both the Blue Cross data and the MVP data. So using  
7 all of that information, they were able to estimate a risk  
8 adjustment transfer in 2017 of \$975,000 to Blue Cross from  
9 MVP.

10 Q. So what was their recommendation?

11 A. They recommended that the risk adjustment  
12 transfer estimate should be \$975,000 to Blue Cross Blue  
13 Shield.

14 Q. And do you agree with the recommendation by  
15 the Board's actuary?

16 A. I do. I've reviewed their assumptions and  
17 their methodology, and I found those to be reasonable.  
18 And while I was not able to review the calculation itself,  
19 based on the assumptions and methods being reasonable, I  
20 feel that the result is reasonable as well.

21 Q. Were there any areas of disagreement with the  
22 Lewis & Ellis recommendations?

23 A. There are none. After adjusting for the risk  
24 adjustment transfer amount, they found the balance of our  
25 assumptions to be reasonable and appropriate, and they

1 opined that the rates -- that the calculations do not  
2 produce rates that are excessive, inadequate or unfairly  
3 discriminatory.

4 Q. And are those part of the statutory standards?

5 A. They are. Yes.

6 Q. So after incorporating their recommendation,  
7 what is the average rate increase that Blue Cross is  
8 requesting?

9 A. It's 8.24 percent.

10 Q. Are you familiar with Vermont standards for  
11 rate approval?

12 A. Yes, I am.

13 Q. And in your professional opinion are the rates  
14 that were filed and under consideration by the Board  
15 inadequate?

16 A. No. Actuarial standard of practice number  
17 eight provides guidance to actuaries who are creating  
18 regulatory rate filings for health insurance rate  
19 increases. And that standard of practice defines rates as  
20 adequate if they provide for payment of claims,  
21 administrative expenses, taxes, regulatory fees, and a  
22 reasonable contingency or profit margin. So these rates  
23 are adequate.

24 Q. And how about excessive? Are these rates  
25 excessive?

1           A.       These rates are not excessive. The same  
2 actuarial standard of practice provides a similar  
3 definition for excessive rates. So it says the rates are  
4 excessive if they exceed the amount required to pay for  
5 those things I just mentioned; claims, administrative  
6 cost, taxes, regulatory fees, and a reasonable contingency  
7 or profit margin. So given that these rates were  
8 developed to be the most affordable possible using  
9 assumptions that are reasonable, both individually and the  
10 aggregate, I feel very comfortable opining that these  
11 rates are not excessive.

12           Q.       And are they unfairly discriminatory?

13           A.       They are not unfairly discriminatory.

14           Q.       And are they reasonable in relation to the  
15 benefits that are being provided?

16           A.       Yes, they are.

17           Q.       And do they meet the statutory standards?

18           A.       They do.

19           Q.       And one of those standards is affordability.  
20 Are these rates affordable?

21           A.       The cost of health care services comprises 90  
22 percent of the premium dollar. Given that these rates are  
23 not excessive, they can only be considered unaffordable if  
24 the underlying cost of health care is unaffordable.

25           Q.       Thank you.

1 MR. HUDSON: Does anyone on the Board  
2 have questions for this witness?

3 MR. HOGAN: You made a statement I  
4 didn't quite understand. You said hospital costs --  
5 I think you said equal 49 percent.

6 THE WITNESS: 44.

7 MR. HOGAN: 44 percent; correct?

8 THE WITNESS: Correct. So costs of  
9 providers who are within the purview of the hospital  
10 budget review comprise 44 percent of the total health  
11 care dollar. So the balance of that are other  
12 facilities or providers with whom we contract. Most  
13 physicians are not part of the hospital budget review  
14 process, for example, out-of-area facilities,  
15 prescription drugs. None of those things are part of  
16 the hospital budget review process. So it's 44  
17 percent of the total claims dollar that is part of  
18 that particular process.

19 MR. HOGAN: And another question on the  
20 issue of the CTR. Your current financial situation  
21 is intact even though the Board over the years has  
22 reduced CTR I think on three occasions?

23 THE WITNESS: Yes. Yes. That's  
24 correct.

25 MR. HOGAN: Okay. Thank you.

1 THE WITNESS: We have had a few good  
2 guys, if you will, that have occurred over the past  
3 few years that have allowed us to maintain our RBC in  
4 that similar level. One of those is a movement of  
5 some large employers from insured business to self-  
6 funded business. So as that happens we need fewer  
7 reserves.

8 Another is in 2014 we had a significant  
9 lift from the results of the three Rs. So the risk  
10 adjustment transfer was much higher than we expected  
11 for 2014. Transitional reinsurance that we received  
12 was much higher than expected. So there have been  
13 some buoying effects elsewhere that have offset the  
14 returns that I mentioned of minus .8 percent on this  
15 subset of our business.

16 MR. HOGAN: I'm done for now.

17 MS. RAMBUR: I just have a couple of  
18 brief questions. Could you clarify the assumption  
19 that -- the basis of the assumption that the group  
20 will be healthier given the aging population and --

21 THE WITNESS: Sure. So a good deal of  
22 that has to do with taking a look at members who have  
23 actually left our roles from 2015 until the time of  
24 the filing. So those members, and we have some  
25 theories as to why, but we don't know the exact

1 reasons, but those members tend to be the less  
2 healthy members who are leaving QHPs. On the face of  
3 it that doesn't necessarily add up. Those are the  
4 members who need their health insurance the most.

5 Our theory is that a number of those  
6 members became eligible for Medicaid or found that  
7 they were eligible for Medicaid and have moved over  
8 to those roles instead. So it's a very good  
9 question, but that's the primary reason why we think  
10 the population will be healthier in 2017 is because  
11 we have observed some of the less healthy members  
12 actually having left already.

13 MS. RAMBUR: And my other question is,  
14 do you have an estimate of the proportion of  
15 Vermonters who have been in this book of business  
16 that receive subsidies?

17 THE WITNESS: I do not have that at my  
18 fingertips.

19 MS. RAMBUR: Just curious.

20 THE WITNESS: I think it's around a  
21 quarter. But I -- I'll see if I can find a better  
22 number for you.

23 MS. RAMBUR: Thank you.

24 MS. HOLMES: Just -- after last year's  
25 rate increases can you tell us a little bit about

1 mobility between plans, how people adjusted their  
2 plan choices?

3 THE WITNESS: We did see some movement  
4 toward less expensive plans, not a great deal of  
5 movement. So people were in slightly less expensive  
6 plans than they had been in the past.

7 MS. HOLMES: Okay. And also with  
8 respect to this small group, 51 to a hundred, you  
9 talked about the claims cost was considerably higher  
10 than what you anticipated.

11 THE WITNESS: Right.

12 MS. HOLMES: Can you talk a little bit  
13 more about why you think that might have been the  
14 case? And going forward as this adjustment settles  
15 out, it should be sort of a temporary issue I would  
16 think; right?

17 THE WITNESS: It should be. So we are  
18 looking at about 5,000 members which is a smaller --  
19 it's a small portion of the total of 77,000 or so.  
20 So there is going to be some additional volatility  
21 when you look at a smaller group like that. I  
22 suspect that we are seeing one of a couple things.

23 One is there is sometimes a rush to  
24 services at a big change in benefits. So we may have  
25 been seeing some of that in anticipation of these

1 groups moving to QHPs. And it may just be a matter  
2 of fluctuation. These are small groups. If you look  
3 at any one of them, they might have really good  
4 experience one year and then suddenly it becomes  
5 really bad. And when you're a decision maker of  
6 these small business if all of a sudden you see that  
7 your health care claims are kind of skyrocketing,  
8 that's going to influence you to say, well how can I  
9 kind of level this out and make it a more reasonable  
10 or more predictable increase. And joining a QHP is  
11 kind of the answer there.

12 They are given a choice, the 51 to one  
13 hundreds. The only way they can avoid being in a QHP  
14 is to self fund. So if they do that, they are going  
15 to ride that wave of volatility. And I understand  
16 that eight percent seems like a big increase for a  
17 lot of Vermonters, but if you're a small business of  
18 51 to 100 employees you might see volatility of 30  
19 percent or more year to year, and that can be really  
20 difficult to budget for and to make happen. So if  
21 you have that kind of volatility and you're seeing  
22 that, you're probably more likely then to join a QHP.

23 DR. RAMSAY: Paul, the premium that we  
24 are talking about today is only one part of what it  
25 costs Vermonters to achieve to have access to health

1 care. And I'm intrigued, though this affected the  
2 premium in a favorable way, why you would estimate  
3 that Vermonters will choose higher cost sharing plans  
4 in 2017.

5 THE WITNESS: A lot of that has to do  
6 with the small groups that are coming on. So group  
7 coverage tends toward higher metal levels than  
8 otherwise. And a lot of these groups we have  
9 implemented a new Gold plan that was very similar to  
10 what a lot of small groups had historically. So we  
11 are expecting to see -- we have seen some movement,  
12 and we expect to see a continued movement toward that  
13 Gold plan particularly in the small group market.

14 DR. RAMSAY: So if we accept all of  
15 Blue Cross Blue Shield's assumptions around their  
16 medical and pharmacy unit cost trend and utilization  
17 which is what drives the paid claims; correct?

18 THE WITNESS: That's right.

19 DR. RAMSAY: If we assume all of those  
20 to be correct, it appears that the only way we can,  
21 as a Board, we can make premiums more affordable are  
22 through your administrative costs; taxes and fees, we  
23 can't do much about that; bad debt; and contribution  
24 to reserve. Basically those are our targets, right?  
25 If we assume all of your assumptions to be correct,

1 which we have had our own actuaries kind of pore over  
2 in a very deliberate way.

3 THE WITNESS: So in this particular  
4 matter, yes, I would agree with that. Sure.

5 DR. RAMSAY: Okay. Could you review  
6 again quickly about where the last three years of  
7 your -- this plan's average risks -- liability risk  
8 scoring, you have that tool, a plan average liability  
9 risk score; correct?

10 THE WITNESS: Yes.

11 DR. RAMSAY: Okay. Could you kind of  
12 go through, let's just go 15, 16 and 17, what you  
13 know about that particular liability score and where  
14 it's going. Up or down.

15 THE WITNESS: It went up from 14 to 15,  
16 we saw that.

17 DR. RAMSAY: Right.

18 THE WITNESS: 15 to 16 is harder to say  
19 for a couple reasons. One is that data is very  
20 immature. This risk score model is a concurrent  
21 model meaning that as claims come in, that's what  
22 it's based on. So we only have a few months of  
23 information. It's a very immature number so far.

24 The other things that makes it  
25 difficult is that they have changed the model, quite

1 frankly, and they anticipate changing the model even  
2 further in 2017. So this makes it pretty difficult  
3 to compare risk scores.

4 DR. RAMSAY: Can you just explain who  
5 "they" is?

6 THE WITNESS: Yes. They is CMS  
7 essentially.

8 DR. RAMSAY: So what are you projecting  
9 for that plan average liability risk score for 2017  
10 based on what you know about the process?

11 THE WITNESS: We -- the portion of that  
12 that is relative -- that is relevant to rates, is how  
13 our risk score compares to MVP's.

14 DR. RAMSAY: I know you talked about  
15 that. Right.

16 THE WITNESS: So I haven't projected an  
17 exact risk score measure for 2017 because I didn't  
18 need to do so in order to prepare these rates.

19 DR. RAMSAY: Right.

20 THE WITNESS: What we did as a starting  
21 point was to assume that the relative difference  
22 between us and MVP would change modestly over time.  
23 Lewis & Ellis in preparing their estimate would have  
24 made their own assumption about that.

25 DR. RAMSAY: That does drive your need

1 for continuing reserves, right? Your average risk  
2 score; your liability risk score.

3 THE WITNESS: It does. Inasmuch as the  
4 risk score is an indication of the relative health of  
5 the population, and therefore an indication of how  
6 much care they are going to receive, then yes, that's  
7 a measure of both how high the rates need to be and  
8 what kind of reserves we need to maintain.

9 DR. RAMSAY: And when you're projecting  
10 healthier people -- you're projecting people to come  
11 into this plan and choose higher cost sharing plans,  
12 by definition you're predicting a healthier group.  
13 If I'm healthy, I'll take a high cost share plan.  
14 If I'm not, I'll take whatever I can get.

15 THE WITNESS: Yeah, that's true.

16 DR. RAMSAY: That's all.

17 MR. GOBEILLE: How are you?

18 THE WITNESS: Well, Al. How are you?

19 MR. GOBEILLE: I'm doing well. So if  
20 you go to page 10 of tab 13, there is a chart that  
21 you referenced, and I'm going to call it the point 8,  
22 point 4 negative chart.

23 THE WITNESS: Yes.

24 MR. GOBEILLE: Okay. So I'm just  
25 trying to understand this. And I just want to

1 preface this by saying I'm going to have the same  
2 pretty much question for our actuaries to understand  
3 how this all works. So basically this is you saying  
4 how you did.

5 THE WITNESS: Yes.

6 MR. GOBEILLE: Okay. Except there is  
7 two things you mentioned that I want to add back in  
8 here.

9 THE WITNESS: Sure.

10 MR. GOBEILLE: What would transitional  
11 reinsurance do to this chart? Plus this crazy CMS  
12 money thing that Dr. Ramsay just tried to touch, but  
13 I won't touch it because it's just too -- it's  
14 gobbledygook. I'm sure everybody in the audience  
15 feels the same way, but just in money or percent add  
16 that back in.

17 THE WITNESS: And that's in there.

18 MR. GOBEILLE: That's in there.

19 THE WITNESS: That's in there.

20 MR. GOBEILLE: Okay. So this is  
21 totaled out for those years.

22 THE WITNESS: It is. So when you look  
23 at 2014 that's a pretty -- the actual number is a  
24 positive 2.8 percent which is the biggest number on  
25 the page. That was driven by the transitional

1 reinsurance and the risk adjustment results in 20--  
2 for 2014. We didn't receive that money until 2015.

3 MR. GOBEILLE: I totally understand  
4 that, but it is reflected in this?

5 THE WITNESS: It is. And the same  
6 thing with 2015.

7 MR. GOBEILLE: The reason I'm asking is  
8 it was my impression that it was in here, but the way  
9 you described it, it almost sounds like it came in  
10 later and wasn't in here. So I just wanted to clear  
11 it up in my own mind.

12 So this is an accurate batting average  
13 of these years including things that happened even  
14 after the year this closed.

15 THE WITNESS: That's correct. Yes.

16 MR. GOBEILLE: Thank you. That's very  
17 helpful. My second question goes back to the lineup  
18 you gave of what was in the 8.2.

19 THE WITNESS: Yes.

20 MR. GOBEILLE: And the first thing I  
21 want to say is that the number that you mentioned  
22 that Con asked about, the 44 percent of -- and I want  
23 to understand this. 44 percent of a dollar of this  
24 money goes toward hospital medical care, how would  
25 you say that?

1 THE WITNESS: 44 percent of the claims  
2 dollar goes toward --

3 MR. GOBEILLE: Of the 90 percent.

4 THE WITNESS: -- 44 percent of the 90  
5 percent, right, goes toward care at those hospitals  
6 that you guys oversee through the hospital budget  
7 process.

8 MR. GOBEILLE: Okay. And so in the  
9 hospital budget process we are estimating right now a  
10 2.2 percent increase in commercial rates for this  
11 year if we were to approve them in mass. Okay.

12 I don't know that it was a question. I  
13 can put in the form of a question. Is the number  
14 that you used for the 44 percent number of the 90 a  
15 2.2 percent lift?

16 THE WITNESS: We looked at the  
17 commercial rate increases that are associated with  
18 that 2.2 percent. So because of the cost shift the  
19 commercial increases are much larger than the 2.2  
20 percent.

21 MR. GOBEILLE: Well no. 2.2 percent is  
22 actually the commercial --

23 THE WITNESS: That's the commercial?

24 MR. GOBEILLE: That's the commercial.

25 So I don't want to --

1 THE WITNESS: I'll revise my answer  
2 then. I'm not as intimately familiar with what you  
3 guys are --

4 MR. GOBEILLE: I'm not trying to trick  
5 you in anyway. Let me just be better about my point.

6 THE WITNESS: Okay.

7 MR. GOBEILLE: 3.7 percent was  
8 identified as the increase in amount providers are  
9 paid. Why are we doing that?

10 THE WITNESS: Okay.

11 MR. GOBEILLE: Meaning if I'm going to  
12 hear for an hour from people who don't want to have a  
13 rate increase, and the Health Care Advocate has said  
14 the only issue is CTR, if the average person in  
15 Vermont is getting a 1.9 percent pay increase, if  
16 that, why are we doing 3.7? Not picking on you. I  
17 just want to hear it from your perspective.

18 THE WITNESS: Understood. So the 3.7  
19 consists of a couple things. That's a net answer.  
20 Our unit cost trend, our one-year trend that we are  
21 projecting from '16 to '17 is four and-a-half  
22 percent. The reason the 3.7 is lower is because  
23 hospital budgets came in lower than what we had  
24 expected in last year's filing. So that ultimately  
25 flows through. If we don't catch it in the filing

1 the first time, we catch it once it actually starts  
2 flowing through the data.

3 MR. GOBEILLE: Right.

4 THE WITNESS: So that good guy is part  
5 of that. But unit cost trend is four and-a-half  
6 percent in total. That consists of a medical piece  
7 and a pharmacy piece. And I don't have the pieces at  
8 the front of mind, but the pharmacy unit cost trend  
9 is closer to 10 percent.

10 MR. GOBEILLE: Of that 3.7. So the --

11 THE WITNESS: If you look at the four  
12 and-a-half percent unit cost trend that consists of  
13 about 10 percent pharmacy, and a number that's going  
14 to be three point something for medical. The three  
15 point something for medical consists partially of  
16 that 2.2 that you're looking at in your hospital  
17 budget review process, as well as out-of-area  
18 providers, and New Hampshire hospitals, and things  
19 like that. I'm not exactly sure where the 2.2 comes  
20 from, so I don't want to go into too much detail on  
21 that.

22 MR. GOBEILLE: Forget the 2.2 then.  
23 That's my number. It doesn't have to be your number.  
24 Let me just be very direct.

25 THE WITNESS: Please.

1 MR. GOBEILLE: What is the 3.7 percent  
2 increase to providers?

3 THE WITNESS: That is the -- if  
4 membership in 2017 gets the exact same services and  
5 the exact same drugs that they received in 2016, we  
6 expect the whole basket of those things to cost 3.7  
7 percent more than what we had expected in last  
8 years's filing.

9 MR. GOBEILLE: So there is no volume in  
10 that number.

11 THE WITNESS: There is no volume in  
12 that number. That's right.

13 MR. GOBEILLE: That's a big number.

14 THE WITNESS: It's a big number.

15 MR. GOBEILLE: Meaning it's very  
16 important.

17 THE WITNESS: It certainly is.

18 MR. GOBEILLE: It's not something  
19 that's debated by actuaries.

20 THE WITNESS: Right.

21 MR. GOBEILLE: Meaning it's really a  
22 question of what's the pricing.

23 THE WITNESS: Yes.

24 MR. GOBEILLE: And so you would say  
25 that this is a rate that is adequate because you're

1 giving a price -- you're given a pricing input, but  
2 you're not deciding the pricing input.

3 THE WITNESS: That's true. I'm not  
4 deciding how much to pay providers or how much to pay  
5 for drugs. That's right.

6 MR. GOBEILLE: You do mathematically  
7 own utilization.

8 THE WITNESS: Well I'll put it this  
9 way.

10 MR. GOBEILLE: Not trying to trick you  
11 here. I'm just saying actuaries have a role in this.

12 THE WITNESS: We do.

13 MR. GOBEILLE: But there is part of  
14 your company that has a role in this which is how  
15 much you're going to pay providers.

16 THE WITNESS: Correct.

17 MR. GOBEILLE: I'm trying to understand  
18 the difference. Pharmaceuticals, we think we can do  
19 things with them. We have limited things we can do  
20 with them. But paying providers is different. And  
21 I'm trying find out the inflation rate for providers  
22 in this filing.

23 THE WITNESS: I can't tell you that  
24 number. I can follow up and absolutely get that  
25 number to you.

1 MR. GOBEILLE: That would be helpful.

2 THE WITNESS: I will do that.

3 MR. GOBEILLE: Thank you.

4 MR. HUDSON: It sounds like the Board  
5 has no more questions at this time.

6 MR. HOGAN: No. I do. That 44 percent  
7 of the hospital costs, can you paint that back over a  
8 few years? What's that number look like?

9 THE WITNESS: I think that's been very  
10 consistent. It probably oscillates a point or two,  
11 but we are not talking about 10 point swings or  
12 anything like that.

13 MR. GOBEILLE: The reason that Con is  
14 asking or I was making a point of it is in the press  
15 you would get the impression that that number is a  
16 hundred percent and that we caused it.

17 THE WITNESS: Right.

18 MR. GOBEILLE: And if anyone from the  
19 press was here -- are there any visitors here today?  
20 I would point out the number is 44 percent, and it's  
21 been that way for how long?

22 THE WITNESS: It's been pretty  
23 consistently a little less than half for the last  
24 several years. Yes. That is true.

25 MR. GOBEILLE: Thank you.

1 MR. HOGAN: Thank you. And my last  
2 question, you indicated that administrative costs, .9  
3 percent of that is attributed to the problems with  
4 the Health Connect.

5 THE WITNESS: Let me clarify. The  
6 administrative costs are driving .9 percent of the  
7 rate increase. And the reason that administrative  
8 costs are up in general is primarily due to ongoing  
9 difficulties in coordinating with Vermont Health  
10 Connect.

11 MR. HOGAN: What does the future look  
12 like there? Is this going to get better soon? Or  
13 what's your prognosis?

14 THE WITNESS: That's a tough question.

15 MR. GOBEILLE: That's a great answer.

16 THE WITNESS: There is a lot of debate  
17 right now at the state and everywhere else as to what  
18 the future of Vermont Health Connect will be. So  
19 it's hard for me to look in my crystal ball and  
20 determine what that is.

21 There is a lot of talk about moving to  
22 a federal platform, so that's going to have  
23 challenges in and of itself if that's the way we go  
24 in Vermont. So that's a really good question, and I  
25 do not have a good answer for you.

1 MS. HOLMES: May I ask one more  
2 question? You know, the higher than expected claims  
3 costs, some people are arguing that this is a lot  
4 reflecting pent up demand now with the ACA and people  
5 who hadn't been getting health care now have access  
6 to health care. So in some sense there is an  
7 expectation that is going to be leveling out.

8 What are you seeing? How much of that  
9 could be driving this need for rebasing and all of  
10 that because of the --

11 THE WITNESS: What we found is that  
12 most of the need for rebasing is not because of  
13 allowed costs. It's not because of the total cost of  
14 care, but rather it's the portion that is paid by  
15 Blue Cross as opposed to paid through cost sharing.  
16 So now that we had -- 2015 was our first full year of  
17 experience with Qualified Health Plans. So it was  
18 the first year where we were able to really take a  
19 look at the experience and say, okay, what portion of  
20 the total dollar are we in fact paying for those  
21 plans. And we had estimates as to that, but what we  
22 found is that the reality was higher than our  
23 estimate. We had estimated around 80 percent. The  
24 reality is something a bit north of 83 percent.

25 So most of that shortfall has more to

1 do with the portion that falls in the paid claims and  
2 therefore goes into premium as opposed to the total  
3 health care dollar.

4 MS. HOLMES: Thank you.

5 MR. HOGAN: One more please. This  
6 question is a little broader than the filing.  
7 Preauthorizations have been an issue here for --  
8 there is some tests, responses. Is this an essential  
9 -- is this an essential piece of work for Blue Cross?

10 THE WITNESS: Can you clarify the  
11 question a bit? An essential piece of work?

12 MR. HOGAN: Is the concept and the work  
13 that you do on preauthorizations an essential part of  
14 your work?

15 MR. HUDSON: Are you referring to prior  
16 auths?

17 MR. HOGAN: Yes, prior auths.

18 THE WITNESS: I'm probably not the  
19 right person to answer that question for you.

20 MR. HOGAN: Who would be? Later?  
21 Okay, thank you.

22 MS. GREENE: I can.

23 THE WITNESS: Ruth can field that one.

24 MR. HUDSON: At this point does the  
25 Agency have questions for this witness?

1 MS. RICHARDSON: I have just a very few  
2 clarifying questions.

3 CROSS EXAMINATION

4 BY MS. RICHARDSON:

5 Q. I wanted to ask you about the estimates on  
6 page 164 of the binder related to risk adjustment. It was  
7 provided in Exhibit 10 by Blue Cross Blue Shield in answer  
8 to some questions from L&E?

9 MR. HOGAN: What was the page number  
10 again?

11 MS. RICHARDSON: 164.

12 THE WITNESS: Okay.

13 BY MS. RICHARDSON:

14 Q. And from your testimony it's my understanding  
15 that you're no longer asking for the rate increase, or  
16 you're no longer estimating the increase that would result  
17 from this risk adjustment transfer that's in that answer  
18 number 6 on page 164.

19 A. That's correct. We are no longer requesting  
20 that we accept the Lewis & Ellis calculation.

21 Q. And that's a smaller calculation with an  
22 increase of .7 percent?

23 A. .07 percent.

24 Q. .07 percent. Excuse me. Yes. Okay. I just  
25 wanted to make sure that we understood that you were no

1 longer standing by that calculation.

2 A. That's correct.

3 Q. And I have a couple of questions about RBC  
4 since some of your testimony related to that. First you  
5 use the term RBC. Could you say what that stands for and  
6 define RBC?

7 A. Sure. RBC is risk-based capital, and that is  
8 one measure of an insurer's solvency.

9 Q. And could you just in general describe what --  
10 how risk-based capital is calculated?

11 A. It is -- if you divide surplus by the  
12 authorized control level, which is one of the concepts  
13 that I talked about earlier, then that gives you the risk-  
14 based capital result.

15 Q. And that's the result that you were referring  
16 to when you were talking about Exhibit 7B?

17 A. That's correct. Yes.

18 Q. In your testimony you also referred to a range  
19 of solvency that's deemed appropriate by the regulator.  
20 And without talking about any specific RBC levels that  
21 Blue Cross Blue Shield has, could you explain what the  
22 range of solvency is?

23 A. The range is an RBC level of 500 to 700  
24 percent.

25 Q. And so when you say that's target range, you

1 would hope that Blue Cross Blue Shield would maintain an  
2 RBC within that range?

3 A. Yes. Our goal is to be within that range.

4 MS. RICHARDSON: Thank you.

5 MR. HUDSON: Okay. Do the Board have  
6 any follow-up questions in light of the HCA's  
7 questions?

8 MR. HOGAN: No.

9 MR. HUDSON: Thank you, Paul.

10 MR. GOBEILLE: Thank you, Paul.

11 MS. HUGHES: I'm going to call Ruth  
12 Greene as our next witness.

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1 RUTH GREENE

2 Having been duly sworn, testified

3 as follows:

4 THE WITNESS: Good morning.

5 MR. HUDSON: Good morning.

6 DIRECT EXAMINATION

7 BY MS. HUGHES:

8 Q. Can you state your full name for the record?

9 A. Ruth K. Greene.

10 Q. And what is your position with Blue Cross?

11 A. My position in Blue Cross is CFO and  
12 treasurer.

13 Q. And her CV can be found in Exhibit 16 at page  
14 221. Ms. Greene, can you describe Blue Cross's purpose  
15 and philosophy in estimating premium rates?

16 A. Yes, I can. As you heard from Paul earlier,  
17 just to recap, we have the overall goal of estimating the  
18 premiums for 2017 as accurately as possible and that's  
19 based on an estimate of claims. You have been through  
20 that.

21 Our goal is really to look at the lowest  
22 possible rate, but still be adequate in the criteria that  
23 Paul described.

24 Q. And how significant is this rate filing to  
25 Blue Cross?

1           A.       This rate filing is very significant to Blue  
2 Cross. Lila mentioned earlier that it's over 77,000  
3 members that we expect in the 2017 plan here. And the  
4 Qualified Health Plan members that will be in that pool in  
5 2017 will reflect nearly half of our risk surplus.

6                   When we talk about the impact on our business  
7 and our ability to protect all of our members and risk  
8 pools, the importance of this rate filing is very, very  
9 high in terms of our financial -- long-term financial  
10 management goals.

11           Q.       So why should the Board approve this rate  
12 filing as adjusted by the L&E recommendation?

13           A.       Well we believe the Board should approve the  
14 8.2 percent for a number of reasons. Mainly because it is  
15 representative of our estimate of the costs of medical  
16 services that will be incurred by the Qualified Health  
17 Plan members in 2017. We also believe that over the last  
18 few years in the previous rate filings that we have had,  
19 as Paul indicated, in the cumulative result of pricing  
20 this business we have been very close to the estimate. So  
21 I think we have a strong track record of reasonable and  
22 adequate estimate of those rates.

23                   And then finally, I would just like to  
24 reinforce that Paul is a qualified actuary and the Board's  
25 own actuary has recommended approval of the 8.2 percent.

1 So the actuarial experts agree that the rates are  
2 reasonable and appropriate.

3 Q. And are you aware of the public comments that  
4 have been coming in to the Board?

5 A. Yes. I am aware, and as Lila indicated  
6 earlier, I did also -- as I read through the comments  
7 realized that many of those comments are focused on the  
8 affordability and the ongoing challenge of cost of medical  
9 services increasing at a faster rate than CPI or salaries.  
10 Unfortunately, we can only look to trying to control the  
11 cost of those medical services and the increases of those  
12 over time as a way to impact the premium rates.

13 Q. So would cutting the rate that's been filed  
14 lower the cost of care in Vermont?

15 A. No. Cutting the premium rate doesn't actually  
16 make any change or difference to the cost of medical  
17 services that our Qualified Health Plan members will incur  
18 in 2017. So a rate reduction is not reducing the cost of  
19 health care. And it is one of those things that we  
20 through our track record of being able to estimate those,  
21 I think it's pretty evident that there are no other built-  
22 in profits or things that could be adjusted in order to  
23 reduce -- reduce the cost of health care.

24 Q. So QHP premiums, what do those premiums go to?

25 A. As Paul indicated earlier, the vast majority

1 of the premiums is the claims cost for the medical  
2 services incurred. And we talked a little bit; that's all  
3 in. That's the hospitals, the community providers,  
4 pharmacy, all of that.

5 Paul mentioned that we also add in our  
6 administrative costs. We have a very competitive  
7 administrative cost load, if you will. We participated in  
8 a benchmark on that administrative cost in 2014. And we  
9 were in the top quartile of per member per month costs in  
10 a population of 29 million members within the study, and  
11 we are very focused on that. We want to be very efficient  
12 and make sure that we are covering our Qualified Health  
13 Plan members as efficiently as possible. And then the  
14 other piece is the taxes and fees and the CTR.

15 Q. Thank you.

16 A. Did we want to follow up on Con's question?

17 Q. Sure. He will ask you, I'm sure.

18 MR. HOGAN: No, that's great. Thank  
19 you. The however you say it the --

20 THE WITNESS: Prior authorization.

21 MR. HOGAN: -- prior authorization  
22 program, is this an essential part of the work of  
23 Blue Cross?

24 THE WITNESS: So what I would respond  
25 to that question is that prior authorization is a

1 component of what we refer to as integrated health  
2 management practices. So we are looking at all  
3 medical and pharmacy, and you know, mental health and  
4 substance abuse services that our members are  
5 incurring. And we have various programs to ensure  
6 that providers are providing the right services at  
7 the right time and in the right combination.

8 So the prior authorizations is a piece  
9 of that process, and I would say it is an important  
10 part of making sure that we are getting the right  
11 medical services to the right people at the right  
12 time.

13 MR. HOGAN: So other parts of that  
14 process include clinical management?

15 THE WITNESS: Not clinical management.

16 MR. HOGAN: What would the other  
17 elements be?

18 THE WITNESS: A good example would be  
19 our Vermont Collaborative Care program which looks at  
20 folks who are incurring pharmacy and medical costs  
21 that have to do with what we call co-occurring  
22 situations, so they might have a mental health  
23 substance abuse issue, and they also have medical  
24 issues. And what we find is that people who have  
25 mental health substance abuse issues their costs of

1 medical care are 40 percent higher.

2 So we will look at opportunities and  
3 making sure that people are getting referred to the  
4 right places. And we found that a program like that  
5 can very much reduce the number of ER visits and the  
6 readmissions for those folks. So it's not clinical  
7 care, but it's looking at the coordination of care  
8 across the various providers that someone might be  
9 navigating.

10 MR. HOGAN: So in your words -- I don't  
11 know if these are your words, but so this is a pretty  
12 important part of your work.

13 THE WITNESS: Yes, I would say it is.

14 MR. HOGAN: Do you have cost/benefit  
15 information? Let me back up. What part, proportion  
16 of the Blue Cross work is this? In other words, is  
17 it a tenth, a fifth, is it a one percent, is it --  
18 you know, I'm trying to get a picture of how big this  
19 is.

20 THE WITNESS: Yeah. So if you think of  
21 it in terms of maybe people in the building working  
22 on this, it's a relatively small portion of the  
23 activity that we do. But we utilize our partnerships  
24 with vendors and other providers to help with the  
25 process. We partner directly with providers as well

1 when there is a program being put in place. It's  
2 often provider led, and we want that to happen. So  
3 we might have an arrangement with a particular  
4 provider practice that is going to do something in a  
5 certain way, and so each one is very different. But  
6 it's -- in terms of -- I'm trying to get a sense of  
7 what kind of dimension you're looking for.

8 MR. HOGAN: I'm trying to understand  
9 how much of your -- of these programs is your  
10 business. I mean how much of your business are these  
11 programs?

12 MR. HUDSON: If I can just jump in  
13 here. Are you asking because you're inquiring about  
14 administrative expenses?

15 MR. HOGAN: I'm trying -- no. I'm not.  
16 I don't understand why you would ask that question.

17 MR. HUDSON: I'm just trying to keep  
18 the -- it does seem to me that it might be related,  
19 and that would be something that is relevant to the  
20 hearing. So I'm trying to keep the questioning tied  
21 in. I'm not saying don't ask the question. I'm just  
22 trying to make sure a record -- that the question  
23 bears on the subject matter of the hearing.

24 MR. GOBEILLE: Con, can I try to --

25 MR. HOGAN: Sure.

1 MR. GOBEILLE: I think what you're  
2 trying to say is do you have financial evidence that  
3 things like prior authorization are worthy?

4 MR. HOGAN: I was going to get to that  
5 point.

6 MR. GOBEILLE: And if you do, great.  
7 If you could explain that, even better. But as a  
8 percentage of your overall effort, how much is that?

9 MR. HOGAN: Right.

10 MR. GOBEILLE: So when I think all your  
11 overall efforts I think about all your employees and  
12 all your efforts. If you have 300 employees do two  
13 people work on that? How much of your effort is it?  
14 Obviously if 90 percent of what you do with your  
15 money is spend it on medical and pharmaceutical,  
16 that's 90 percent of your effort.

17 THE WITNESS: Right. We are processing  
18 claims and answering phones for customer service.  
19 Another way to think about it, and the only reason I  
20 was possibly putting it into admin terms is another  
21 way to think about it is of the -- on average, this  
22 is not the Qualified Health Plan specifically, but on  
23 average across all of our businesses if we spend 29  
24 dollars per member per month on everything, the  
25 utilization management and our integrative health

1 management is probably less than \$2 per member per  
2 month of that magnitude, if that helps.

3 MR. GOBEILLE: That's a good way to put  
4 it for me.

5 MR. HOGAN: That is a good way too. I  
6 understand that.

7 THE WITNESS: If I may, I could also  
8 speak to the return on the programs. We are  
9 constantly looking at the existing programs and how  
10 we can more efficiently both for us and the providers  
11 get to outcomes that are good for members with less  
12 of the overhead burden. So if someone is looking at  
13 the number of prior auths or the number of referrals  
14 for a certain area, we are always looking to make  
15 sure that the outcome is benefiting and that there is  
16 a return on investment. I don't have those stats  
17 with me today but it is a part of our ongoing  
18 reviews.

19 MR. HOGAN: Any chance of getting a  
20 picture of that?

21 THE WITNESS: We could certainly  
22 provide some information to the Green Mountain Care  
23 Board on some of those programs. I think we have  
24 done some of that in the past, especially in some of  
25 our pharmacy areas.

1 MR. HOGAN: I appreciate it. Thank  
2 you.

3 THE WITNESS: Yeah.

4 MS. RAMBUR: So just for the record,  
5 the question that I asked Mr. Schultz about the  
6 proportion of Vermonters in this book of business who  
7 receive subsidies, I believe you nodded at the 25  
8 percent.

9 THE WITNESS: Yes. We have looked it  
10 up. It's -- what page was it on? Exhibit 2B in our  
11 actuarial exhibit.

12 MR. GOBEILLE: What page is that in the  
13 book? Sorry.

14 THE WITNESS: It's tab one.

15 MS. HUGHES: Page 51.

16 MR. GOBEILLE: Page 51.

17 THE WITNESS: The percentage is not  
18 there, but we calculated the percentage based on the  
19 membership -- projected membership on page 51 is  
20 77,538. If you look up on the list there is the  
21 individual subsidized QHP of 17,000. So that's --

22 MS. RAMBUR: Great. Thank you. My  
23 other question I think follows up a little bit on  
24 what Con is asking. As you've seen we receive heart  
25 wrenching E-mails and stories. And clearly from what

1       you're presenting so much of the cost really is a  
2       mirror of the utilization and the cost of that care.  
3       So how do we resolve this conundrum that we are in,  
4       and how do you see payment reform shaping in with  
5       things like prior auth, et cetera, as providers take  
6       more accountability for the outcomes of the cost of  
7       the care?

8                       THE WITNESS: I think I would just like  
9       to say that I believe that Blue Cross Blue Shield of  
10      Vermont has demonstrated for many years that we are  
11      very active and interested in finding ways to improve  
12      the trend rate of medical -- cost of medical  
13      services. We are very active in looking --  
14      partnering and working on payment reform initiatives.  
15      We have -- I'll call them more micro payment reform  
16      initiatives -- that go on all the time where we are  
17      working with certain providers to reduce the cost of  
18      medical services. I do think that the -- that is the  
19      ultimate improvement in order to reduce the premium  
20      rates.

21                      The other thing is the mix of healthy  
22      and less healthy people. We absolutely need to find  
23      ways to have people be able to participate and buy  
24      insurance in order to make sure that the overall cost  
25      --we have community rating here in Vermont as we all

1 know. And it really is important to be consistent  
2 with our rates and sustain those over time so healthy  
3 people feel like they can get benefit from that  
4 process as well. It does help with the overall  
5 affordability.

6 MS. RAMBUR: In essence the well carry  
7 the sick financially; you would agree with that?

8 THE WITNESS: Yeah.

9 MR. GOBEILLE: So can I go to Jess's --  
10 can I just add to what Betty was asking. This is not  
11 necessarily a part of the percentages and all the  
12 math and everything. So if we can't answer it here,  
13 I don't mind waiting, you know, until after the --  
14 after we are done with all this.

15 I read that Secretary Burwell had made  
16 a comment that the average person buying an  
17 individual plan in the exchange was paying some  
18 number like \$75 a month. Now I don't know. There  
19 was no footnote. It was just sort of a comment. And  
20 so when I look at these numbers I wonder what that  
21 is, and I wonder if you know, if you were just to  
22 take a look at the individual marketplace which is,  
23 you know, 29,000 lives, would we have -- would you or  
24 would possibly DVHA have the average amount paid for  
25 those folks?

1 THE WITNESS: I don't have that here.  
2 But we could find -- you mean with after the  
3 subsidies?

4 MR. GOBEILLE: Yes.

5 THE WITNESS: I'm quite sure that  
6 actually one of the reports that DVHA reports  
7 quarterly or monthly might actually have that  
8 information in it. But we could track it down for  
9 you.

10 MR. GOBEILLE: Yeah. I don't think  
11 they meet weekly in public.

12 MS. RAMBUR: That would be very  
13 helpful.

14 MR. GOBEILLE: I would like to know  
15 that personally, because it would help me understand.  
16 And the second point I would make is that 11,000  
17 people, 10,872 are individuals in a non-subsidized  
18 QHP. And it's striking that that's I believe 1.7  
19 percent of our population. And so if you look at the  
20 200,000 people on Medicaid that receive an incredible  
21 amount of subsidy, Medicare has its own actuarial  
22 value, you look at what small businesses like my own  
23 pay for employees, and everyone else on here, it's  
24 amazing that 11,000 people are sort of just in a  
25 whole 'nother health care system in the United

1 States. And I offer that just as an opinion. But it  
2 makes me want to know the number. If that makes  
3 sense.

4 THE WITNESS: The number for the 17 --

5 MR. GOBEILLE: The number that the  
6 average person pays in the individual marketplace.  
7 Because we know what the people without subsidy pay.  
8 So if you give me the average, I can see -- I can do  
9 the math in my head.

10 THE WITNESS: Yeah.

11 MR. GOBEILLE: But I just think it's  
12 something that folks don't know. Saying that health  
13 care is unaffordable is just too brief of a sentence.  
14 I think there is a lot more to it based on the  
15 cohorts. And this page 51 really shows it for your  
16 company, but I have the whole state in my mind.

17 THE WITNESS: Right.

18 MR. GOBEILLE: So I'm thinking of  
19 118,000 people on Medicare, 200,000 -- all those  
20 folks have coverage of some kind that is not as  
21 costly as these 11,000. So --

22 THE WITNESS: Yeah.

23 MR. GOBEILLE: I'll let Jessica go, and  
24 I'll go after.

25 MS. HOLMES: Okay. So I think

1 everybody is sort of concerned with sustainability in  
2 so many different ways. Insurance premiums that are  
3 outpacing wages and inflation are not sustainable.  
4 Cumulative losses that you all have incurred over,  
5 you know, the past few years in your business -- book  
6 of business is not sustainable.

7 The fact of the matter is, and I  
8 believe the actuaries will attest to this, 90 cents  
9 of every dollar of premium is going to cover the cost  
10 of medical services. To Betty's point, the problem  
11 is the cost of medical services, right? To growing  
12 and growing at rates that we can't all continue to  
13 afford. Costs are made up obviously of price and  
14 volume, right? Or price and utilization.

15 So I'm wondering, and sometimes -- can  
16 you talk a little bit more about what Blue Cross Blue  
17 Shield is doing to sort of think through or  
18 incentivize or change? You have a lot of purchasing.  
19 Do you have a lot of large market shares? Do you  
20 have a lot of bargaining power with contractual  
21 negotiations with providers? You know, what impact  
22 can you have there? And what impact can you have on  
23 utilization in terms of how do we incentivize  
24 providers to be directing the most cost effective  
25 appropriate care? How can we infuse, you know, more

1 cost conscious consumers in the decision-making  
2 process using evidence-based medicine, cost-effective  
3 care? What can Blue Cross Blue Shield and what are  
4 you already doing to have some impact on actual cost  
5 of medical services? If you could talk about that,  
6 that would be great.

7 THE WITNESS: Sure. I'll repeat a  
8 little bit, if you don't mind, some of the things  
9 that we do in partnering with providers on programs  
10 that are changing from the fee for service to  
11 programs that look at the outcomes, and a lot of  
12 times the providers, you know, they are motivated to  
13 get to the right outcome, but the coding of claims  
14 and things gets in the way. So we will sit down with  
15 them and figure out how do we make that work better.  
16 And those are small, incremental, but nevertheless  
17 important things that we do over time.

18 We are also very much looking at all of  
19 our contracting negotiations and do our level best to  
20 use our buying power, if you will. I mean we have a  
21 large market share, and we are big for Vermont, but  
22 we are probably not that big in some of the other  
23 vendors out there. Our pharmacy benefit manager has  
24 been a place of success for the last couple of years.  
25 We had benefits to our 2016 rates, and again as Paul

1 mentioned, in 2017 rates. We have done a great job  
2 just really pushing on some of the areas that we know  
3 can be more efficient in that area.

4 I think the -- you talked about the  
5 sustainability going back to your earlier comment.  
6 One of the elements of the rate increase in 2017 as  
7 Paul described had to do with this first year of  
8 experience that we had for a full-year experience in  
9 '15. And the usage or the medical costs of the  
10 Qualified Health Plan members was much higher than we  
11 had originally or previously estimated. And so as we  
12 get more familiar with the Qualified Health Plan risk  
13 pool and over time get those premiums reflective of  
14 what the risk pool -- the members are utilizing, that  
15 will settle in over time.

16 So that one of the components in this  
17 year's rate increase is I think a function of coming  
18 into some much better information reflecting that,  
19 but that will not be a repeating thing. So I'm  
20 optimistic that in the future, we will have the cost  
21 of health care and all of the things we have talked  
22 about on that and just becoming more and more  
23 efficient as a provider of that financing. So the  
24 consistent need for fully-funded rates is really what  
25 will help us in continuing that work that I

1 described. A lot of components there.

2 MS. HOLMES: I guess I'm probably  
3 thinking about even things like we hear a lot about  
4 pharmaceutical pricing is driving -- the  
5 pharmaceutical trend is 10 percent this year. And so  
6 I'm wondering, pharmacy benefit manager, I know that  
7 new contract has really led to a reduction in the  
8 premium growth rate. But what about, you know,  
9 steering people towards generics versus brand name  
10 drugs?

11 THE WITNESS: Absolutely. The question  
12 that Con asked about programs that we have. We have  
13 a very comprehensive step we call -- internally call  
14 it a step program -- where when someone that's one of  
15 the prior authorizations has to do with pharmacy, and  
16 we have our medical services area looks at, you know,  
17 the evidence-based application of things, and that  
18 process is to get people to the right medication.  
19 And a lot of times it is to try an effective generic  
20 version before the other version is approved.

21 So a lot of these programs really are  
22 pushing in those typical areas that we have.

23 MS. HOLMES: Do you think it's going to  
24 move the needle at all?

25 THE WITNESS: The generic piece has

1 sort of run out of runway in recent years. There was  
2 a large benefit a few years back, and but as you get  
3 closer to people, most people using generic, there is  
4 less increase that you can get over time.

5 What's now coming into the pharmacy  
6 world, as the Board I'm sure is aware, is the  
7 specialty drugs. Paul did not go into that in a lot  
8 of detail, but our actuarial memorandum outlines in  
9 great detail how we are dealing with the estimation  
10 of a lot of the expensive, important and very  
11 important for our members, but yet expensive costs of  
12 some of the cystic fibrosis and Hep C drugs, and we  
13 are doing our level best to make sure that those are  
14 incorporated but in a way that we know is not  
15 overreacting or underreacting to the impacts of that.

16 So again we are working with our  
17 medical services area to understand how will those  
18 drugs really be, you know, as prescribed in the real  
19 world, if you will, rather than just having it be a  
20 guess, if you will, on the actuarial side.

21 MS. HOLMES: Is there -- and this is my  
22 final question. Is there any program that you find  
23 in one of your innovative programs that has the  
24 significant help for, the most optimism for in terms  
25 of lowering these medical costs and changing

1 outcomes? You know, maintaining high quality  
2 outcomes but at a lower cost. What about those?

3 THE WITNESS: That's a great question.  
4 When we come back and bring some of the programs we  
5 can certainly ask my colleagues what they would say.

6 But from a financial point of view, I  
7 have been quite involved in a lot of our programs,  
8 the Vermont Collaborative Care initiative, which  
9 looks at the people who are both a mental health  
10 substance abuse issue and the medical issue. I'm  
11 very excited about that because it is such a win/win  
12 for everybody. It really gets at people's needs,  
13 people that don't want to have to go to the emergency  
14 room if they really need to have some other service.  
15 So having something that really is benefiting members  
16 also help in terms of reducing costs. I think that  
17 would be one that would be high on my list.

18 MS. HOLMES: Thank you.

19 DR. RAMSAY: Yes. Thanks again, nice  
20 to see you again, Ruth. And I guess remind you that  
21 I'm not an economist, I'm not a policy expert. I'm  
22 just a family doctor. And that's the lens that I put  
23 on this, and I'm glad to have reassurance from Paul  
24 that we are not going to regulate our way to  
25 controlling health care costs. You know, we have

1           tried that. We have been doing it for five years.

2                           And so what are we going to do? I mean  
3           it's pretty clear in my mind after my experience here  
4           we are going to have to develop an integrated system  
5           of care. And we are going to have to put providers,  
6           my clinician friends and colleagues at risk, and we  
7           are going to have to invest more in primary care. So  
8           I know that this 3.7 percent in clinician or provider  
9           increase contracting that goes on, it's not -- there  
10          is no way for you to direct that to primary care to  
11          my colleagues. I understand that. We talked about  
12          that last year. I asked about it.

13                          I respect the investments you've made  
14          in the Blueprint and the patient-centered medical  
15          home that has reduced, whether you believe it or not,  
16          or Blue Cross has believed it or not, has reduced the  
17          total cost of care.

18                          So I just have to reflect back on this  
19          passionate testimony that I heard from my primary  
20          care colleagues in the legislature this year about  
21          their lives and what they are most concerned about.  
22          It didn't have to do with this 3.5 percent. They are  
23          most concerned about the difficulty -- the  
24          administrative burdens, mainly measurement, these are  
25          primary care doctors, my colleagues. They are mostly

1 concerned about the difficulty of the electronic  
2 health record, my colleagues, and they are most  
3 concerned about the burden of prior authorization.

4 Now you can't do much about electronic  
5 health records. You can't do much about measurement  
6 burden. But getting back to Con's point, we did a  
7 pilot project with Blue Cross Blue Shield, MVP and  
8 DVHA, or Medicaid, to reduce the burden of prior  
9 authorization in primary care by eliminating prior  
10 authorization for two widely prescribed classes of  
11 drugs, most all generic, not much brand competition  
12 in these two classes, for a select group of primary  
13 care physicians in the state for a year. And Blue  
14 Cross Blue Shield was a big part of that, and I  
15 appreciate their efforts. And we proved -- we showed  
16 that this would not increase the cost of any pharmacy  
17 trend in Blue Cross Blue Shield over this study  
18 period.

19 Now you would think that that would be  
20 something you would want to scale up. But it ended  
21 on July 1. Now let me remind you of another thing.  
22 These drugs that you call -- that are specialty drugs  
23 PCSK 9 inhibitors, column B, Hep C drugs. No primary  
24 care physician in this state prescribes those drugs.

25 So I'm just saying that one of those

1 components about how we reduce the total cost of care  
2 in this state is what investments we make in not only  
3 paying primary care doctors better, but making the  
4 quality of their lives better. So I just want to  
5 make it clear that that's what we did, and that's  
6 what we proved. And I would invite any of the  
7 insurers, you, or any of your leadership, to come to  
8 the Board meeting when we actually finally do present  
9 that data which will be sometime later in the fall.  
10 I think it would be helpful for you.

11 THE WITNESS: Sure, of course.

12 DR. RAMSAY: I know this is way below  
13 your radar screen. I understand that completely, but  
14 this study was done under statute, led by the payers,  
15 the commercial payers and Medicaid, and we did have  
16 significant evidence that it was not going to  
17 increase the cost of the pharmacy trend in those  
18 classes of drugs. So I'll invite you; a personal  
19 invitation.

20 THE WITNESS: Sure. And I believe the  
21 Board will agree that Blue Cross Blue Shield is  
22 always willing to come and understand what you're  
23 finding in your research and share what we might be  
24 finding. If I may, the three components that you  
25 mentioned, the electronic health records, the prior

1 auths, and the measurements.

2 DR. RAMSAY: Measurement burden; right.

3 THE WITNESS: I would argue that we  
4 actually are concerned with all of those. We would  
5 agree that it's the integration of all of that and  
6 getting to the right outcomes, knowing the  
7 measurements, and providing information so the  
8 measurements can be understood.

9 DR. RAMSAY: And I assume you would  
10 also agree, Blue Cross Blue Shield would also agree,  
11 that when we clinicians take on financial risk, the  
12 necessity of putting us through a prior authorization  
13 process will significantly decline. I hope that  
14 that's understood on the part of the --

15 THE WITNESS: What I would agree to and  
16 clearly understand, and I would completely understand  
17 your study and the results of your study, and that is  
18 a good example of one of the reviews and constant  
19 looking at the programs and seeing which ones are  
20 working and which ones aren't. If we can do a pilot  
21 that shows that there was no change, then of course  
22 we are going to agree that we want to move forward to  
23 implement a change that would do that. But it's not  
24 every prior auth will have that same. So you sort of  
25 have to constantly look at the direction.

1 DR. RAMSAY: No. I agree that these  
2 specialty drugs are going to need close scrutiny,  
3 even more scrutiny when we accept financial risk on  
4 the total cost of care. I agree. I'm talking about  
5 how we make primary care physicians' lives better in  
6 this state. And how a commercial or any payer can do  
7 that.

8 THE WITNESS: Understood.

9 MR. HUDSON: Any other questions?

10 MR. GOBEILLE: I'll just say, Ruth, I  
11 always appreciate your plain language explanation of  
12 things. I find it helpful. So thank you.

13 THE WITNESS: I appreciate that. I  
14 sometimes worry that we can't translate to our  
15 complex world something that makes better sense for  
16 folks.

17 MR. GOBEILLE: Absolutely. Thank you.  
18 I'm all set.

19 MR. HUDSON: Does the HCA have  
20 questions for this witness?

21 MS. RICHARDSON: Yes, I have a few  
22 questions.

23 CROSS EXAMINATION

24 BY MS. RICHARDSON:

25 Q. You were describing some of the costs

1 associated with the provider contracts and the increases  
2 for those. Could you describe Blue Cross's cycle of  
3 negotiating contracts with different providers and when  
4 that occurs during the year?

5 A. Sure. The -- it's sort of an ongoing cycle.  
6 A lot of the contracts have different effective dates and  
7 different time frames. So typically the large facilities,  
8 hospital facilities, will be kicking off in the fall. It  
9 comes usually after the hospital budget review process.  
10 And so that process is ongoing through the end of the  
11 year, and in some cases goes into the early part of the  
12 following year given that some of our contracts go July 1  
13 to June 30, so it's kind of a rolling contract process.

14 Q. And just to clarify, when you say would be  
15 after the budget review process, would it be after the  
16 Board has actually issued its decisions on the hospital  
17 budgets reviews?

18 A. That's when a lot of it gears up. But as Paul  
19 indicated in his testimony, we know there is a couple of  
20 large contracts that impact us significantly. So we will  
21 be working with our provider contracting team internally  
22 to understand, you know, what's coming in the next cycle  
23 of the contracting year.

24 And I think Paul went to some detail to show  
25 how we had incorporated that into our rates. So we look

1 at what's happened in the past, and start there, and then  
2 we talk to our contracting folks to say, okay, where are  
3 we at with this particular partner? Is that going to be  
4 improved upon or not? And in particular, this time  
5 around, with the submission of the budgets, we did have a  
6 look at what the commercial ask was in those submissions  
7 and kind of calibrated that to what we have included in  
8 the rate filing and found it was very close.

9 Q. A question about the pharmacy trend. And you  
10 mentioned the cost of specialty drugs being incorporated  
11 into that trend as a significant component. When you are  
12 reviewing new pharmacy offerings such as the specialty  
13 drugs that you alluded to, do you have any process for  
14 determining how the availability of new specialty drugs  
15 might impact the medical trend, use of other types of  
16 expenses?

17 A. New ones coming into the cycle beyond what we  
18 might have already estimated in the rate? Is that what  
19 you're asking?

20 Q. Well in -- when you're developing the rate,  
21 I'm asking if you look at the impact that relatively new  
22 or brand new specialty drugs might have on medical trend?

23 A. Yes. In fact, we go to great lengths in our  
24 rate filing to elaborate on what we know about the  
25 existing new specialty drugs, and what -- in the case of

1 some of them, what's the utilization in the current year  
2 and what based on that we might expect going forward.

3 We also watch the approval process for  
4 specialty drugs to see if there might be some new ones  
5 coming. So I think these three drugs that we talked about  
6 at length in our filing this year played a part in our  
7 rate filing last year and maybe even the year before  
8 because we could see them coming down the road. And in  
9 fact, I think some of them -- when we are looking at them  
10 there might be one manufacturer, and then by the time we  
11 are making our rate filing we are getting up-to-the-minute  
12 information about where that drug is coming from and how  
13 much it would cost.

14 Q. My question is really more about whether the  
15 availability of the drugs or whatever costs you're  
16 determining has an impact on medical trend?

17 A. Yes. It does.

18 Q. And do you incorporate that?

19 A. When you say availability, what do you mean?

20 Q. The fact that there are ways of treating  
21 certain conditions such as cystic fibrosis and Hepatitis C  
22 that did not exist in the past. Do you look at your  
23 medical trend and see whether some of the medical costs  
24 associated with those diseases might decrease as a result  
25 of the pharmacy --

1           A.       Yes.  If we were looking at the -- a multi-  
2 year view, we would in theory be looking for, for  
3 instance, when population and the utilization of medical  
4 services in our experience period, when we see that  
5 emerge, we would be putting estimates in.  But that  
6 usually happens over a period of time.  So the treatment  
7 is usually shorter term on a relative basis, and the other  
8 medical costs we would be seeing in our experience base.

9           Q.       So over time you would expect to see some  
10 savings in -- I think my question was over time you would  
11 expect to see some decrease in medical costs if the new  
12 pharmacy products are effective.

13          A.       And yes, that would be the case.  That's the  
14 premise for the authorization for the services.

15                   MS. RICHARDSON:  Thank you.  I don't  
16 have any other questions.

17                   MR. HUDSON:  Okay.  Are there any  
18 follow-up questions from the Board?  I believe Allan  
19 had one.

20                   DR. RAMSAY:  I just had one question.  
21 Your reserves are a combination of what component of  
22 the premium goes into the reserves.  And am I correct  
23 in saying it also has -- includes your investment  
24 portfolio?

25                   THE WITNESS:  The earnings on

1 investment portfolio serve to contribute to the RBC.

2 DR. RAMSAY: And I suspect that's  
3 somewhat proprietary, but you know, we all know how  
4 the stock market's been doing. So would you say that  
5 that component of your reserves has been flat, has  
6 gone down, or gone up?

7 THE WITNESS: That component of the  
8 reserves has gone down in recent years. Our  
9 portfolio is mostly fixed income. It's not a lot of  
10 equity. So it more has to do with long-term interest  
11 rates. And so with treasury rates and corporate  
12 rates coming to -- I mean they have been at historic  
13 lows for many, many years now, so our investment  
14 portfolio is earning a certain interest rate on those  
15 fixed maturities, and it's been pretty consistent  
16 over the last four or five years.

17 I mean it's published in our financial  
18 statements. I didn't bring the numbers with me. But  
19 it's a couple million a year.

20 DR. RAMSAY: But there's an upward  
21 trend I suspect.

22 THE WITNESS: The interest rates have  
23 been very, very low for a long time.

24 DR. RAMSAY: Sure. But one, two  
25 percent. Maybe low but one or two percent a year on

1 a large --

2 THE WITNESS: Yeah.

3 DR. RAMSAY: Okay. That's all I have.

4 MR. HUDSON: All right. Thank you,  
5 Ruth. At this point I have had a request from the  
6 Board to take a very brief recess. We will try and  
7 cap it at five minutes. That would be great.

8 (Recess was taken.)

9 MR. HUDSON: Okay. Hello everybody.  
10 We are going to reconvene the hearing. At this point  
11 just to review the order and to make a minor  
12 correction, I omitted Lewis & Ellis from my original  
13 lineup. I apologize. We are going to hear from the  
14 Department of Financial Regulation on solvency. We  
15 are going to hear from the Board actuaries at Lewis &  
16 Ellis. And we are going hear from the HCA. And that  
17 will be the order of the hearing, and then we will  
18 move on to public comments at that point.

19 At this point I would like to call to  
20 the stand the Department of Financial Regulation.

21

22

23

24

25

1 RYAN CHIEFFO

2 Having been duly sworn, testified  
3 as follows:

4 MR. HUDSON: Good morning, sir. Would  
5 you state your full name for the record please?

6 THE WITNESS: Good morning. My name is  
7 Ryan Chieffo. C-H-I-E-F-F-O. I'm the Assistant  
8 Director of Rates and Forms at the Department of  
9 Financial Regulation. I'm here today as Commissioner  
10 Piacek's designee for the hearing.

11 MR. HUDSON: Good morning. Thanks for  
12 coming. And could you direct us to the item that  
13 you'll be offering commentary and explanation on?

14 THE WITNESS: Sure. So the Department  
15 as part of its -- or really its statutory role in  
16 this process is to provide an opinion on solvency for  
17 the company as it relates to this rate filing. And I  
18 believe that is item 12 in the binder on the exhibit  
19 list.

20 MR. HUDSON: Item 12, and possibly also  
21 item 17; is that correct?

22 THE WITNESS: So yeah. I think what  
23 you're seeing in item 17 is the parties had  
24 stipulated to also including last year's solvency  
25 opinion from the Department as part of the exhibit

1 list. There was some background information on our  
2 solvency analysis that we narrated and described in  
3 last year's opinion that we omitted from this year's  
4 opinion but referenced into the last one. And we  
5 have been told by a few different corners that that  
6 was unhelpful. So it's in the exhibit list, and I  
7 think in the future we will add all of that  
8 information all in one place.

9 But for now, for this year, our opinion  
10 which is item 12, does reference all of that  
11 background, and that all is still relevant and  
12 applicable.

13 MR. HUDSON: Okay, thanks. I will let  
14 you proceed with your commentary.

15 THE WITNESS: Sure. Thank you. You  
16 know much of what I have to say really isn't service  
17 to a lot of that background and the analysis we do.  
18 I'll speak very briefly to that general solvency  
19 regulation role that DFR has, and then I'll also  
20 speak quickly to our solvency analysis for this  
21 filing. DFR is the primary regulator for Blue Cross  
22 Blue Shield of Vermont, and that's a very broad role.  
23 One of the major aspects of that role certainly as it  
24 relates to the potential impact to Vermonters is our  
25 role of solvency regulator.

1 Solvency is a dynamic, prospective  
2 analysis, and the Vermont legislature has granted DFR  
3 with significant authority and a wide range of tools  
4 to be effective solvency regulators. We use all of  
5 those tools in an effort to gain and maintain an  
6 understanding of Blue Cross and all of our regulated  
7 entities' solvency outlook and risks to solvency on a  
8 going forward basis.

9 To go through it, very quick list of  
10 ways the Department engages with its regulated  
11 entities in an effort to be these effective solvency  
12 regulators. First, we conduct periodic,  
13 comprehensive financial examinations of each company  
14 focused on prospective risk which includes going on  
15 site to the companies, sometimes I think for weeks at  
16 a time. There is one of those examinations ongoing  
17 with Blue Cross Blue Shield of Vermont right now.  
18 Sometimes from start to finish including the  
19 preparation at the front end and preparation of  
20 reports at the back end, these examinations can take  
21 upwards of 9 to 12 months. So they are very  
22 comprehensive.

23 We also on a regular basis review all  
24 non-insurance risks including credit risk, investment  
25 risk, operational risk and reputational risk. We

1 have complete access to all books and records of the  
2 company at all times. We conduct interviews with all  
3 board members and senior management at the companies.  
4 We analyze all lines of business, including non-  
5 insurance lines. We analyze all entities and holding  
6 companies including non-insurance entities. We also,  
7 for Blue Cross specifically, hold quarterly meetings  
8 based on their projections and their risk-based  
9 capital plan which they have developed.

10 Of course, one significant tool which  
11 you are all familiar with is risk-based capital.  
12 That is a program and a calculation that is an  
13 incredibly sophisticated tool that is just  
14 phenomenally helpful in understanding and regulating  
15 solvency. However, it has one significant limitation  
16 in that is a point in time historical measurement.  
17 It essentially measures past performance. And so in  
18 investment, in business, certainly in insurance  
19 business, you know, past performance does not  
20 indicate future success. And so to have a method, a  
21 measure to predict future success or lack thereof, I  
22 mean that's fundamental to solvency regulation.

23 So RBC works beautifully in conjunction  
24 with all of the other tools, all the other  
25 engagements that I spoke about earlier. However, at

1 the same time, it itself is not solvency. Because it  
2 lacks that forward looking perspective. It lacks  
3 that ability to gain the insights that all of those  
4 other tools give to DFR. And I stress this  
5 distinction between RBC and solvency only because I  
6 think it is at issue in this rate filing.

7 The Health Care Advocate's consulting  
8 actuary, NovaRest, has issued a report that does  
9 opine on Blue Cross's solvency using only a customary  
10 look at publicly available historical RBC numbers.  
11 Any analysis using that information is, regardless of  
12 the conclusion it comes to, is necessarily done  
13 without the information, context and access that is  
14 required to be adequate and reliable. And so to that  
15 end, we urge the Board to use just a tremendous level  
16 of caution when determining how much weight to give  
17 to the conclusions as they relate to solvency in the  
18 NovaRest actuarial report.

19 Moving on to our analysis specifically  
20 of this rate filing for solvency, we concluded that  
21 unless the actuaries find rates to be excessive or  
22 inadequate, the filed rates are unlikely to  
23 significantly impact DFR's overall solvency  
24 assessment for Blue Cross. That conclusion worded a  
25 little bit differently should be familiar to all of

1 you and for good reason. In a growing number of an  
2 ever growing number of rate filings in front of this  
3 Board, that conclusion from DFR has remained the  
4 same.

5 And our assessment of Blue Cross's  
6 solvency outlook has not changed. Part of that is a  
7 credit to the management of the company. Part of  
8 that is a credit to this Board. In this QHP line,  
9 part of that is due to positive non-recurring events  
10 that were spoken about earlier. Part of that is due  
11 to a lack of negative events occurring that would  
12 impact solvency negatively. And regardless of the  
13 combination of inputs, the output is a remarkably  
14 consistent solvency outlook which we value very much  
15 and we view as a very good thing.

16 So one thing that has changed about  
17 this opinion as opposed to previous ones is that  
18 there is a specific reference to contribution to  
19 reserves requested by Blue Cross. We thought it  
20 important to highlight this aspect of the filing. If  
21 other projections in the filing come to bear as  
22 expected, and I point out as others have, that both  
23 Blue Cross and Lewis & Ellis agree that these  
24 projections are reasonable, asking for less  
25 contribution to reserve than necessary will have a

1 negative impact on risk-based capital and on  
2 solvency.

3 Now, the reason -- a big reason why we  
4 highlight this is if you juxtapose that to our  
5 overall conclusion, which is our solvency outlook  
6 would not change, those things are not contradictory.  
7 I think that speaks to the idea that risk-based  
8 capital is not solvency. While this would have a  
9 real negative impact to risk-based capital, due to  
10 all of the other things that we look at, and due to  
11 Blue Cross's general health and solvency, that would  
12 not change our overall solvency outlook despite the  
13 negative impact on risk-based capital.

14 That being said, the conclusion in our  
15 opinion is that -- and that I want to reiterate here,  
16 is that we advise that both the CTR, the contribution  
17 to reserve, and the other elements of the rate filing  
18 not be decreased. The actuaries have found them to  
19 be reasonable. The rate essentially builds in  
20 decrease to risk-based capital and builds in a risk  
21 to solvency as a result. We don't recommend adding  
22 additional risks by lowering rate components further,  
23 especially given that this filing represents well  
24 more than 50 percent of Blue Cross's insured premium.

25 So I'm happy to take any questions.

1 MR. HUDSON: Does the Board have any  
2 questions at this time?

3 MR. HOGAN: I do. You know basically  
4 your quote is any reduction of CTR will have a  
5 negative impact on solvency. That's a quote.

6 THE WITNESS: I think the context of  
7 that quote is if all the other projections in the  
8 rate filing are as is.

9 MR. HOGAN: Okay. We did reduce CTR  
10 three years of the five years we have been doing  
11 this. Has that had a significant impact on solvency?

12 THE WITNESS: Overall, on the health of  
13 company, on the solvency of the company, no. It has  
14 not in our outlook. But again, there is a lot of  
15 other moving parts there.

16 MR. HOGAN: Thank you.

17 THE WITNESS: Including on that table  
18 that I think has been spoken about earlier which is  
19 that expected and actual CTR over the last five  
20 years.

21 MR. HOGAN: Okay.

22 MS. RAMBUR: So to put it in plain  
23 terms, the responsibility that DFR has on solvency is  
24 to protect the public.

25 THE WITNESS: Yes, that's absolutely

1 correct.

2 MS. RAMBUR: And your charge is on  
3 solvency but not affordability; is that correct?

4 THE WITNESS: For these particular rate  
5 filings, that is correct.

6 MS. RAMBUR: So we heard earlier from  
7 Mr. Schultz about sort of a targeted range that they  
8 look at for risk-based capital. Is there any place  
9 that there is a point at which DFR in their  
10 assessment of solvency would consider it to be  
11 excessive amount of risk-based capital?

12 THE WITNESS: Yes. Actually the top of  
13 that range is where we would fall on that. My  
14 understanding, and it's the range of risk-based  
15 capital I think predates my involvement here, is that  
16 that was something, you know, presented to the  
17 Department by Blue Cross, and something that we sat  
18 down with them and discussed and agreed to. And  
19 those quarterly meetings that I mentioned are much in  
20 service of making sure that Blue Cross can continue  
21 to satisfy us that that's an appropriate range.

22 So we have deemed that range reasonable  
23 which means that both the lower end is too low and  
24 the higher end is too high. You know, should there  
25 be other information that changes that in one way or

1 the other, we would absolutely take that into  
2 account.

3 MS. RAMBUR: Thank you.

4 DR. RAMSAY: Thank you, Ryan. Does the  
5 risk-based capital range, is that dependent in anyway  
6 on -- because this is health insurance, on the health  
7 of a population? In other words, do you have the  
8 same range in Florida where you have a lot of very  
9 elderly, very much more complicated patients, than  
10 Vermont?

11 THE WITNESS: So I can maybe clarify.  
12 The risk-based capital percentage is a very  
13 complicated formula that I don't fully understand.  
14 But I do believe takes into account just about  
15 everything you're saying and well more.

16 The risk-based capital range is a very  
17 unique creature to this Department and Blue Cross  
18 Blue Shield of Vermont. I don't know if that exists  
19 in a relationship between any other regulator and any  
20 other insurance company.

21 DR. RAMSAY: You know you mentioned, I  
22 think, all insurers; life, disability, auto,  
23 homeowners, use some kind -- some type of risk-based  
24 capital formula; correct?

25 THE WITNESS: That is correct. Yeah.

1 DR. RAMSAY: But we all agree that  
2 health insurance indemnifying someone against an  
3 illness when we know they are all going to need it is  
4 a little different too. Right?

5 THE WITNESS: I would agree.

6 DR. RAMSAY: Hopefully I won't need my  
7 auto insurance in the next few days or my homeowner's  
8 insurance. I might, but a lot of times a lot of  
9 people go through their whole lives paying and they  
10 never have a claim. But health insurance there is  
11 going to be a claim. There are no other financial  
12 formulas or tools to compare to risk-based capital,  
13 it's specifically in health insurance?

14 THE WITNESS: Formulas and tools, I am  
15 not familiar.

16 DR. RAMSAY: Total assets to liability,  
17 total premium to enrollees, anything?

18 THE WITNESS: I mean I think all of  
19 those things exist, and those are all equations and  
20 formulas that can be gleaned both from confidential  
21 information we have, and in large part I think from  
22 publicly available annual statements. You know there  
23 are also, you know, ratings companies that do this,  
24 you know, this is their business. So yes, all of  
25 those things do exist.

1 DR. RAMSAY: But DFR only looks at  
2 risk-based capital?

3 THE WITNESS: No, that's not true.

4 DR. RAMSAY: But that's their primary  
5 solvency determinant.

6 THE WITNESS: No. I would disagree  
7 with that. I think that is one tool. And again, I  
8 would like to stress, and I don't want to read them  
9 for you again, but there is a tremendous amount that  
10 goes on, you know, in addition to looking at  
11 risk-based capital.

12 And maybe to illustrate, you know,  
13 without context here, I think it's very fair to say,  
14 and I would be confident that everyone across the  
15 hall in the Department would agree with, is that if  
16 you have two companies; one with a higher risk-based  
17 capital percentage, but other indicators that are  
18 negative, that the Department's concerned about, you  
19 know, lines of business, management, membership, you  
20 know, and any number of other things, versus a  
21 company with a lower risk-based capital percentage  
22 but very positive outlook on all other indicators, I  
23 think the healthier company and I think the company  
24 the Department would prefer is the one with the lower  
25 risk-based capital percentage.

1 DR. RAMSAY: And the healthier other  
2 indicators.

3 THE WITNESS: And the healthier other  
4 indicators. Exactly.

5 DR. RAMSAY: That's what I wanted to  
6 hear. Thank you.

7 MR. HUDSON: HCA have questions for  
8 this witness?

9 MS. RICHARDSON: Just one follow-up  
10 question.

11 CROSS EXAMINATION

12 BY MS. RICHARDSON:

13 Q. You listed some of the other areas of concern  
14 that DFR would have beyond risk-based capital such as the  
15 lines of business and management. Are there any of those  
16 other indicators that cause you concern in reviewing Blue  
17 Cross Blue Shield's solvency?

18 A. I would say that nothing that I can speak to  
19 now. A lot of that does go through the confidential  
20 process of analysis. But in general, broadly speaking,  
21 Blue Cross is a healthy solvent company, and we don't have  
22 those concerns.

23 MS. RICHARDSON: Thank you.

24 MR. HUDSON: All right, Ryan. Thank  
25 you very much.

1 MS. HUGHES: May I ask a question?

2 MR. HUDSON: I apologize. Of course.

3 CROSS EXAMINATION

4 BY MS. HUGHES:

5 Q. Okay. So Mr. Chieffo, you would be applying  
6 the health risk-based capital formula to Blue Cross Blue  
7 Shield and not the P&C risk-based capital formula. I  
8 mean -- and do they have different considerations based on  
9 the type of business that those respective companies are  
10 in?

11 A. Yes. That's a fair point. Thank you. I'm  
12 not going to be able to speak very coherently to the  
13 overall risk-based capital system, but yes. I do know  
14 that there are different inputs to risk-based capital for  
15 different lines of business. And I believe while the  
16 formulaic nature remains the same, you know, all of these  
17 things are unique to each company. So there are different  
18 equations by a line of business. I probably won't be able  
19 to give much more detail than that just because I'm  
20 unfamiliar with the rest of it.

21 Q. Could you turn to page 228 in the binder.

22 A. Sure.

23 Q. And first can you identify what Exhibit 17 is  
24 in the binder?

25 A. Yes. So as I briefly described earlier, this

1 is the solvency opinion the Department issued to the Board  
2 for last year's Qualified Health Plan rate filing.

3 Q. And does this year's refer to the background  
4 and the analysis of solvency to opinions like this that  
5 the Department has issued in the past?

6 A. Yes. That's correct. And further I would add  
7 that analysis of threats to solvency to that reference  
8 point.

9 Q. And specifically, the analysis of threats to  
10 solvency, could you explain to the Board what each of the  
11 bullet points are in that section of the opinion?

12 A. Sure. I think we try to word as plainly and  
13 carefully as we could, you know, this part of the analysis  
14 and the whole opinion. Adverse medical cost trends, you  
15 know, as has been spoken about, you know, there is a great  
16 deal of effort by the actuaries and by the company and by  
17 the Board and the Board's consulting actuary, to get a  
18 sense of what the trend is going to be going forward. But  
19 as no one can predict the future, that's all using  
20 historical data and the best projection available.

21 To the extent that those trends exceed what's  
22 expected, that can be a threat to solvency certainly if it  
23 exceeds it, you know, by a large amount. Adverse  
24 utilization, you know, similarly there can be a project  
25 and a prediction and an expectation of what the

1 utilization will be, of what services will be used. But  
2 if that exceeds those projections, again, you've allocated  
3 a certain amount of premium dollars, you know, to pay  
4 those claims and to contribute to reserves.

5           If more is needed, and you don't have that,  
6 that is a threat to solvency. Premium inadequacy I think  
7 goes to that same idea. You know, you build the premium  
8 based on all of these things, and if that is inadequate  
9 based on any number of reasons, you know, then you have  
10 issues with the amount of capital, and you know, that  
11 becomes a threat to solvency as well.

12           And the last bullet we have is membership  
13 growth. And the sufficiency of surplus, I think is how we  
14 word it, is necessarily proportionally related to the  
15 members, to the amount of membership. So you may need a  
16 disproportionate amount of increased surplus to serve to  
17 protect, you know, an increased amount of members. So  
18 certainly you do need more surplus per member or else you  
19 dilute that amount. But depending on the membership  
20 growth you may need more than a proportional amount of  
21 surplus.

22           And so you know, I don't want to detail too  
23 much more what goes into those factors because I don't  
24 think I would do it service. I may do it a disservice. I  
25 think the actuaries can all speak to that, you know, from

1 any angle. But that's generally where we are coming from  
2 and highlighting those sorts of things that can all be  
3 threats to solvency.

4 Q. Is this considered an exclusive list of things  
5 that you would be concerned about?

6 A. No. I don't think so. I think these are  
7 major components. And I think those are major recurring  
8 components. I think there is always additional risks,  
9 insurance is a risk business. And so any number of other  
10 things I think can also be a threat to solvency. These  
11 are the expected, unexpected, if you will.

12 Q. And do any of these things that are bulleted,  
13 did any of these appear in the filing?

14 A. I think they all appear in the filing. I  
15 think these are all accounted for in any rate filing. You  
16 know, to build the rate you have to project these things.  
17 There are certain aspects of, you know, maybe utilization  
18 and why utilization will increase that, you know, may not  
19 appear in the filing, but to my knowledge, to my  
20 understanding of the filing, yes, these things are all  
21 addressed.

22 Q. And were you here when Mr. Schultz testified  
23 that we did have some events occur that buoyed the results  
24 from last year's filing?

25 A. Yes.

1 Q. Thank you.

2 MR. HUDSON: Okay. Blue Cross has no  
3 another questions. I know we have at least one  
4 follow up from the Board.

5 DR. RAMSAY: Thank you for bringing  
6 this page up. It reminds me of our hospital  
7 budgeting process where in 2015 our actual hospital  
8 budgets came in above what we had budgeted for,  
9 actual to budgeted because of a flu shot that didn't  
10 work, 2015.

11 Now at the same time we have adjusted  
12 the contribution to reserves in each of the last two  
13 years. But you're still reminding us that we have a  
14 healthy -- financially healthy organization at Blue  
15 Cross Blue Shield; correct? Based on all of your  
16 indicators?

17 THE WITNESS: That's correct.

18 DR. RAMSAY: So we made an adjustment.  
19 We had a flu not epi -- pandemic, but we had a flu  
20 event that we couldn't have predicted, but we are  
21 still doing okay.

22 THE WITNESS: I mean, yes. I think  
23 there are also other things that happens to --

24 DR. RAMSAY: I know membership went up.  
25 I understand all that.

1 THE WITNESS: -- happened to that.

2 DR. RAMSAY: I'm looking from the  
3 clinical perspective.

4 THE WITNESS: No. I think that's --  
5 it's an excellent illustration of why we can't always  
6 predict and get rates exactly perfect.

7 DR. RAMSAY: Sure.

8 THE WITNESS: What happened there I  
9 think is that that negative event happened and cost  
10 more but was offset by a positive event that  
11 happened. And it's never one to one. There is any  
12 number of things that go into this.

13 DR. RAMSAY: Not the least of which a  
14 positive effect, we have a well managed, you know,  
15 financially healthy organization that can weather  
16 those things.

17 THE WITNESS: I think that is  
18 predictable. It's the unpredictable and non-  
19 recurring things such as a flu shot that doesn't work  
20 or such as an unexpected payment from the three Rs.  
21 Those things are the non-recurring ones. And as you  
22 pointed out, you know, in this rate hearing context,  
23 in this rate filing context, DFR's charge is not  
24 affordability. It's solvency. And while we, you  
25 know, within the real world we recognize that should

1 that flu shot issue happen without a corresponding  
2 offsetting positive non-recurring event, then things  
3 are a lot more negative.

4 And so that is the lens we look at  
5 things through, while also being realistic where the  
6 company is and the company's health as it stands.

7 MR. HUDSON: Okay. Hearing no more  
8 questions, thank you very much.

9 THE WITNESS: Thank you.

10 MR. HUDSON: At this point I'll turn  
11 this over to the Board's attorney who will be calling  
12 Lewis & Ellis actually.

13 MS. HENKIN: Dave Dillon actually.

14 MR. HUDSON: Representing Lewis &  
15 Ellis.

16 MS. HENKIN: We have J and D here; not  
17 L&E.

18

19

20

21

22

23

24

25

1 DAVID M. DILLON

2 Having been duly sworn, testified  
3 as follows:

4 DIRECT EXAMINATION

5 BY MS. HENKIN:

6 Q. So you have been sworn. Why don't you  
7 introduce yourself and tell us where you work.

8 A. Yes. My name is David Dillon. I'm Vice  
9 President and Principal with Lewis & Ellis.

10 Q. How long have you worked for them?

11 A. 17 years.

12 Q. You have been here before; not your first  
13 rodeo with the Green Mountain Care Board?

14 A. That's correct. We have done work with the  
15 Board since January of 2014.

16 Q. Briefly what are your professional  
17 affiliations?

18 A. So I'm a fellow of the Society of Actuaries.  
19 I'm also involved -- I'm a member of the Society of  
20 Actuaries Health Section Council. Those are my primary  
21 credentials.

22 Q. So your area of expertise is?

23 A. Is health insurance, and since the passage of  
24 the ACA, the bulk of my work has been with ACA-related  
25 projects.

1 Q. Do you do work with other states besides  
2 Vermont?

3 A. Since the passage of the ACA I have personally  
4 worked with nine states regarding ACA-related issues.

5 Q. Were those review of exchange filings?

6 A. The bulk of those, yes, were exchange filings.  
7 We have -- I have been involved with over 300 ACA filings  
8 since the passage of the Act.

9 Q. Over those nine states.

10 A. Over those nine states in the four years, that  
11 is correct.

12 Q. How many reviews have you done in Vermont for  
13 this Board, do you have any idea?

14 A. We have done approximately 40 since the  
15 January of '14. Approximately half were for Blue Cross  
16 and their affiliates.

17 Q. So you're very familiar with the company and  
18 with the state. Why don't you explain to everyone what  
19 your process is once you get a filing, and how it comes  
20 in, and what the review process is for --

21 A. Sure. Since 2014 we have assigned a reviewer,  
22 Josh Hammerquist, who is the first signature on our  
23 report. He has been assigned to the Blue Cross filings.

24 Q. Is he an actuary also?

25 A. He is. He's an associate of the Society of

1 Actuaries. And he has been the primary reviewer on all of  
2 the Blue Cross filings. So for consistency across all the  
3 filings, we have had one reviewer. I am the -- I'll call  
4 it primary peer reviewer for the Blue Cross filings. So  
5 all the Blue Cross filings I'm involved with and consult  
6 with Josh on what to do. And then I am also what I would  
7 say a secondary peer reviewer for all other filings by  
8 other carriers.

9 As we will get to later, a lot of the  
10 assumptions are market-wide assumptions. And so I'm  
11 involved on both filings, just for consistency sake,  
12 assumptions that do affect both carriers.

13 Q. When you say market wide, you're talking about  
14 the exchange for now, the two carriers in the exchange?

15 A. Yes, that's correct.

16 Q. There is a process that you go through that  
17 there is a back and forth once you get a filing. Can you  
18 explain that a little bit?

19 A. Yes. Once we get the filing in mid May we  
20 begin our initial review. Josh from that initial review  
21 will generate a list of questions. We do also as part of  
22 the review, we have a kind of what I would say a  
23 preemptive data set that we have developed that the  
24 carriers provide some information on the front end that we  
25 are going to ask them anyway. So it should help reduce

1 some of the questions as we go along.

2           However, there are other obviously always  
3 questions that we must ask. So we usually -- within the  
4 first two weeks we send out the -- our initial request to  
5 the carriers, in this case Blue Cross. We typically give  
6 a week or so to get a response. And for this filing I  
7 believe we had five sets of questions. One of those was  
8 on behalf of the HCA, some questions that they had.

9           Q.       Who is your contact over at Blue Cross  
10 generally?

11          A.       Typically we deal with Paul Schultz and  
12 Martine Lemieux.

13          Q.       So it's an actuary-to-actuary type of  
14 discussion?

15          A.       Yes, it is.

16          Q.       And is that public in anyway? That  
17 discussion, how does that discussion take place, it's in  
18 writing?

19          A.       Yes. So this is through the SERFF system  
20 which is the NAIC. And the responses are -- the questions  
21 and the responses are submitted through that system and  
22 then that will be ultimately released and has been  
23 released for the public.

24          Q.       And available on the Board's Web site, as you  
25 know.

1 A. That is correct. Yes.

2 Q. And you produce a report out of all this back  
3 and forth for the Board; correct?

4 A. Yes.

5 Q. Let's turn to the -- to that report. It's  
6 Exhibit 13.

7 A. Yes.

8 Q. Let's look first at what your standard of  
9 review is which is on page 184. And there was a couple of  
10 terms, and I think Paul Schultz referred to them, and  
11 you're familiar with those also. There is -- the last  
12 part of that paragraph says: The rate is not excessive,  
13 inadequate or unfairly discriminatory.

14 Did you agree with his statement about those  
15 first two terms? I don't think you've talked about the  
16 last.

17 A. Yes. Those terms are defined in the actuarial  
18 standards of practice number eight regarding health  
19 insurance rate filings.

20 Q. So excessive is not equated with  
21 affordability?

22 A. Correct.

23 Q. Kind of terms of art?

24 A. Correct. It is. Yeah. So excessive is  
25 really defined as, you know, we have looked at the

1 assumptions for the claims, the expenses, and the fees,  
2 and we determine if a carrier is not overcharging for  
3 those specific segments.

4 Q. When reviewing this you also broke down the  
5 components of what you looked at on page three. Why don't  
6 we take a look at that. You have that in front of you?

7 A. Yes. So before we go down the list, I would  
8 like to just clarify that when companies submit these  
9 filings, and developing rates, carriers do not have to do  
10 it the same way. So Blue Cross and MVP can do -- you  
11 know, there is no standardized approach.

12 However, with the passage of the ACA there is  
13 a standardized report that they -- both companies must  
14 use. So just for the ease of the Board and for comparing  
15 things, this exhibit is based on the unified rate review  
16 template. So we have standardized it between the two  
17 companies so you can easily see, you know, and compare.

18 However, if you take a number out of this  
19 table, it may not exactly match something that has been  
20 presented elsewhere by the company because they may have  
21 developed that differently. So I just wanted to clarify  
22 that maybe the order we have put it in, and do this as to  
23 reporting that may not tie exactly to some other numbers.

24 Q. Can you just explain that a little more?  
25 Because I know that we talk in approximations some. And

1 is actuarial work exacting between your firm and Blue  
2 Cross? Do you match everything they do exactly when you  
3 do the calculations?

4 A. No. Blue Cross comes up with an estimate, and  
5 we will come up with an estimate. And generally speaking  
6 we will talk about some of the components later. But as  
7 long as they are -- how we would determine reasonable, we  
8 would say that our estimate is not materially different  
9 from their estimate. But it is all estimates, yes.

10 Q. It may be order of calculation or data that  
11 you do not have in-depth from Blue Cross that they will be  
12 using?

13 A. Yes.

14 Q. Let's look at a few little factors here. And  
15 we don't have to go through the whole thing, but you have  
16 a percentage change, and then per member per month. So  
17 that's dollars; correct?

18 A. That is correct. And I would like to  
19 highlight I think one of them that may be -- may have  
20 touched on a little bit. But one of the big factors is  
21 the federal transitional reinsurance recoveries, which is  
22 line eight. I just want to highlight that that is 2.6  
23 percentage change out of the total. And that is out of  
24 Blue Cross's control. That is a part of the three Rs.  
25 The reinsurance risk adjustment and the risk corridor

1 program put in by the feds, and that program is going  
2 away. And because of that program going away, additional  
3 premium has to be charged for that because the government  
4 -- federal government actually covered those claims prior,  
5 and they no longer do.

6 Q. We will get to this a little more in-depth,  
7 but you said the three Rs. Are any of those programs  
8 remaining permanently?

9 A. Yeah. So the risk adjustment program is the  
10 only permanent program that will -- that applies to this  
11 2017 filing. The risk corridors and reinsurance are  
12 sunsetting at the end of this year and do not apply to  
13 this filing.

14 Q. As a major part of this review you look at the  
15 trends that are developed by Blue Cross, and that's been  
16 at issue with the Board before. I know we have looked  
17 closely at trends. As far as the medical trend, how is  
18 that calculated by Blue Cross, and do you find it's a  
19 reasonable calculation?

20 A. Yeah. So the medical side of the trend  
21 calculation Blue Cross provided all of our -- their  
22 historical information, and basically what is done is that  
23 experience is, you know, aggregated by -- into --  
24 separated into different months. And measure -- Blue  
25 Cross measures how that changes monthly, annually and so

1 forth. So they monitor kind of the change in the per  
2 member per month costs.

3 They provided a lot of detailed information.  
4 We reviewed that information for the medical side. And we  
5 agree with their estimates.

6 Q. Did you give a range of member trend?

7 A. We do. So we take the historical results, and  
8 we create a model, the most likely values that trend will  
9 end up. And around that 4.3, I believe we have it in a  
10 footnote, that you know, we believe that the most likely  
11 range is right around that 4.3. So we believe 4.2 to 4.4  
12 is the most likely range of trend. But we do comment  
13 that, you know, sometimes things do vary from expectation,  
14 and there could be possibly higher or lower values than  
15 that. But we do believe that the 4.2 to 4.4 is the most  
16 likely range and where that trend will end up for medical.

17 Q. So each point along the range that you've  
18 given which is broad are not as likely.

19 A. No. Statistically speaking about 2/3 of the  
20 possible outcomes are very centered around the expectation  
21 of 4 point. So 2/3 should be right around the middle.

22 Q. What about the prescription drug trend in this  
23 filing? Did you develop a range on that also?

24 A. We did. Blue Cross had a slightly different  
25 approach to pharmacy in that they did utilize historical

1 information. But due to the dramatic impact of certain  
2 specialty drugs, those were separated, and so it was  
3 basically modeled separately. Kind of the regular drugs  
4 primarily used historical results. And then more of a  
5 detailed individual drug projection for those specialty  
6 drugs. And then it was brought back together for one  
7 aggregate number.

8           And I believe the total estimate was about  
9 10.2, and again you know, we give a range, a total range  
10 of 7.8 to 12.6. However, we believe that approximately  
11 2/3 of the time it's going to be really close to that 10,  
12 10.2. So that's where we believe the bulk of the  
13 estimates will be.

14           Q.       So no recommendations on the trends at all.

15           A.       Correct.

16           Q.       And you didn't recommend anything on the  
17 following categories here. There is a population risk  
18 adjustment, and other factors.

19           A.       No. We believe all of these factors were  
20 appropriately quantitatively supported by the information  
21 provided by Blue Cross.

22           Q.       Okay. Then let's go to the risk adjustment  
23 which is where you've made some --

24           A.       Sure.

25           Q.       This has changed over time; correct, the risk

1 adjustment?

2 A. Yes. So you know, I'm going to give kind of a  
3 brief example of risk adjustment. Because it is an --  
4 it's a very key assumption to both filings. It affects  
5 both filings. And it is, as I think Mr. Gobeille  
6 mentioned, it is a lot of gobbledygook, so I will try to  
7 give a very simplistic example.

8 Q. That is a federal program; correct?

9 A. This is a federal program. So as I alluded  
10 when the ACA came on board, there were the three Rs to  
11 help stabilize the markets. Because of the ACA, insurance  
12 companies cannot turn away a consumer. If they walk in  
13 the door, they have to take them. So the risk adjustment  
14 was to -- set up to help bring stability to the market.

15 So for example, let's say you have two  
16 insurance companies in a market and they both agree they  
17 should charge 500 bucks a person. Okay. And all the  
18 consumers come in the door, and everyone that goes to  
19 carrier A has bad backs, cancer, heart attacks. They get  
20 all of the consumers with health problems. Carrier B gets  
21 every person that's healthy. Okay. Well the company that  
22 is healthy at the end of the year they don't have a single  
23 claim, they don't get to keep that 500 bucks. They were  
24 just lucky that they got all of the healthy people. They  
25 cannot just pocket that \$500 a month and just take it and

1 put it in the bank.

2 Similarly, the company that got all of the  
3 sick people, they don't have to go out of business because  
4 they ended up having to pay for all of those MRIs that  
5 they weren't expecting. So the CMS -- CMS developed a  
6 risk adjustment formula which helped estimate the give  
7 back. So that healthy company that didn't have a single  
8 claim is going to have to give back and give money to the  
9 other consumer. So that's the risk adjustment program.  
10 In Vermont, in 2014, MVP gave back approximately \$2  
11 million to Blue Cross because due to the risk adjustment  
12 formula, they were deemed healthier and Blue Cross was  
13 deemed slightly sicker. So MVP paid an amount of money to  
14 Blue Cross.

15 MR. GOBEILLE: Just as a question of  
16 clarity, that's not paid directly from MVP to Blue  
17 Cross is it? Is it a CMS thing?

18 THE WITNESS: I believe it's through  
19 CMS, yes.

20 MR. GOBEILLE: I kind of remember where  
21 I think MVP had to pay it, but Blue Cross didn't get  
22 it right away.

23 THE WITNESS: I don't remember that.

24 MR. GOBEILLE: There is a question of  
25 how that was going to work.

1 THE WITNESS: I don't remember that  
2 specific issue. So for this specific rate filing at  
3 the time of this filing, both carriers had  
4 information on 2014 data. They had final data. But  
5 they only had interim information on 2015. So CMS  
6 had some information that they provided to the  
7 carriers.

8 So at the time of the filing they did  
9 not have the final 2015 information. And one thing I  
10 want to highlight as well is when CMS provides  
11 information to the carrier, they provide very  
12 detailed information to the carrier itself.

13 BY MS. HENKIN:

14 Q. On its own business?

15 A. On its own data, on its own basis, very  
16 detailed. However that carrier has very limited, if any,  
17 information on the other companies. So when they -- even  
18 with that interim data, so the companies make projections  
19 from this 2015 interim data, and project it to 2017. And  
20 basically how much give back is there going to be and who  
21 is going to give it back.

22 From the initial filings MVP estimated a give  
23 back that was three times more than what Blue Cross  
24 thought they were going to receive to MVP. So both  
25 companies estimated that MVP would be giving money to Blue

1 Cross but the magnitudes were different. And one thing I  
2 want to highlight again is in Vermont since you only have  
3 two carriers it's very easy to add up, the sum is zero.  
4 It's one company giving money to another company. So it's  
5 not like in other states where there is eight or nine  
6 companies passing money around. It's pretty clear if  
7 there is an estimate for one company, the opposite number  
8 is what the other company is.

9 So with the original filing MVP had estimated  
10 quite a bit more. And so the sum was not zero. However,  
11 during the filing on June 30, CMS released the final 2015  
12 report. In that report the give back for 2015 was  
13 approximately five to six hundred thousand dollars from  
14 MVP to Blue Cross as a result of that new final  
15 information. And so the carrier had more information, we  
16 went back and asked questions of both companies; would you  
17 -- how do you think this final report affects your filing.  
18 Do you believe there are -- any modifications need to be  
19 made based on this additional information.

20 Based on that, Blue Cross modified their  
21 assumption, as previously discussed that they believed  
22 based on this new info. that they would be giving back to  
23 MVP. MVP responded that they still believed that their  
24 original estimate of give back was still appropriate. And  
25 at that time they did not modify their assumption.

1 Q. Did that make sense to you that both would be  
2 giving?

3 A. So that is the issue that is now after the  
4 release of the final report, both companies estimated that  
5 they would be giving money to the other companies. Well  
6 in a world where X minus X should be zero, that does not  
7 make sense. So it was a nonsensical result.

8 However, as I mentioned, each carrier has very  
9 limited information on the other carrier. So it's not  
10 completely surprising that their two estimates didn't sum  
11 to zero. However, we were in the unique position such  
12 that we had the details of the information from both  
13 companies.

14 Q. Does that mean that you could do an exact  
15 calculation of what was due?

16 A. It is still an estimate. However, we were  
17 provided information on both companies, and so we utilized  
18 the detail information that the companies didn't have, and  
19 so we had more information than the carriers had  
20 separately. And we created our own estimate for the risk  
21 adjustment. And that was a give back of \$975,000. And  
22 that is outlined in our report.

23 And so what that would do is -- as we have  
24 outlined is a slight increase to the Blue Cross rates as a  
25 result of that change in how much money they will be

1 receiving from MVP. And conversely we have a  
2 recommendation that MVP -- that mirrors that 975 thousand  
3 dollar estimate.

4 Q. Why is this only a slight recommended increase  
5 where MVP's is recommended to be a significant decrease?

6 A. While the aggregate amount is obviously the  
7 same because it's -- one is giving a dollar amount to the  
8 other, Blue Cross has approximately 90 percent of the  
9 market. So the 975,000 divided by the 77,000 members or  
10 whatever is a much smaller amount. So the change -- their  
11 original estimate was just over a million dollars of what  
12 they would receive. So that difference between the  
13 million and our 975,000 divided by all the number of  
14 members that Blue Cross is expected to receive is a very  
15 small amount.

16 So conversely MVP with a smaller amount of  
17 membership, that dollar amount impacts them more on a per  
18 member per month basis.

19 Q. Okay. Let's talk a little bit about the  
20 contribution to reserve. You've listened to DFR and  
21 you've read their report; correct?

22 A. Yes.

23 Q. And you heard the witnesses today?

24 A. Yes.

25 Q. You did address this in your report. However,

1 and I direct you to page 192 of the binder, did you review  
2 the request of two percent increase for contribution to  
3 reserves, a two percent contribution to reserves that was  
4 in this request?

5 A. Yes.

6 Q. And what did you decide was necessary -- did  
7 you look at their 3.8 number also?

8 A. Yes. So we reviewed the company's  
9 calculations. And we believe that their short-term  
10 estimate of 3.8 percent was reasonable. We followed their  
11 calculation and felt like it was reasonable. However, we  
12 also agreed with the company due to short-term volume  
13 tilts, year-to-year fluctuations, things like that, that  
14 it is appropriate to use a long-term estimate. The  
15 company's long-term estimate is the two percent.

16 Based on our experience of looking at other  
17 companies, and possible fluctuations and solvency and  
18 things like that, we believe that two percent is a  
19 reasonable long-term estimate for CTR.

20 Q. As part of your work with other states, do you  
21 look at other Blues, other Blue Cross entities?

22 A. Yes. So part of our review is what I would  
23 call a peer analysis. Looking at other Blue Cross plans,  
24 and their ratios and metrics, and there are other metrics  
25 that we look at other than -- in addition to let's just

1 say the RBC that's been discussed. And the company's  
2 ratios are right in line. My last memory the RBC ratio  
3 was in the bottom third across all --

4 MR. GOBEILLE: Can you say that again?

5 THE WITNESS: -- the bottom third.

6 Therefore there was about 2/3 of the companies that  
7 had higher RBCs.

8 MR. GOBEILLE: Meaning more?

9 THE WITNESS: More.

10 BY MS. HENKIN:

11 Q. Are all those all Blue Cross companies you're  
12 talking about?

13 A. Yes, just the Blue Cross, yes. We believe  
14 that the Blue Cross of Vermont's solvency metrics are  
15 right in line and are not excessive, and we believe the  
16 two percent for this line of business. One thing I want  
17 to highlight is companies do set aside different CTRs for  
18 different magnitudes based on different lines of business.  
19 And that is because there is more chance for fluctuation.  
20 There is more risk involved in certain lines of business.  
21 And we believe that for this line of business, a two  
22 percent CTR is appropriate.

23 Q. You also put a chart in here on page 192. We  
24 have discussed this before, and I think that Paul Schultz  
25 referred to it. Can you just explain where -- did you

1 check this chart, is this from Blue Cross directly?

2 A. Yes. This was provided by Blue Cross. And it  
3 has been touched on a little bit. But I'll make a few  
4 comments on it as well. So you know after the Board's  
5 decisions and things like that, you know, they had an  
6 expected profit level. And they had the actual profit  
7 level. And what this table tells me is that their -- that  
8 for the majority of this time aggregate over those five  
9 years, Blue Cross's estimates for all the assumptions has  
10 pretty much been on target. There is no implicit margins  
11 in their assumptions. There are no questions that, you  
12 know, other states and other filings, other carriers, you  
13 know, sometimes they might -- a company might always  
14 overestimate trend or overestimate something. This table  
15 demonstrates that there does not appear to be any pattern  
16 of overestimation or underestimation in their assumptions.  
17 You can see that the actuals expected is very close.

18 One other thing I want to point out as well is  
19 one of the years where the actual appears to be way better  
20 than expected was primarily as a result of -- out of their  
21 hands was primarily a change in the federal reinsurance  
22 numbers post filing. So they were giving -- the federal  
23 government had received more money than they originally  
24 expected and passed it out. And so that's primarily the  
25 reason that number is higher.

1 MR. GOBEILLE: I also thought this is  
2 just because I remember how painful this was for  
3 people, we let people stay on their plans. Folks in  
4 2013 plans were allowed to stay in them into the  
5 first quarter of 2014. And that had to have an  
6 impact.

7 THE WITNESS: There is no question that  
8 for Vermont specific, there were a lot of issues and  
9 a lot of volatility.

10 MR. GOBEILLE: Yeah.

11 THE WITNESS: But primarily the gain  
12 I'm just focusing here was a change from the federal  
13 government. That is correct.

14 BY MS. HENKIN:

15 Q. The only recommendation that -- modification  
16 here is the risk adjustment?

17 A. Correct.

18 Q. How much does that change the rate?

19 A. Well, I'll follow up with one additional  
20 comment in a minute. But in terms of a rate  
21 recommendation, that is correct. Our only recommendation  
22 is due to the risk adjustment which is .07 percent  
23 increase. I want to highlight that while some people  
24 might look at that number and say it's immaterial, we  
25 believe it is important to implement that increase because

1 it is a market-wide adjustment. It is not just an  
2 assumption that impacts Blue Cross.

3 There is the other side of the coin of this  
4 assumption does affect the other carrier in the market.  
5 Therefore, we are recommending that the same change, that  
6 same process change be applied to both companies. It just  
7 happens to be .07 percent for Blue Cross.

8 Q. So that's not a dollar issue. But what you  
9 consider a fairness issue?

10 A. Correct. Yes.

11 Q. And one other thing I want to point out. It's  
12 on page 163 paragraph two. This is something else that  
13 you said that was not affecting the rate that should be  
14 changed.

15 A. Yes. There is one other slight modification  
16 that is not in our report. But however, it is listed here  
17 in the documentation. As I mentioned earlier the URRT is  
18 a reporting document created by the federal government.  
19 And they have a set -- a prescribed way of filling out  
20 that report. There was one assumption that I'll say was  
21 in column one, it should have been in column two. Blue  
22 Cross agreed with our -- the discovery of this, and they  
23 have agreed once all things -- all things have been  
24 settled, they will make that correction in the URRT.

25 Again I want to highlight it is a non-rate

1 issue. It is just a reporting issue based on the federal  
2 reporting template.

3 Q. And one last thing I want to touch on. Did  
4 you get a preliminary look at any hospital budget  
5 information?

6 A. Yes. That was provided to us by the Green  
7 Mountain Care Board.

8 Q. And that's the preliminary that came out on  
9 July 1?

10 A. That is correct. Yes.

11 Q. Did that affect your review any? Did you find  
12 any modifications based on what you saw there?

13 A. So while it's impossible to draw a direct one-  
14 to-one correlation from that -- those budget amounts to  
15 all the little assumptions in the filing, you will notice  
16 in the filing though that, you know, the trend -- the unit  
17 cost trend numbers have gone down from the prior years.  
18 And it looked like a reasonable -- the adjustments -- all  
19 the support provided to us, based on their new contracts  
20 and things like that appeared reasonable.

21 Q. With the modification that you're  
22 recommending, do you find that this filing meets those  
23 three standards we talked about earlier, not excessive,  
24 not inadequate, and not unfairly discriminatory?

25 A. Yes. We believe that it meets the standard of

1 review.

2 Q. Do you have anything else you want to tell the  
3 Board about this filing?

4 A. No.

5 MS. HENKIN: Thanks, David.

6 MR. HUDSON: Thank you, Attorney  
7 Henkin. Are there any questions from the Board?

8 MR. HOGAN: Just a quick one. I'm just  
9 wondering if you know, you rate these as reasonable,  
10 and I'm wondering if -- some of these are different  
11 summary might be -- like this is a requirement of the  
12 federal government or this is, you know, does that  
13 make any sense?

14 THE WITNESS: No, I'm sorry. Could you  
15 clarify?

16 MR. HOGAN: The changes to population  
17 risk adjustment. There are several elements in  
18 there. Aren't some of those federal requirements?

19 MS. HENKIN: What page are you looking  
20 at, Con?

21 MR. HOGAN: Excuse me. Page 16.

22 MR. GOBEILLE: Can I ask a question?

23 MR. HOGAN: Yeah.

24 MR. GOBEILLE: Is your point there is  
25 some things that it's not whether or not they are

1 reasonable or not, it's just a fact that they are  
2 law.

3 MR. HOGAN: That's exactly right.

4 MR. GOBEILLE: I felt that way, too.  
5 There are some things in here that are just changes  
6 to federal law. It's not whether they're affordable  
7 --

8 MR. HOGAN: It's not a choice on Blue  
9 Cross's part.

10 THE WITNESS: I do not believe as I  
11 quickly look through those bullet points, I mean I  
12 guess, you know, the definition of the small group  
13 you could say that was based on a change in a law, so  
14 they had to make an estimate based on that. As I  
15 mentioned earlier, the transitional reinsurance there  
16 is a change in the federal program that had to be  
17 done. So yes, some of those are based on  
18 requirements, statutory or federal authority. Yes.

19 MR. HOGAN: And Al said it better than  
20 I did. Basically the public thinks that this is all  
21 Blue Cross, and it's not.

22 THE WITNESS: No.

23 MR. HOGAN: Okay.

24 DR. RAMSAY: So could you go to page  
25 188, David.

1 THE WITNESS: Okay.

2 DR. RAMSAY: I want to go over this  
3 change in population risk adjustment. These two  
4 middle categories which adds to the premium of --  
5 assuming that -- let's talk about Medicaid transition  
6 to Qualified Health Plan. Blue Cross Blue Shield  
7 assumed -- is there any other way than to assume the  
8 same morbidity as the current individual subsidized  
9 members? This is a non-experienced group so they had  
10 to make an assumption, right?

11 THE WITNESS: Yes.

12 DR. RAMSAY: Just made a flat  
13 assumption that these people -- this group was going  
14 to come in, and they were going to be at the silver  
15 level, and they were going to be subsidized similar  
16 to those that are already in.

17 THE WITNESS: Yes.

18 DR. RAMSAY: Okay. And then the second  
19 one was the definition of small group again. These  
20 enrollees have already -- if they are employed or  
21 these employers of 51 to 100 employees -- have  
22 already made their decision for 2016; correct?

23 THE WITNESS: Yes. I believe of the  
24 small groups here about 85 percent of them they  
25 already have information on and were enrolled in

1 2016, yes.

2 DR. RAMSAY: Right. So they have that  
3 information.

4 THE WITNESS: It's approximately 85  
5 percent of this adjustment was based on the  
6 experience that they have seen to date.

7 DR. RAMSAY: So why would it go up 1.1  
8 percent? These are already in for 2016, right?

9 THE WITNESS: Right. As previously  
10 discussed, the estimate there was -- versus last year  
11 was higher. So last year they made an assumption how  
12 many were going to come in for '16. Now they can  
13 actually see it.

14 DR. RAMSAY: Right.

15 THE WITNESS: And the claims were  
16 higher, higher than what they assumed last year. So  
17 that's the reason for the increase.

18 DR. RAMSAY: All right. That's all I  
19 have.

20 MS. HOLMES: Thank you. So given -- I  
21 guess Paul's -- the question I asked earlier, given  
22 the 90 percent market share and the presumed leverage  
23 in contract negotiations, how much of the medical  
24 trend do you think is actually in their control?

25 THE WITNESS: Quite a bit of it is -- I

1 would say I don't know if I could give you a great  
2 split. I would say that not specifically for just  
3 their company, but I have been historically surprised  
4 by the amount that the company cannot control. We  
5 have seen in our experience since we have been here  
6 in 2014, we have specifically seen, you know, one  
7 hospital chain really impact things where the  
8 carriers could not do much to prevent it. So you  
9 know, it does vary by year, and you know, it varies  
10 based on the leverage of the hospitals. But you  
11 know, in a state like yours, that you know, doesn't  
12 have a whole lot of metropolitan areas, and there is,  
13 you know, certain hospitals or provider groups that  
14 have more power than others, it can be very difficult  
15 for carriers to negotiate even if they do have a lot  
16 of membership.

17 MS. HOLMES: And obviously a rate of  
18 eight percent is high no doubt. Right? Plenty of  
19 public comment, and we know that this is high. It's  
20 going to hit people's pockets pretty hard. But news  
21 across the country is double digit increases, right?  
22 We are seeing in California just announced this week  
23 13 percent. We are seeing double digits, over 20  
24 percent increases.

25 THE WITNESS: Yes.

1 MS. HOLMES: You have seen nine states,  
2 or you have been working with the filings of nine  
3 states. So I'm wondering if you can -- your work  
4 spans all these states. Can you put Vermont in the  
5 context of other states? In some sense what are we  
6 doing right that makes it say only eight percent when  
7 other states are in the 10s and 20s and even higher  
8 than that. And what can we be doing differently?  
9 What are your learnings from the other states that  
10 help us?

11 THE WITNESS: There is no question  
12 across the states that I work with the market average  
13 increase that we are seeing in Vermont is by far the  
14 lowest of the states. Now to my knowledge, there may  
15 be some other states that I do not work with and I  
16 don't have as much detail on that also have some  
17 lower numbers. But there is no question that the  
18 pattern over the last three years in Vermont the  
19 average increase has been significantly lower than  
20 other states.

21 I think maybe it was Dr. Ramsay that  
22 asked a very similar question last year or two years  
23 ago, and unfortunately I don't know if I can give a  
24 great answer on necessarily what has been done right.  
25 But I would confirm that the carriers are doing

1 something right, because it is significantly lower  
2 than other states. And of those -- I'm trying to  
3 think off the top of my head, of those six to seven  
4 states that I'm actively working with, I believe that  
5 the Blue Cross Vermont filing is the smallest of the  
6 other Blue Cross plans that I'm reviewing.

7 MS. HOLMES: Can you think through what  
8 some of the others have put in? What are the drivers  
9 in those other states?

10 THE WITNESS: Well I do think one of  
11 the issues here that helps kind of stabilize things  
12 is the merged market, so the merged market does help  
13 bring some stability. The individual market in  
14 itself is very unstable, and bringing in a small  
15 group market does help that. That's probably reason  
16 one.

17 Outside of that, I do think probably  
18 having -- I do think having the budgetary process  
19 for, you know, roughly half of the hospitals that  
20 piece of the claims pie helps a lot. A lot of states  
21 do not have that. And so there is not as much  
22 limiting trend there because the budget process is  
23 not there. So I believe those are probably the two  
24 best reasons.

25 MS. HOLMES: Okay. Thank you.

1 MR. GOBEILLE: Can I just add to that?  
2 So it seemed like when the first numbers came out  
3 from the ACA that our per member per month was one of  
4 the highest. And a lot of that had to do with the  
5 age they picked, and we don't do age.

6 THE WITNESS: Yes.

7 MR. GOBEILLE: Lot of it had to do with  
8 smoking versus non smoking. It seems like a lot of  
9 states, Georgia had a 65.9 percent request. Oregon  
10 had a 29.7. I could read the whole chart to you.  
11 It's not right in front of me. Point being was it  
12 because we had a high base at all, and do you have  
13 any opinion on that? And have you seen anything on  
14 that?

15 THE WITNESS: Well, I have not done  
16 let's say a complete apples-to-apples comparison.

17 MR. GOBEILLE: Nor can you because we  
18 have a merged market. We are the only one.

19 THE WITNESS: You have the merged  
20 market issue. But the other -- I think one of the  
21 primary issues that wasn't delineated in some of  
22 those comparisons was the family tier issue. You  
23 guys have a defined tier structure such that the  
24 families are paying a little bit less than what they  
25 should be paying.

1 MR. GOBEILLE: In Vermont.

2 THE WITNESS: In Vermont. So that has  
3 to be covered somewhere else and is covered in the  
4 individual market premium, individual person  
5 premiums. So I think that's one thing when you look  
6 at these comparisons that most states don't require  
7 less premium on the families. So you've got -- and  
8 so for example, Blue Cross's individual premium rates  
9 may look higher versus somebody else, but it's  
10 because they are subsidizing some of the family  
11 coverage.

12 MS. RAMBUR: That was my question.

13 MR. HOGAN: And one of the other  
14 interesting comparisons, I want to be careful because  
15 I don't want to violate any rules here, but the risk  
16 capital numbers that we were talking about earlier,  
17 in many states are twice those of Vermont, yet  
18 Vermont still remains in the words of DFR, a healthy  
19 company. It's a mystery.

20 THE WITNESS: Well so there are a --  
21 there are a lot of variables that go into the  
22 solvency. One thing I want to highlight is the RBC  
23 formula is not necessarily to be used as a  
24 comparison.

25 MR. HOGAN: Okay.

1 THE WITNESS: It is designed as almost  
2 like an early warning signal for companies. And so,  
3 you know, it is based on a lot of different variables  
4 and types of products and things like that. It was  
5 -- that formula is not -- and you know, not designed  
6 to say well someone's at a thousand, it's way better  
7 than 800. Even if someone that's at 500, there are a  
8 lot of factors involved. It is an early warning sign  
9 and is not really to be used for comparison. It can  
10 be and it is, but that is not really the original  
11 design of the formula.

12 MR. HOGAN: Thank you.

13 MR. HUDSON: Okay. Hearing no more  
14 questions from the Board, Blue Cross, do you have any  
15 questions for this witness?

16 MS. HUGHES: I do have a few. Thanks.

17 CROSS EXAMINATION

18 BY MS. HUGHES:

19 Q. So earlier you were questioned about the  
20 health status of new members. And in looking at page 188,  
21 did you quantify the impact of that in a filing, in a  
22 footnote?

23 A. Are you specifically talking about the  
24 Medicaid population? Yes. We footnoted that the total  
25 estimate or total change to the rate increase as a result

1 of the Medicaid population was 0.1 percent.

2 Q. And looking at trend, you testified earlier  
3 with respect to medical trend, that it was reasonable, is  
4 it also your opinion that it is appropriate?

5 A. Yes.

6 Q. And how about pharmacy trend, is that the  
7 same?

8 A. Yes.

9 Q. And Blue Cross's administrative expense  
10 assumptions, does that compare favorably to other  
11 companies that you review?

12 A. Yes. It does.

13 Q. And on page 192, the paragraph, in your  
14 opinion, just below the chart, can you review that with us  
15 and describe whether or not that is your opinion?

16 A. Yes. So what we are basically saying here is  
17 what I alluded to earlier that, you know, we believe that  
18 the two percent trend, or I'm sorry, the two percent CTR  
19 is an appropriate level to -- for the company to withstand  
20 possible issues on a long-term basis.

21 Q. But the filing did support a higher short-term  
22 value?

23 A. That is correct. Yes.

24 Q. And can you describe for us how you arrived at  
25 your recommendation for the risk adjustment without

1 revealing any confidential information?

2 A. Yeah. So what we did there again is we were  
3 in the position to receive confidential information from  
4 both companies. And so in Blue Cross's filing, you know,  
5 they made -- they obviously can make -- you know, they  
6 make their projections on their own information. But they  
7 also have to make educated guess on what is going to  
8 happen to the market entirety -- in the entirety, which  
9 also implies that they have to make adjustments regarding  
10 MVP. And so that is the other case with MVP as well.

11 So we took the information that was not  
12 available to each carrier and came up with new estimates  
13 based on the additional information we were provided.

14 Q. Okay. Thank you.

15 MS. RICHARDSON: I have --

16 MR. HUDSON: Does HCA have questions?

17 MS. RICHARDSON: I have a few

18 questions. The Board asked some of my questions, so  
19 that will shorten it.

20 CROSS EXAMINATION

21 BY MS. RICHARDSON:

22 Q. I just wanted to clarify something about the  
23 public record. You testified that the answers to the --  
24 the responses to the questions that were posed were  
25 included in a SERFF filing. And just reviewing the table

1 of contents there are some of the exhibits that are  
2 labeled confidential.

3 A. Yes. The one I guess exception to that rule  
4 is there is some information that has been deemed  
5 confidential, and that it would hurt the company if it was  
6 released to the market and the other carrier had that  
7 information. So yes, there were certain number of  
8 questions that were deemed confidential. Yes.

9 Q. And not uploaded to SERFF as a result of that?

10 A. Correct.

11 Q. I just wanted to clarify what the public  
12 record contains. I also had a clarifying question on page  
13 187. And just looking at the final full paragraph  
14 beginning "our best estimate." That refers to the best  
15 estimate of medical trend, but the rest of the section is  
16 about pharmacy trend. Is that intended to be pharmacy  
17 trend?

18 A. As I'm reading through that, that looks like  
19 that should be pharmacy. That is correct.

20 Q. Okay. That was what I understood from  
21 context, but just wanted to check to make sure.

22 A. I believe that's correct. Yes.

23 Q. Okay. And when you talked about a reasonable  
24 range for above medical and pharmacy trend, you said the  
25 most likely would be close to the figures that were used

1 by Blue Cross, and you gave a range of probably between  
2 4.2 to 4.4 percent for medical, and said really close to  
3 the 10.2 to pharmacy?

4 A. Yes.

5 Q. Could you quantify how close is really close  
6 to pharmacy?

7 A. We did not footnote that number. And I do not  
8 recall the specific range. But I believe it was very  
9 analogous to the medical, so it was let's say 10.1 to  
10 10.3. Something in that range. It was a very de minimis  
11 range.

12 Q. Close to the --

13 A. Correct.

14 Q. But on either side there is a slight range.

15 A. Yes.

16 Q. I don't have any further questions.

17 MR. HUDSON: Okay. Thank you. Any  
18 follow-up questions from the Board at this time?  
19 Dave, thank you very much.

20 THE WITNESS: Thank you.

21 MR. HUDSON: So at this point in the  
22 hearing it is the HCA's turn to present its witness.  
23 If I could just make a brief announcement, because I  
24 know many members of the public arrived at opening  
25 statements. I just wanted to clarify for them that

1 the Vermont Office of the Health Care Advocate is a  
2 separate organization from the Green Mountain Care  
3 Board and Blue Cross Blue Shield. And they have been  
4 present as a party to this proceeding from the  
5 beginning and are a public interest advocacy group.

6 MS. RICHARDSON: Call Donna Novak as  
7 our witness.

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1 DONNA NOVAK

2 Having been duly sworn, testified

3 as follows:

4 DIRECT EXAMINATION

5 BY MS. RICHARDSON:

6 Q. Could you state your name and address please?

7 A. Donna Novak, 156 West Calle Guija in  
8 Sahuarita, Arizona.

9 Q. And where are you employed?

10 A. NovaRest, Inc.

11 Q. And what is NovaRest?

12 A. It's an actuarial consultant firm.

13 Q. And how long have you worked there?

14 A. The firm was founded in 2001. I'm sorry.  
15 2002.

16 Q. Okay. So as Blue Cross said, I'll try to  
17 shorten some of the professional experience testimony by  
18 having you refer to Exhibit 14 in the filing. And can you  
19 identify that document in the binder?

20 A. Yes. That's my report.

21 Q. And does any part of that document include a  
22 description of your education and professional experience?

23 A. Yes. My CV is attachment A, starts on page  
24 10.

25 Q. Okay. When you say page 10 of the report, are

1 you referring to page 206 of the binder?

2 A. It actually starts on page 207. Yeah.

3 Q. And does this CV that you have presented with  
4 your report, detail your experience with the actuarial  
5 review of health insurance filings?

6 A. Yes, it does.

7 Q. Is there anything else you would want to add  
8 to that that you think is relevant to your experience,  
9 report that you filed?

10 A. Well I mean I could add a little bit of detail  
11 at least. This year I've already reviewed including these  
12 two filings, 64 filings for ACA for 2017. Also I do some  
13 small group quarterly and grandfathered and transitional.  
14 I've got another 12 that landed on my desk while I was  
15 flying here, and so that's how many I'll be reviewing this  
16 year, and similar in the last previous years.

17 Q. Okay. When you said in addition to these two,  
18 are you referring to Blue Cross and MVP filings for the  
19 health agency in the state?

20 A. Yes.

21 Q. And how much of your time do you spend working  
22 on issues that involve health insurance rates or other  
23 issues?

24 A. All of my time is involved with health  
25 insurance; rates or solvency.

1 Q. Okay. Just referring to the fact that some of  
2 your work involves solvency or review of solvency of  
3 health care insurers, could you describe briefly what that  
4 experience is?

5 A. Well I was responsible for the development of  
6 the medical factors in the health risk-based capital  
7 formula that was developed originally by the American  
8 Academy of Actuaries and adopted by the National  
9 Association of Insurance Commissioners with some  
10 modification.

11 I led the group that recently rewrote the rate  
12 filing and review ASOP, actual standard of practice number  
13 eight that's been alluded to in order to add the ACA to  
14 it. I worked for Blue Cross Blue Shield Association  
15 monitoring the Blue Cross Blue Shield plans for solvency,  
16 the ones that were -- looked like they could possibly have  
17 some solvency issues.

18 I have participated in a number of financial  
19 exams that -- similar to what was described earlier that  
20 takes months to go into, insurance carriers to review  
21 their solvency. Something else I'm thinking of, but quite  
22 a bit of work, working with regulators and working with  
23 carriers to determine the right level of solvency and what  
24 is a risk to solvency in an insurance carrier.

25 Q. What procedures did you follow in performing

1 your review and analysis of the Blue Cross rate filing?

2 A. Over the last few years we have developed a  
3 set of procedures, as a matter of fact on our Web site,  
4 for reviewing carriers that follow along requirements of  
5 having an effective rate review state. We have a number  
6 of issues that we look at. We review those, and often the  
7 filing is thorough enough that they can be answered by the  
8 filing. If they aren't, then we put together a set of  
9 questions.

10 We also do some comparisons, especially within  
11 the state, of filings and final rates, and sometimes with  
12 other states, but states are so unique that we find it  
13 very difficult to compare from state to state, but usually  
14 within the state.

15 In the case of Vermont often Lewis & Ellis  
16 asks our questions, and so we kind of cross those off the  
17 list. I have a peer reviewer, another senior actuary that  
18 also looks at the filing to see if there are any issues  
19 that I may have missed and potentially add some questions  
20 to our questions. And then, of course, we review the  
21 answers both that are supplied by Lewis & Ellis and  
22 supplied to our questions.

23 Q. And I refer you to page 213 in the binder.  
24 Could you describe what that is?

25 A. It's a list of materials that I reviewed, some

1 more thoroughly than others. Other CVs I didn't look at  
2 that closely.

3 Q. And are the types of information that you have  
4 listed in this attachment to your report the type  
5 reasonably relied on by actuaries who would be working to  
6 review health insurance rates?

7 A. Are you asking if these are the typical types  
8 of things?

9 Q. Yes.

10 A. Yes. Absolutely.

11 Q. And did you prepare a report with your  
12 analysis and conclusions after reviewing the filing?

13 A. Yes. That's what can be found starting on  
14 page 197.

15 Q. So referring to Exhibit 13, is that the total  
16 report that you filed for this filing?

17 A. Yes.

18 Q. So did you come -- as you prepared your  
19 report, and relayed your analysis, did you come to any  
20 conclusions about whether the requested rate should be  
21 approved or modified or disapproved based on the statutory  
22 criteria?

23 A. If it should be approved or disapproved?

24 Q. Did you come to any conclusions about whether  
25 there were -- there should be a modification, or approval

1 as filed or disapproval?

2 A. I'm not recommending any modification to the  
3 rate filing.

4 Q. Okay. Did you come to any conclusions about  
5 changes that could be made in the recommended rate from  
6 Blue Cross Blue Shield, the requested rate of 8.2 percent?

7 A. After reviewing the financial -- well the  
8 projections that were associated with the rate filing, and  
9 Blue Cross Blue Shield's financial statements, I felt that  
10 the requested contribution to reserve or CTR could be  
11 lower, especially considering that the current level of  
12 risk-based capital is within their target range.

13 Q. So I'll ask you some more questions about that  
14 point in a minute. Did you review the Lewis & Ellis  
15 recommendation about the slight increase in the rate due  
16 to new information about risk adjustment transfer?

17 A. Yes. I did.

18 Q. And did you hear their testimony -- Blue  
19 Cross's testimony today?

20 A. Yes, I did.

21 Q. Do you recommend rate increase or change for  
22 Blue Cross from the rates that were requested due to this  
23 risk adjustment factor?

24 A. No. I have no recommendation on that point.  
25 I think there are a lot of moving parts, and I'm not

1 comfortable making a recommendation on the risk  
2 adjustment.

3 Q. I would then like to turn to the issue that  
4 you identified about contribution to reserves level and  
5 ask you to go try to make sure everybody is on the same  
6 page literally.

7 Could you turn to page 202 in the binder. And  
8 page 202 and page 203 where you discuss your conclusions  
9 and findings about the issue of contribution reserve  
10 level.

11 A. Yes.

12 Q. So I would like to ask you to read the first  
13 paragraph on page 203.

14 A. Okay. It says: "I reviewed the Blue Cross  
15 Blue Shield of Vermont third quarter 2016 large group  
16 rating program filing. In the Exhibit 7A, which is  
17 attached in attachment D, to this report. Shows I  
18 required insured CTR factor to maintain target," that's  
19 the title of it, "of 1.3, 1.3 percent and that the 1.3  
20 percent is across all product lines, and also there would  
21 be no reason that you would have to give the same amount  
22 to each product line."

23 Q. So when you are referring to Exhibit 7A  
24 attachment D, is that the attachment that -- chart that  
25 would be found in the binder at the final page of your

1 report?

2 A. Right. On page 218.

3 Q. 218. Okay. And could you review this chart  
4 which is labeled Third Quarter 2016 Large Group Rate  
5 Program Filing and explain why that would be relevant in  
6 your opinion to the filing in this case which is the  
7 Vermont Health Connect filing?

8 A. Well it's for large group. But it's for large  
9 group over the same period of time including -- what do I  
10 want to say, issue dates of January 2017. It included  
11 slightly different assumptions, so these assumptions are  
12 changing. But I felt that since it had been filed about  
13 the same time as, you know, give or take a few months, I  
14 don't know the exact dates it was filed, as this filing  
15 that they should tie together in some way.

16 Q. And were there any parts of this calculation  
17 in this chart that are particularly relevant? You  
18 reviewed them briefly in your report. But could you  
19 explain what's important about this filing and your  
20 conclusions?

21 A. Well they are -- the estimate is based upon  
22 the change in the ACL or authorized control level. It  
23 doesn't address though what the current level is. It's  
24 just the change in the level. But the change in the level  
25 results in an increase after adjustment for taxes of 7,

1 584,180 which within -- when divided over all of the  
2 premium equivalents for QHP and cost plus and other  
3 insured, results in an increase to maintain the target of  
4 1.3 percent.

5 Q. And again why -- what about this finally is  
6 relevant to the filing of the Qualified Health Plans?

7 A. It's for approximately the same period of  
8 time.

9 Q. And does this include information about the  
10 Qualified Health Plans?

11 A. It does. It includes their premium as part of  
12 the total premium.

13 Q. So I would like to now direct you back to page  
14 203 of your report. And ask you to read the second and  
15 third paragraph, and not to read any of the specific  
16 information contained in the chart following as it  
17 contains information we don't want to discuss in public.

18 A. Right. It says that I'll expand --

19 Q. If you could just read it.

20 A. Okay. "BCBSVT has testified in prior hearings  
21 that its target RBC is between 500 to 700 percent. And  
22 its current RBC value is in the upper 25 percent of the  
23 target range. The following table shows the risk-based  
24 capital, RBC, for BCBSVT over the past five years derived  
25 from data in the five-year historic chart from BCBSVT's

1 2015 annual statement. That chart is attached in  
2 attachment C."

3 Q. So turning to attachment C in your filing page  
4 216, is that what you're referring to?

5 A. Yes.

6 Q. Okay. Is that information in your report the  
7 same information that's contained in Exhibit 18 at the  
8 back of the binder?

9 A. I believe so. But let me check. Yes, it is.

10 Q. And what information does this five-year  
11 historical data chart include that's relevant to solvency?

12 A. Well under the title Risk-based Capital  
13 Analysis, the row numbered 14 has the total adjusted  
14 capital over the years. And row 15 is the authorized  
15 control level, or the ACL, that we have been referring to.  
16 Risk-based capital amount.

17 Q. And does this chart include actual RBC values  
18 that are analogous to something referred to before?

19 A. No. It does not include the risk-based  
20 capital percentage.

21 Q. And is there a way to use this chart to  
22 calculate risk-based capital percentages?

23 A. The risk-based capital percentage is the total  
24 adjusted capital divided by the authorized control level  
25 risk-based capital.

1 Q. And you've heard some testimony about what  
2 risk-based capital is. Do you have anything to add to  
3 that?

4 A. Well the risk-based capital formula that is--  
5 that actually calculates the authorized control level  
6 risk-based capital is for health insurance companies only  
7 and takes into consideration the risk of a health  
8 insurance company including offsets for the amount of  
9 premium that's under capitated arrangement and -- how much  
10 of the ASO business is or cost plus business is compared  
11 to totally at risk business. So it takes in -- a lot of  
12 factors into consideration. It's tailored for health  
13 insurers.

14 Q. And you just used the acronym ASO?

15 A. I used the acronym because -- administrative  
16 services only.

17 Q. So using this information in the five-year  
18 historical data chart, did you calculate the risk-based  
19 capital for Blue Cross over the five-year period?

20 A. Yes.

21 Q. And going back to your report in the binder at  
22 page 203.

23 A. Yes.

24 Q. Could you explain without reading whole -- all  
25 the figures in, what that chart represents?

1           A.       It's basically those two rows from the five-  
2 year historic exhibit.

3           Q.       And there is a last row that's labeled RBC.  
4 Could you explain what that is?

5           A.       That's the two rows guided by each other or  
6 the risk-based capital percentage.

7           Q.       Okay. And this shows -- this chart shows that  
8 percentage over a five-year period for Blue Cross Blue  
9 Shield?

10          A.       Yes.

11          Q.       So going beyond the chart, on page 203, can  
12 you read the next paragraph beginning: "Considering, 1.3  
13 percent."

14          A.       Okay. "Considering 1.3 percent CTR shown in  
15 the Blue Cross Blue Shield of Vermont Q3, 2016 large group  
16 rating program filing, the CTR for this filing could be  
17 reduced -- could be reduced from..." I think -- sorry --  
18 that should say, but it says to 1.3 percent.

19 "Additionally, since RBC level is at the upper range of  
20 BCBSVT's target, and the CTR for the merged market could  
21 be less than the other lines of business, the CTR could  
22 safely be reduced below 1.3 percent."

23          Q.       Okay. So starting with the first sentence  
24 there when you talk about reducing to 1.3 percent, would  
25 that be from the two percent CTR that's requested in the

1 filing that Blue Cross has testified?

2 A. Yes.

3 Q. It's continuing to request?

4 A. Yeah.

5 Q. And could you explain why you think that 1.3  
6 percent would be appropriate rather than two percent?

7 A. Well because it was found in a recent filing.  
8 It was -- yeah, it was part of Blue Cross Blue Shield of  
9 Vermont's recent filing for the large group -- for the  
10 approximate period of time.

11 Q. And for the second sentence you have indicated  
12 that you believe that the RBC level could be reduced below  
13 the 1.3 percent. And could you explain a little bit more  
14 about why you think that that is appropriate?

15 A. Okay. Again, it's because right now they are  
16 already in the upper quartile of the range. And because  
17 they are already in the upper quartile of the range,  
18 adding, you know, they don't need as much in order to stay  
19 at the 600 percent target that they have targeted.

20 Q. When you say the range, could you be clear  
21 about which range you're talking about?

22 A. I'm sorry, yes. It was what was previously  
23 testified to be between 500 percent and 700 percent.

24 Q. So could you read your conclusory paragraph on  
25 page 203 please?

1           A.       Okay. Under conclusions: "Since BCBSVT's  
2 solvency level is strong with only a slight reduction from  
3 2014 to 2015, a reduction in the filed CTR would not  
4 likely be a threat to BCBSVT solvency and would make the  
5 products more affordable."

6           Q.       So you've heard the testimony from the other  
7 witnesses today and read the reports from Lewis & Ellis  
8 and from Department of Financial Regulation?

9           A.       Yes.

10          Q.       And do you still believe that this conclusion  
11 in this report is appropriate?

12          A.       Yes.

13          Q.       Have one final general question about the  
14 actuarial review standards that are used. When an actuary  
15 is determining whether a requested rate increase is  
16 inadequate or excessive, is there a precise number that  
17 must be reached in order to use those two phrases? Is  
18 there a very precise target?

19          A.       It's a range. And it's based upon a range of  
20 assumption -- ranging of assumption that ends up with a  
21 range of not excessive but adequate rates.

22          Q.       And in this filing would you say that that's  
23 also a possible finding about adequacy and/or inadequacy  
24 and excessive rates that there would be a range?

25          A.       Absolutely. I think we talked a lot today

1 about ranges and different alternatives.

2 Q. And even within a range an actuary could find  
3 that there is an adequate not excessive rate filing?

4 A. Absolutely.

5 MS. RICHARDSON: I don't have further  
6 questions.

7 MR. HUDSON: Okay. HCA has concluded  
8 its direct. I know we have some questions from the  
9 Board.

10 MR. GOBEILLE: Sure. My first question  
11 would be how do I reconcile the fact that Lewis &  
12 Ellis and Blue Cross did math to get to an -- I think  
13 it was a 3.8 or 3.7 percent contribution in reserve  
14 and you got to a 1.3 off of a document. How do I  
15 think about that?

16 THE WITNESS: It's Blue Cross Blue  
17 Shield of Vermont's document. It was in their large  
18 group.

19 MR. GOBEILLE: But I mean the math  
20 part. Did you do math to figure out what they --

21 THE WITNESS: I looked at the  
22 difference in assumptions. But there was no  
23 documentation of the development of those  
24 assumptions. So I couldn't -- I can tell the  
25 different assumptions that went into the two of them.

1 MR. GOBEILLE: Let me ask it a  
2 different way. Do you disagree with their -- with  
3 the way that they did their process? As actuaries?

4 THE WITNESS: No.

5 MR. GOBEILLE: So a 3.8 is reasonable.

6 THE WITNESS: There is a slight  
7 disagreement about the 3.8 number, but the process is  
8 mine.

9 MR. GOBEILLE: Meaning if all you had  
10 to look at was this filing, and you didn't find  
11 document on another product, which way or may not be  
12 relevant to this, what math would you have used to  
13 determine what contribution for reserve would be  
14 appropriate if you're doing this as an actuary? I  
15 mean it sounds like Lewis & Ellis did math. And Blue  
16 Cross did math. And it sounds like DFR does their  
17 math. What math did you use?

18 THE WITNESS: Okay. I did not include  
19 it in my report. But I did an analysis of the  
20 increase in claims and the increase in premium, and  
21 how much that would impact the authorized control  
22 level. And therefore how the authorized control  
23 level would change.

24 MR. GOBEILLE: So did you --

25 THE WITNESS: Very similar to what was

1 in the large group, very similar process to what was  
2 in the large group filing.

3 MR. GOBEILLE: Let me be clear. I  
4 would be more comfortable if you disagreed with  
5 something and said it's a math issue. So you're not  
6 taking issue with their math.

7 THE WITNESS: No.

8 MR. GOBEILLE: Okay. That's all I  
9 have.

10 MS. RAMBUR: Can I follow up on that?  
11 I just wanted to make sure I heard this correctly.  
12 So the independent actuary that the Board has hired  
13 to help us meet our responsibility to the public of  
14 solvency and affordability testified that they  
15 concurred that a short-term contribution to reserve  
16 of 3.8 was reasonable, if I'm remembering correctly.  
17 And but they concurred that an evening out to two was  
18 also a reasonable approach.

19 Do you agree or disagree with the 3.8?

20 THE WITNESS: When I looked at the  
21 calculation of the 3.8 I thought it should be 2.8.  
22 But it's just the way it was calculated in the  
23 spreadsheet. But I don't disagree with the process.  
24 We could look at the math in the spreadsheet, but I  
25 thought it should be 2.8.

1 MR. GOBEILLE: So then that would mean  
2 that the math would lead you to a 2.8 percent  
3 contribution in reserve.

4 THE WITNESS: Short term. Yeah. Yeah.

5 MR. HOGAN: But I'm trying to figure  
6 this out. You did testify that the CTR could be  
7 reduced to 1.3 percent.

8 THE WITNESS: Yes. The other filing  
9 led me to believe that 1.3.

10 MR. HOGAN: And then further you  
11 indicated that it could be reduced more than 1.3  
12 percent.

13 THE WITNESS: And that's based on the  
14 current solvency level and the impact of reducing it  
15 to that amount.

16 MR. HOGAN: How much further could it  
17 have been reduced?

18 THE WITNESS: I've not done that math.

19 MR. GOBEILLE: Is there a math that  
20 could do that?

21 MR. HOGAN: That's -- can you -- can  
22 that be calculated?

23 MR. GOBEILLE: It sounds like the math  
24 get us to a 2.8, and some other thing gets you to a  
25 1.3 or lower.

1 THE WITNESS: You could calculate how  
2 much the reserve level currently is over the six --  
3 the mid point. And taking all of the assumptions on  
4 trend and everything as true, what the contribution  
5 to reserve would have to be in order to hit the six  
6 when you take into consideration the solvency level  
7 that's currently in existence. You could do that  
8 math.

9 MR. HOGAN: If the CTR were reduced to  
10 1.3 percent, what then would the impact of that be on  
11 the rate that Blue Cross has requested?

12 THE WITNESS: I believe it would  
13 decrease it .7 percent. .7 percent.

14 MR. GOBEILLE: That hasn't always  
15 worked that way in a linear fashion in the past. I  
16 would --

17 THE WITNESS: Well that's why I said  
18 approximately.

19 MR. GOBEILLE: No, I mean like last  
20 year a three point reduction in CTR was a .5 percent  
21 reduction in rate. I don't know what it is because  
22 my actuaries didn't come back with that. I don't  
23 have that figured out. But basically, and I don't  
24 want to start throwing around numbers, but that would  
25 -- that math would have to be done and would have to

1 be knowable.

2 THE WITNESS: And it could be done, you  
3 know, what the impact would be on the premiums.

4 MR. GOBEILLE: I mean I think that --  
5 all right.

6 MS. HOLMES: CTR question too. It  
7 seems to me from what I've heard CTR is a function of  
8 risk.

9 THE WITNESS: Yes.

10 MS. HOLMES: So you're using 1.3 which  
11 is the large group market as a benchmark for what  
12 this could then be. Are you assuming then that the  
13 risk is the same across the two pools?

14 THE WITNESS: No. The filing included  
15 the whole market. The 1.3 was calculated on the  
16 whole market.

17 MS. HOLMES: So is the risk the same  
18 then?

19 THE WITNESS: No. The risk is not the  
20 same between the large group market and the merged  
21 market.

22 MS. HOLMES: Okay.

23 DR. RAMSAY: I have a question. So Ms.  
24 Novak, you know, the adequacy of the contribution to  
25 reserve which we struggle with really plays directly

1 into the solvency of the company. And we heard from  
2 DFR earlier that RBC was not the only factor; their  
3 are corporate governance structure, their risk  
4 mitigation strategy, their periodic financial  
5 analysis which DFR does, claims reserves development,  
6 all of those things go into the fact that our DFR  
7 says if all those things are good, RBC can fluctuate  
8 more. You heard that; correct?

9 THE WITNESS: Yes, I did.

10 DR. RAMSAY: But you don't have access  
11 to any of that information about corporate governance  
12 or periodic financial analysis of the company or the  
13 risk by condition strategies, you don't have that?

14 THE WITNESS: I did not. No.

15 DR. RAMSAY: Thank you.

16 MR. HUDSON: Okay. Hearing no further  
17 questions from the Board, Blue Cross Blue Shield, do  
18 you have any questions for this witness?

19 MS. HUGHES: I do.

20 CROSS EXAMINATION

21 BY MS. HUGHES:

22 Q. So would you say that the Department of  
23 Financial Regulation has more information than you do  
24 about the financial condition of Blue Cross?

25 A. Yes.

1 Q. At any given point in time?

2 A. Yes.

3 Q. And you reached different conclusions than DFR  
4 on the CTR request, so is DFR wrong?

5 A. DFR is more conservative, I believe, in their  
6 requirements.

7 MS. HUGHES: I would like to recall  
8 Paul Schultz at this time.

9 MR. HUDSON: Aside from the question of  
10 whether Blue Cross can recall a witness, Ms. Novak is  
11 still on the stand.

12 MS. HUGHES: I'm done with my questions  
13 for her. Thanks.

14 MR. HUDSON: Hold on. Were there any  
15 follow-up questions from the Board before -- you want  
16 to do redirect?

17 MS. RICHARDSON: I had one area to ask  
18 some additional questions for redirect.

19 REDIRECT EXAMINATION

20 BY MS. RICHARDSON:

21 Q. There have been a number of questions about  
22 the calculation of a required CTR factor from Blue Cross  
23 Blue Shield which is on page 75 of the binder. Could I  
24 ask you to turn to that, please.

25 MS. HUGHES: This is beyond the cross

1 examination.

2 MS. RICHARDSON: If I may, I'm trying  
3 to respond to the questions that were brought up by  
4 the Board, not just by Blue Cross.

5 MR. HUDSON: Well it's hard to tell  
6 before you ask the question whether it's beyond the  
7 scope. So I'll allow it.

8 BY MS. RICHARDSON:

9 Q. In answering your questions to the Board you  
10 indicated that you thought that the 3.8 percent figure on  
11 this chart should be 2.8 percent.

12 MS. HUGHES: Again I object. This is  
13 beyond the scope of cross examination.

14 MR. HUDSON: But it's not beyond the  
15 scope of the questions the Board asked.

16 MS. HUGHES: That's true.

17 BY MS. RICHARDSON:

18 Q. My follow-up question relating to the Board's  
19 question is could you explain how you would use the  
20 information in this chart and arrive at a 2.8 percent  
21 instead of a 3.8 percent figure? And just to clarify,  
22 you're referring to the 3.8 percent which is associated  
23 with the line that says required insured CTR factor to  
24 maintain target RBC; is that correct?

25 A. Yes. That's calculated by taking the

1 estimated year-end authorized control level, and I'm  
2 assuming that's for the whole company because it's a  
3 little bit higher than what the whole company's authorized  
4 control level was at the year end 2015. That's an  
5 assumption I made. And the year end 2017 authorized  
6 control level which I had no documentation of how that was  
7 determined. So the difference between those two with some  
8 adjustments for investment income, and some adjustments  
9 for the tax, resulted in a needed amount of 17,436,082.  
10 That amount when I looked at the calculation in the  
11 spreadsheet, when I went to the spreadsheet and tried to  
12 understand how it flowed, was divided only by the QHP  
13 premium equivalent, and not by the total premium  
14 equivalent.

15           And then I went to the large group filing and  
16 pretty much the same process was-- it was followed. It  
17 was determined a little differently, but in that filing  
18 all of the premium for all lines of business were used to  
19 determine what the increase was needed as it was done as a  
20 premium, so I concluded that the 17 million should have  
21 been divided by the total premium shares which is 616  
22 million plus instead of just the QHP. So I just went into  
23 the spreadsheet and divided by the total premiums instead  
24 of just the QHP premium.

25           Q.       When you did that, did you come up with the

1 figure of 2.8 percent that you testified to?

2 A. Yes.

3 Q. That's how you arrived at it?

4 A. Yes. Some of my assumptions about what was  
5 represented could be wrong.

6 MR. GOBEILLE: So just to be clear  
7 though, your -- if their math leads to a 3.8 and they  
8 yield to a two, your math leads to a 2.8?

9 THE WITNESS: For short term. Yes.

10 MR. GOBEILLE: Well that would be long  
11 term. This is short term.

12 THE WITNESS: Short term.

13 MR. GOBEILLE: And then long term is a  
14 two.

15 THE WITNESS: Two.

16 MR. GOBEILLE: Thank you.

17 THE WITNESS: And again, that's just on  
18 the difference.

19 MR. HUDSON: Are you renewing your  
20 request to call Paul Schultz?

21 MS. HUGHES: I am. Yes.

22 MS. HENKIN: I believe that's fair. I  
23 know we did not bring that up earlier, but it's  
24 relaxed rules under administrative procedure.

25 MR. HUDSON: Right. There is also

1 limits.

2 MS. HENKIN: They will have to be brief  
3 based on time constraints.

4 MR. HUDSON: If there is consensus from  
5 the Board, they will allow the recall, and I'll allow  
6 it.

7 MS. HENKIN: No objection to it.

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1 PAUL SCHULTZ

2 Having previously been duly sworn,  
3 testified as follows:

4 DIRECT EXAMINATION

5 BY MS. HUGHES:

6 Q. Can you turn to page 218 of the binder.

7 A. Yes, I'm there.

8 Q. You heard Ms. Novak's characterization of that  
9 particular exhibit, and did she correctly characterize  
10 what that exhibit demonstrates?

11 A. No. This exhibit was a demonstration of the  
12 contribution to reserve that was required only for  
13 increases in health care cost trend. This did not  
14 contemplate membership increases or any other causes of  
15 premium increases.

16 Q. And was there information that developed after  
17 that large group filing was made?

18 A. Yes. After the time the large group filing  
19 was prepared we learned that DVHA -- that the state was  
20 going through a Medicaid recertification process. As I  
21 testified earlier, that's expected to lead to some pretty  
22 significant membership increases on QHP business.

23 Q. And even though that says 1.3, what was the  
24 amount that Blue Cross requested for its CTR in the large  
25 group filing?

1 A. We requested two percent CTR in that filing.

2 Q. And what did the Board do in reaction to that  
3 request?

4 A. The Green Mountain Care Board approved the two  
5 percent CTR in that filing.

6 Q. And turning to page 75.

7 MR. GOBEILLE: Page 75 did you say?

8 MS. HUGHES: Yes.

9 BY MS. HUGHES:

10 Q. Did Ms. Novak's assumptions about this page,  
11 were they accurate?

12 A. No. As Ms. Novak testified, she did make some  
13 assumptions in coming to her 2.8. I can clarify that the  
14 projected 2017 ACL as I testified earlier, was looking  
15 only at premium increases in the QHP line of business. It  
16 was not looking across all lines of business. So because  
17 it's looking only at ACL increases through the QHP line of  
18 business, it would be appropriate to divide by the premium  
19 of the QHP line of business.

20 So I would conclude that 3.8 is the correct  
21 short-term CTR rather than the 2.8 that Ms. Novak  
22 calculated.

23 Q. And why is Ms. Novak's approach to calculate  
24 two percent wrong?

25 A. Two percent?

1 Q. 2.8?

2 A. The 2.8 -- just as I testified, she because of  
3 the labeling -- I will say the label was somewhat unclear,  
4 so I understand why you had to make some assumptions, but  
5 the assumptions that she made was not correct. It was  
6 prepared differently than what she had assumed.

7 MS. HUGHES: Thank you.

8 MR. HUDSON: Further questions?

9 MS. RICHARDSON: Just one.

10 CROSS EXAMINATION

11 BY MS. RICHARDSON:

12 Q. You testified that the CTR that was approved  
13 for the large group rate filing was two percent, so that  
14 was a larger amount than the amount that was determined  
15 required to maintain target which was 1.3 percent?

16 A. Yes. It was larger than the amount required  
17 to maintain target relative only to health care cost  
18 increase. So we have heard a lot of testimony about what  
19 other sort of events may impact a solvency level,  
20 including membership increases, including potential  
21 adverse events, things like that. So yes, that's correct.

22 MS. RICHARDSON: Thank you. I don't  
23 have any further questions.

24 MR. HUDSON: Anything further from the  
25 Board? Okay. Thank you, Paul.

1 All right. That concludes the  
2 witnesses that we had scheduled to hear from today,  
3 who are actual witnesses attached to the party that  
4 is.

5 I would like to take a very brief  
6 moment to confer with the Board's rate review staff.

7 MR. GOBEILLE: I think we are good on  
8 all that.

9 MS. HENKIN: And Noel, I think if they  
10 do have a close, we should probably do that before  
11 the public comment briefly. And I know that there  
12 has been briefing dates already given for the  
13 parties.

14 MR. HUDSON: I agree. So at this point  
15 we will move to closing statements.

16 MS. HUGHES: We will put ours in  
17 writing. Thank you.

18 MR. HUDSON: Thank you.

19 MS. RICHARDSON: In the interest of  
20 making the process go more quickly, we would also  
21 reserve comments.

22 MR. HUDSON: On behalf of the Board I  
23 thank all parties.

24 MR. GOBEILLE: Is it back to me?

25 MS. HENKIN: I believe the evidence

1 will be closed, and then we take public comment.

2 MR. HUDSON: Okay.

3 MR. GOBEILLE: So is there a sheet for  
4 public comment, Jaime?

5 MS. FISHER: Yes.

6 MR. GOBEILLE: Does the person on the  
7 top of the sheet know who they are? We could start  
8 now. I know we are bumping up against 1 o'clock.

9 MR. NELSON: I believe I know who I am.

10 MR. GOBEILLE: Perfect.

11 MR. NELSON: At least right now.

12 MR. GOBEILLE: Trying to figure out  
13 about myself.

14 MR. NELSON: I'm Wayne Nelson,  
15 president of an engineering firm in Winooski. It's a  
16 small firm.

17 We have seen health care costs --  
18 insurance cost increases go up on average of seven  
19 percent over the past 12 to 15 years. We have seen  
20 engineering salaries go up anywhere from zero to two  
21 percent over that same range, and I'm just one of  
22 them. I'm representing other companies today.

23 Company owners are just concerned about  
24 the divergence between the cost of health insurance  
25 and the salaries which is obviously -- everyone

1 understands that already. After witness -- I had  
2 lots of questions, but after witnessing this I have a  
3 whole new understanding of generally what isn't going  
4 on. So I was wondering is it possible that there  
5 could be a symbiotic relationship between all the  
6 organizations where they can communicate ahead of  
7 time and develop a system where we can come up with a  
8 proactive way to improve health care outcomes, but at  
9 the same time reduce health care costs to the  
10 consumer? Is that a possibility? To kind of change  
11 the way we do our regulation? I don't even know who  
12 can answer that.

13 MR. GOBEILLE: We will take it just as  
14 a comment. I don't think anyone can right now, but I  
15 think it's a good comment.

16 MR. NELSON: Okay. And then the next  
17 comment I have is assuming that Vermont Health  
18 Connect survives the next political situation in the  
19 state, what happens when the larger employers like  
20 the State of Vermont and maybe some of the other non-  
21 health-care employers that do their own health care,  
22 health insurance, when they do join if Health Connect  
23 survives, what impact will that have on all the  
24 conversations regarding cost increases? Now that we  
25 are going to have a larger pool of people inputting

1 into the same system. That's my second question.

2 MR. GOBEILLE: Thank you. Matt. How  
3 are you, Matt?

4 MR. BIRONG: I'm good. How are you  
5 guys? I was planning on saying good morning, but now  
6 it's good afternoon. Anyway. My name is Matt  
7 Birong. B-I-R-O-N-G.

8 I am the owner and president of Three  
9 Squares Cafe, Incorporated which is actually just a  
10 small cafe in Vergennes. I am here as not just a  
11 representative of small business but also of a health  
12 care consumer.

13 Since the inception of Vermont Health  
14 Connect the Affordable Care Act, I have seen my  
15 health care costs personally for my wife and myself  
16 increase from roughly the low 500-a-month range to  
17 now 925 a month plus deductibles, et cetera, which  
18 shockingly matches the first mortgage of my first  
19 home.

20 That being said, seeing this as an  
21 expensive business expense and expense of family  
22 costs for individuals such as myself, I'm not only  
23 seeing it as spiraling out of control but also  
24 siphoning money out of our economy that should be  
25 circulating through maybe education initiatives,

1 small businesses, things of that nature. And to see  
2 it sort of getting pigeonholed in this other  
3 direction is a frustration of mine because I feel  
4 like it could be managed better, circulated more  
5 effectively.

6 And one thing I'm also not hearing  
7 throughout the course of this entire discussion is  
8 words like families, loved ones, neighbors, the  
9 people that it's directly impacting. I'm hearing,  
10 you know, line item statistics. I'm hearing aged  
11 population statistics or risk adjustment transfers.  
12 I think we are missing the big picture about  
13 humanity, about what's directly being impacted here.

14 You know, I mean I run a company. I  
15 run a hospitality restaurant service industry that  
16 runs exceptionally tight margins, so I get you have  
17 to operate your business within a realm of  
18 profitability. But at what expense? You know, when  
19 I have to make adjustments with my bottom line to  
20 ensure the success of my business, a lot of times I  
21 just can't arbitrarily raise prices 8.2 percent every  
22 year. I might have to take a look at administrative  
23 costs. I might have to take a look at the functions  
24 within my own business to make sure that I'm not  
25 taking advantage of my customer base.

1                   That being said, I agree with Wayne.  
2                   We need to take a look as a greater whole,  
3                   functioning entities, not combative ones to work  
4                   together, to find a resolution to this problem.  
5                   Because it's not going away. It's only getting  
6                   worse.

7                   So I just ask that everybody kind of  
8                   maybe take a financial perspective step back for a  
9                   moment and just take a look at a societal one for a  
10                  few minutes. I guess that's all I've got for you.

11                  MR. GOBEILLE: Thank you, Matt.  
12                  Daniel?

13                  MR. QUIPP: Good afternoon. Daniel  
14                  Quipp, Q-U-I-P-P. I'm going to read my statement  
15                  because I'm too tired to really think straight.

16                  So I'm a teacher in an alternative  
17                  school in Brattleboro. I receive a salary of 40,000  
18                  annually which equates to about 32,000 after  
19                  deductions. And my employer doesn't offer health  
20                  care. My wife's employer can't provide affordable  
21                  health care to me. My health care premium costs  
22                  amount to 25 percent of my annual net income. Our  
23                  gross household income is 75,000. Net -- so after  
24                  deductions -- is 6,150 -- 61,500 which means that we  
25                  receive zero subsidy for our health care. A

1 two-person household such as ours that earns over  
2 50,000 -- 58,000 doesn't receive any subsidy. If our  
3 household earned 150,000, we would pay the same price  
4 -- I would pay the same price for my health care that  
5 I do today. If I earned the same as the CEO of Blue  
6 Cross Blue Shield, who I believe is sitting behind  
7 me, and he could clarify his salary if he wishes, we  
8 would pay the same premium. That's upsetting to me.

9 When choosing my health care plan I had  
10 to make a choice between a cheaper plan such as the  
11 Bronze plan of \$409 per month which is 16 percent of  
12 my monthly take home, or more costly plan such as the  
13 Platinum which is 656, which equates to 25 percent of  
14 my monthly income. If I chose the cheaper Bronze  
15 plan, then I have to come up with \$4,000 before the  
16 health plan will start paying for any care. And  
17 earning the kind of money that I earn, I don't have  
18 \$4,000 sitting around. So I chose the Platinum plan  
19 because it actually does work as health care even  
20 though it costs more than my rent, it costs more than  
21 my car payments, it costs more than my heat, and it  
22 costs more than my groceries each month.

23 By increasing premiums you're forcing  
24 people to make difficult decisions about what they  
25 can spend on their piece of mind, because the amount

1 of money that we spend on our health care has a  
2 direct impact upon our, you know, mental health, and  
3 that has a real -- I'm sure Dr. Ramsay knows, an  
4 effect on our physical health.

5 So this year I'm going to get a 2.5  
6 percent wage increase. People -- this is from the  
7 Bureau of Labor statistics, so 125,000 Vermonters in  
8 the most common employment areas are going to receive  
9 an annual salary increase of around about 1.6  
10 percent. I've heard four hours worth of testimony  
11 this morning about line items. I understand these  
12 are complex issues, but the majority of people in  
13 this state cannot afford another 8, 10 percent  
14 squeeze on their income.

15 So thank you for your time.

16 MR. HOGAN: Daniel, we are only  
17 supposed to listen, but I'm detecting an accent.

18 MR. QUIPP: I'm from the U.K.

19 MR. HOGAN: From the U.K.

20 MR. QUIPP: Do you want to hear a side  
21 note?

22 MR. GOBEILLE: Can you use more rugby  
23 terms like knock on?

24 MR. QUIPP: I actually have some data  
25 on that. I was looking through old paperwork. I

1 found one of my last paychecks from my last teaching  
2 job in London. The deduction from my salary each  
3 month was equivalent to about six percent for the  
4 stuff that goes towards my free health care in the  
5 U.K. rather than 25 percent, and that's post tax, you  
6 know. In the U.K. that deduction comes out before  
7 tax as well, so it's like I'm being asked to pay for  
8 it twice here.

9 MR. HOGAN: Thank you very much.

10 MR. GOBEILLE: Can we get a copy of  
11 that so we have it in writing?

12 MR. QUIPP: Yeah, I've got it.

13 MR. GOBEILLE: Thank you. Mark -- I'm  
14 not going to get this right.

15 MS. RICKS: Dottie. Dottie.

16 MR. GOBEILLE: Dottie Riggs?

17 MS. RICKS: Ricks. My name is Dottie  
18 Ricks. R-I-C-K-S. And I hope you're not going to  
19 ask me about my accent. I know I have two minutes.  
20 I'm going to talk as quickly as possible. I have  
21 point -- two points of order I would like to present  
22 to this Board.

23 One is I request that you consider  
24 having these meetings in the evenings. Working class  
25 people have to take off from their work to come here,

1 and it costs them to sit through four hours of  
2 listening, you know, to the business that you really  
3 need to listen to. You know, it sometimes is  
4 goddledygook to us.

5 Secondly, I would request -- I know I  
6 spoke with you, and I understand the legal, you know,  
7 scheduling you have to do. But you did not say that  
8 legally we have to wait until the end of the meeting  
9 to do our presentations. I'm requesting that you  
10 consider having 15 to 20 minutes at the beginning of  
11 the meeting, let us give our presentation. And you  
12 can spend all day, you know, going back and forth  
13 with them. It's a win/win for you because then you  
14 can refute, you know, the things that we disagree  
15 with. So I would ask that you consider that.

16 You guys have talked about nothing but  
17 statistics, and people are not actuarial figures on a  
18 spreadsheet. I am not. I can tell that you have not  
19 put on your jeans and your T-shirts and your sneakers  
20 and gone down and sat in the farmers' market and  
21 talked to people. Because if you did that, you would  
22 never sit here and say this is affordable. I have  
23 done that. Young people that want to do the right  
24 thing, \$20,000 a year, have been self-insuring  
25 themselves, paying for their insurance. Paying for

1 their health care needs out of pocket. Now we are  
2 asking them to pay 4 to 5,000 above.

3 They understand insurance. They  
4 understand everybody contributing, but do we have to  
5 gouge them? I just, you know, I challenge everyone  
6 of you on this Board, I challenge you people, to call  
7 Heather at the Vermont Workers Center and come down  
8 with she and I and walk through -- walk through the  
9 street, the farmers' market and talk to people.

10 I talked to small business people that  
11 have said they can't afford Vermont Health Connect,  
12 that they can pay less, you know, getting it on their  
13 own. So we want to increase it by five to 15  
14 percent. I've talked with retirees that are living  
15 off Social Security like me. They are paying -- the  
16 problem is that everybody has \$3,500 deductible.  
17 They never make that deductible, so they are just  
18 contributing money into the general fund. That's not  
19 fair when they are living off of 20, \$25,000 a year.

20 My daughter -- I had to get Vermont  
21 health care for her. The cheapest I could find was  
22 \$225 a month with a \$6,500 deductible. So she  
23 doesn't have insurance. I self -- that's out of my  
24 pocket. I self fund her.

25 I was unemployed five years ago. I was

1 on Vermont health care. I took in maybe 15,000 with  
2 earnings and unemployment. I paid 125 a month. That  
3 was doable with my savings. So you know, the people  
4 we have talked to, none of them have paid less than  
5 \$400 a month with the \$3,500 deductible. If they are  
6 making \$20,000 a year, that's fully one third of  
7 their income, which is what a mortgage is.

8 What are you thinking about and what --  
9 the bottom line for me is that I read this article,  
10 special report: "Despite regulation, hospital  
11 profits up. Vermont's hospitals have prospered over  
12 the last 10 years more than doubling assets, tripling  
13 profits and increasing the amount of cash they have  
14 on hand for rainy days." You're funding this, and we  
15 are funding this when we pay these increased  
16 premiums. Instead of balancing your budget on the  
17 backs of people that make \$20,000 a year, why not go  
18 after these profits and say, no, we are not going to  
19 pay you so much. That's going to open up enough  
20 money to cover your .4, or your .5, or .8 or whatever  
21 deficit which by the way is -- you know, that doesn't  
22 sound like a big percentage to me.

23 Revenue patient care is down to about  
24 2.3 billion annually and yet hospitals charge  
25 insurance services and companies for five billion

1 dollars. I have a disconnect with that. I don't  
2 really understand it. But it says to me there is  
3 something off and we're overpaying.

4 Peter Galbraith says what's happening  
5 is instead of keeping costs down using the extra  
6 revenue, lowering prices so that it focuses entirely  
7 on the service, the extra money is going into empire  
8 building and these outside salaries. Balance your  
9 budget off these people. Okay. Not off of us.  
10 People cannot afford health care as it is, and you  
11 want to increase it? You know, what are they going  
12 to give up? Food. Clothes. You know, we have to  
13 have a sense of decency about this. And with profits  
14 like this from hospitals where they could be getting  
15 their money from, I just don't know how you could  
16 possibly, you know, try and do this off the backs of  
17 people that can afford it.

18 And I'm going to chal -- as I said, I'm  
19 challenging everyone of you. I'm waiting to hear  
20 from Heather which one of you is going to call up and  
21 say I've got on my jeans, my T-shirts and sneakers  
22 on. I'm going to come down and look these people in  
23 the face, see how decent they are. They are  
24 committed to doing their share. They pay that  
25 because they believe they are doing their share.

1 They don't want to go to the emergency room and make  
2 all of us pay for it. So I hope to hear from you.  
3 Thank you.

4 MR. GOBEILLE: Thank you, Dottie. Mark  
5 Tulley.

6 MR. TULLEY: Hello.

7 MR. GOBEILLE: Good morning, Mark.

8 MR. TULLEY: My name is Mark Tulley.  
9 I'm a citizen of Brattleboro, Vermont. I'd like to  
10 speak to the Board's mandate to serve all citizens of  
11 Vermont regardless of their health care and health  
12 insurance situation. I myself am not going to see an  
13 increase in my health care cost if these rate hikes  
14 go through. I am, however, part of a three-person  
15 household, one of whom has Blue Cross Blue Shield's  
16 health plan before you today.

17 When I spoke to him yesterday about why  
18 I was coming up here, he didn't know about this  
19 increase. He has it pretty good. He's got a  
20 full-time job, though at minimum wage. Our shared  
21 expenses result in a fairly reasonable rent and  
22 utility bills. Our house is not particularly  
23 struggling, and yet when he heard eight percent, he  
24 went to speak, but he began shaking in fear. And his  
25 words were strangled, and he just fell silent. So

1 this stuff is like -- these rate increases are  
2 threatening the stability of my household regardless  
3 of my direct costs in like going to the doctor. It's  
4 actually threatening the existence of my household  
5 and so many household like it because folks have got  
6 to pool together in group housing. We didn't even  
7 know each other before last November, us three.

8 I'm also part of a peer group of people  
9 who have gone through like enormous sacrifice to  
10 lower their basic living cost so they can work on  
11 building community space and refuge for people who  
12 suffer relentless harassment and oppression. And  
13 many of these people need care for HIV. And so where  
14 they live -- what state they live in depends on what  
15 health care system. It took a lot of these people a  
16 long time to get to Vermont because of that  
17 transition, the necessities of that transition. And  
18 they -- and their ability to pursue these aspirations  
19 has been -- is challenged by the current system.

20 This no doubt will take at least two or  
21 three key players in these efforts out of the game if  
22 not out of the state altogether. And the knock on  
23 effects of that are huge.

24 So I just want to say for every citizen  
25 of Vermont whose viability is imperiled, imperils the

1 viability of many, many more people around them.  
2 Many more. And so if there is -- whatever percentage  
3 of people this may be creating hardship for it's  
4 huge. It's 10-fold, maybe a hundred fold, the  
5 viability of communities, the viability of the entire  
6 state is at risk here.

7 And so I understand that it's -- your  
8 mandate to take care of people's well being through  
9 health care is kind of twisted by also needing to  
10 take care of, you know, corporate profit lines.  
11 That's really an unfortunate situation. I hope the  
12 state changes. But to rely on rate increases -- to  
13 even allow rate increases to be the mechanism to  
14 address the financial exigencies created by that  
15 conflict of interest is unacceptable, and I for one  
16 would pay more taxes and take on more  
17 responsibilities as a citizen of Vermont to avoid  
18 forcing this upon the back of folks who actually need  
19 the help the most.

20 I would just like you to keep that in  
21 mind. Thank you.

22 MR. GOBEILLE: Thank you, Mark. Pete.

23 MS. PIPINO: Hi. I would like to  
24 testify for Pete.

25 MR. GOBEILLE: Are you Heather?

1 MS. PIPINO: I'm Heather. Pete had to  
2 go to a funeral today and he asked if I would read  
3 his testimony.

4 MR. GOBEILLE: I just thought Pete had  
5 a really cool last name.

6 MS. PIPINO: Yeah, so it's Pete  
7 Gummere. G-U-M-M-E-R-E. And my name is Heather  
8 Pipino. P-I-P-I-N-O.

9 MR. GOBEILLE: If you're going to read  
10 something, if we could have a copy of it before you  
11 go, that would be great.

12 MS. PIPINO: Certainly.

13 MR. GOBEILLE: Thank you.

14 MS. PIPINO: When I use the word I,  
15 it's Pete. I had my first job -- I had my first job  
16 in health care when I was 19. I have had almost  
17 continuous involvement in the health care field since  
18 then. Most of that time has been as a non-clinical  
19 manager for a not-for-profit and for-profit  
20 organizations. During that time I have also taught  
21 in a Master's program in health care management at  
22 the New School in New York City.

23 The last 29 years has been here in  
24 Vermont. For the past several years the health care  
25 costs control focus has been on squeezing the

1 hospitals. Hospital rates and budgets have been  
2 under control for several successive years. Some  
3 budgets have come in under targets set by the state.  
4 Hospitals that have come in at or under state  
5 guidelines have often been asked to squeeze further.  
6 Physician reimbursements have also been squeezed. I  
7 know physicians that have moved out of state because  
8 of the health care reimbursements in Vermont. Yet  
9 the state has continually given greater increases to  
10 the insurance companies. And it appears that they  
11 are simply not under the same kinds of economic  
12 pressure that the rest of the industry is.

13 Now retired, I have the perspective of  
14 the senior citizen. However, affordability of health  
15 care for all Vermonters remains a serious question of  
16 social justice. I know many working people whose  
17 health insurance costs have gone up rather than down.  
18 Wasn't reducing cost the point of health care reform?  
19 It is incumbent upon the state to do the same thing  
20 to the insurers that they have done to the hospitals  
21 for several years. Just say no to these unreasonable  
22 rate hikes, or have the intellectual honesty to admit  
23 your own ineffectiveness or unwillingness to do the  
24 tough part of your responsibility.

25 And if anybody would like to go

1 canvassing and door knocking with me, please be in  
2 touch. Thanks.

3 MR. GOBEILLE: Thank you, Heather.  
4 Avery Book. Did I get that right?

5 MR. BOOK: Yes. I did write it, but I  
6 probably need to e-mail it to you. It's not very  
7 legible.

8 MR. GOBEILLE: That would be great.

9 MR. BOOK: My name is Avery Book. Like  
10 it sounds. I grew up here in Vermont, right down the  
11 road in Worcester. I currently live in Burlington.  
12 I'm currently on Vermont Health Connect with Blue  
13 Cross Blue Shield. And I, like many others, many in  
14 Vermont, can't afford the proposed rate increase.

15 The cost of living in Vermont is  
16 totally out of control, and health care costs are an  
17 enormous part of that. There was a report that  
18 Public Assets Institute did that showed from 2004 to  
19 2014 health care costs rose 70 percent. This is at  
20 the same time that child care costs, college,  
21 location, housing, out of control housing was also  
22 rising. In that same period median household income  
23 was dropping by seven percent. So I think all this  
24 in the context of seeing the insurance executives  
25 continue to get six figure salaries -- I agree with

1 the statement this is a social justice issue.

2 I'm insured through Blue Cross Blue  
3 Shield on Vermont Health Connect and what many people  
4 would call under insured where I've -- I'm insured  
5 and am relatively healthy, but God forbid I actually  
6 need to use my health insurance, because I can't  
7 afford that \$3,000 deductible. Twice in the last  
8 three years I have had to leave Vermont to find work  
9 that pays a livable wage. As you can imagine that  
10 was an extraordinarily difficult thing to have to do  
11 multiple times over the last three years. And  
12 uprooting myself from my community, the family I have  
13 here to go find a job that just pays the bills.  
14 Extraordinarily difficult thing I think a lot of  
15 young Vermonters face, the prospect of having to  
16 leave the state they love because of how expensive it  
17 is to live here.

18 This fall my contract with the  
19 long-term temporary job is up. And I expect my  
20 income to drop probably close to half. Half of what  
21 it is for next year. The rate increases being  
22 proposed here year after year are just simply  
23 untenable for me and for thousands of other  
24 Vermonters, and I fear if this and other cost of  
25 living continues in Vermont, it's going to drive me

1 and other people out of the state to look for a place  
2 where they can afford to live.

3 I encourage the Board to reject this  
4 rate increase. I encourage the Board to do  
5 everything in its power to move forward with Act 48.  
6 Actually moving toward universally, equitably  
7 financed public health care where health care is  
8 treated as a human right not as a commodity to be  
9 bought and sold. Thank you for your time.

10 MR. GOBEILLE: Thank you. Paul  
11 Langevin. How are you, Paul?

12 MR. LANGEVIN: Good. How are you?

13 MR. GOBEILLE: Doing well.

14 MR. LANGEVIN: Who is talking?

15 MR. GOBEILLE: I am.

16 MR. LANGEVIN: I have to put my glasses  
17 on.

18 MR. GOBEILLE: I looked down to write.

19 MR. LANGEVIN: So yeah, I'm Paul  
20 Langevin from Johnson, Vermont. L-A-N-G-E-V-I-N. I  
21 wanted to give a short story. I lost my wife to  
22 cancer. She died a little over two years ago. She  
23 originally had a thyroid cancer. Had surgery. And  
24 she was in remission for about five and-a-half years.  
25 They said well you're doing great. Well up comes

1 another cancer that nobody knew about, and she died  
2 within two years of it.

3 So following that, I asked the people  
4 at Fletcher Allen how was it that there isn't some  
5 type of an assessment, a yearly evaluation to see if  
6 there is any other kind of cancer that's growing,  
7 especially for someone who is in remission. The  
8 answer was that would be just too costly. I want you  
9 to hear that silence, because that's what I had to  
10 listen to. People should not be equated to price for  
11 insurance companies.

12 During the time we were having chemo,  
13 we had to get a pill. Blue Cross Blue Shield -- I  
14 had the best policy, denied five times her pills.  
15 Shopping around for the cheapest pill. The day my  
16 wife died they tossed the pills on my porch, 20 below  
17 zero, Mr. UPS guy. This is disgusting. This is  
18 unacceptable. I'm an advocate strongly for single  
19 payer, because I know if we have government  
20 regulated, and I mean regulated seriously, and they  
21 don't do a good job, I vote, and I vote them out of  
22 office. With insurance companies, they have got tons  
23 of lawyers to just dust the story, and you'll never  
24 get to the truth. That's all I have to say.

25 MR. GOBEILLE: Thank you, Paul.

1 Rachel, and I don't know the last name.

2 MS. DESILETS: Desilets. D-E-S-I-L-E-T  
3 -S. Thank you.

4 MR. GOBEILLE: Thank you, Rachel.

5 MS. DESILETS: As a new retiree living  
6 on a fixed income, mostly Social Security, my  
7 Medicare payments plus my Blue Cross Blue Shield  
8 supplemental is greater than what I was paying when I  
9 was working. And I'm not sure how much longer I'm  
10 going to be able to -- you know, how long I'm going  
11 to be able to pay those rates without having to look  
12 at other sources of insurance. And I don't know  
13 about Health Connect. I don't know what that would  
14 cost me. But I'm very concerned. As you know, right  
15 now having to pay my own supplemental is more than  
16 what I can afford really. And then thinking of  
17 Health Connect what I've heard, I'm not very  
18 optimistic, and I'm a little concerned about where  
19 that's leading me.

20 With all respect to hospitals, I know  
21 that while I was working with victims of crime we  
22 would compensate for their medical expenses, and we  
23 would see SANE exams that would range between maybe  
24 \$400 in one hospital and 23 hundred dollars in  
25 another hospital. And I wonder how much -- I mean a

1 SANE exam is a SANE exam. I'm wondering how much of  
2 that really goes towards the patient's care and how  
3 much of it might go towards administrative. And you  
4 know, right now the state pays for some of those  
5 expenses, especially if it's going to try to  
6 prosecute the crime. But when it goes to the  
7 insurance, you don't have that avenue. So -- and  
8 that's not the only practice. There is also like  
9 prophylaxis, you have some hospitals that would pay  
10 for three, they are not cheap. And then you have  
11 some that will start off at the onset of treatment  
12 with one treatment.

13 And my experience in talking with women  
14 is that they often don't go the full three treatments  
15 because they get such an adverse reaction to the  
16 treatment. So we are paying for things maybe that,  
17 you know, we need to look at. I'm not saying we  
18 shouldn't take away the prophylaxis. I'm just saying  
19 do we pay for it once, and then have someone have  
20 them go back and refill that -- you know -- that  
21 prescription.

22 So I think there are ways that might be  
23 wasteful. And I'm wondering if those are being  
24 examined. And then also why is there such a  
25 divergent cost in care between carriers, and is it --

1 and I know there are different costs between  
2 hospitals. But at the same time, I wonder how much  
3 of that is administrative and how much of it is  
4 really patient care. Thank you.

5 MR. GOBEILLE: Thank you, Rachel.  
6 Ellen Schwartz.

7 MS. SCHWARTZ: S-C-H-W-A-R-T-Z. Hi.  
8 I'm probably the most fortunate person of people  
9 you're going to hear testify today, because I am  
10 lucky to be old. Lucky to be -- also lucky to be old  
11 enough to be on Medicare. I'm lucky that when I was  
12 actually a much younger person our country  
13 established Medicare so that nobody in my age group  
14 would go completely without medical care, and I'm  
15 further lucky that I worked over the border. I live  
16 in Brattleboro. I worked over the border in  
17 Massachusetts as a public employee, so I'm able to  
18 purchase a Medicare extension plan through the Group  
19 Insurance Commission of Massachusetts that I can  
20 actually afford.

21 But access and affordability -- access  
22 to health care and affordability shouldn't depend on  
23 being old enough to get Medicare or poor enough to  
24 qualify for Medicaid. Like one of the previous  
25 speakers, I did a lot of surveying this winter down

1 in Windham County, and I also have a lot of  
2 conversations -- informal conversations with people  
3 about health care. And some of the anecdotes I  
4 heard, and this is not statistical, but these are  
5 real people, people who were not insured because they  
6 said they'd pay the penalty rather than buy -- all  
7 they could afford is the Bronze plan -- they would  
8 rather pay the penalty, because even if they got the  
9 Bronze plan it wouldn't do them any good because they  
10 couldn't meet the deductible. So they just pay a  
11 penalty. Or people who get the Bronze plan but  
12 aren't actually using it, they're just sort of  
13 hedging their bets. They are going to have it in  
14 case they end up in a real catastrophe. They are not  
15 actually using it for primary care or preventive  
16 care.

17 The third set of stories I heard is  
18 from people who are on Medicaid, are working in  
19 what's increasingly the case in Vermont and elsewhere  
20 what we call the gig economy, meaning like they have  
21 several different jobs, none of which offer health  
22 insurance, or they are not working in any of them for  
23 enough hours, or they are freelancing and they are  
24 basically watching their income to stay poor enough  
25 so they can stay on Medicaid. Because they have

1 serious medical conditions or chronic medical  
2 conditions, and they know that if they got on to  
3 Vermont Health Connect they wouldn't be able to  
4 actually meet their health needs on the only plan  
5 that they could afford. So these are the kind of  
6 stories that I'm hearing when I'm out talking to  
7 people in Brattleboro.

8 And to me, that makes absolutely no  
9 sense on a medical level. As a state, we should be  
10 increasing access to care rather than creating  
11 greater barriers to care. Increasing premiums is a  
12 barrier to care. Deductibles and copays are barriers  
13 to care. They are different pockets of money when  
14 you're looking at the insurance industry, but for the  
15 person who is paying it, it's all coming out of their  
16 pocket.

17 This morning I listened to this  
18 testimony. I heard a lot about statistics, about  
19 insurance liability risks, about adverse utilization,  
20 decrease -- and decreases and increases in  
21 utilization, positive and negative events. All very  
22 heady sort of mathematical stuff. But I want to just  
23 remind this Board on the other end of each one of  
24 these policies is a person who at some point in their  
25 life is going to need health care.

1                   And I ask that the Green Mountain Care  
2 Board exercise its regulatory authority to deny this  
3 rate increase so we don't move further from the goal  
4 of health care as a public good for all of us,  
5 equitably financed, and not just for people like me  
6 who are lucky enough to be old. Thank you.

7                   MR. GOBEILLE: Thank you very much,  
8 Ellen. Sheila Linton, I don't know if I'm saying  
9 that right. Did I get it right?

10                   MS. LINTON: Yes. Sheila Linton.  
11 L-I-N-T-O-N. And I'm actually going to start with  
12 just my question, and then I'm just going to say a  
13 little story.

14                   So I had a question as I was sitting  
15 here for the last almost five hours now, and I was  
16 wondering if the insurance increase does happen, how  
17 does that affect the subsidies that the state  
18 currently gives? And is that sort of like a double  
19 whammy for the community? And what I mean by that is  
20 that the community talks about how those state  
21 subsidies come from people paying taxes, and then  
22 there is -- there is going to be an increase which  
23 for myself who is on Vermont Connect Blue Cross Blue  
24 Shield will be impacted as well. So for those  
25 people, I'm just wondering about that of if this was

1 -- how does that really affect the subsidies that  
2 Vermont does give in these plans?

3 So I would like to start by saying  
4 thank you to all the people who have testified today,  
5 specifically the people in the audience here.  
6 Daniel, Paul, and Ellen had very good points that  
7 resonate with my story as well.

8 Again my name is Sheila Linton. I'm a  
9 native Vermonter, and I live in Brattleboro. I'm a  
10 single mom with two daughters and currently have  
11 Vermont Blue Cross Blue Shield. For the last three  
12 years my income has been such that my family no  
13 longer qualifies for Medicaid which was a reasonable,  
14 affordable system and plan for my family. It was  
15 equitable and based on my income, so my income --  
16 when my income went up, my premium went up a little  
17 bit, but it never exceeded \$200 a month for my family  
18 as a whole while having the same or similar care and  
19 access to service that I have now.

20 Over the last three years since being  
21 on Vermont Health Connect this has not been the case.  
22 I have many concerns. Currently my premium, not  
23 including the subsidy, is around 600 out of pocket a  
24 month. In the first two years that I have been on  
25 Vermont Health Connect Blue Cross Blue Shield I sent

1 my oldest daughter to college. In addition to  
2 college debt, she came back -- my young adult  
3 daughter incurred health debt as well. And the  
4 health debt was due to the out-of-pocket costs for  
5 her as an 18 year old at the time of a 12 hundred  
6 dollar deductible, 20 dollar copays for visits, 50  
7 dollars for her inhaler, 20 dollar copays for  
8 physical therapy, and that's just right off the top.

9 So those stories that we hear about our  
10 youth are very serious. That story turned into us  
11 having to pay that penalty. My daughter last year  
12 decided that we couldn't afford that any more. And  
13 so she was no longer on my plan. And I was on a  
14 single plan. And she took the hit, \$325 a month for  
15 not being -- having a health plan. Of course she  
16 couldn't afford to pay that, so we know where those  
17 costs got absorbed, and that was within our  
18 household.

19 So I also have some of my own medical  
20 issues. And I currently have a Platinum plan. I  
21 have the Platinum plan because of many reasons why  
22 people said, it's a lower deductible and I can at  
23 least have smaller copays entering into the doctor  
24 where I know my medical situation requires me to do  
25 that. I'm paying out of pocket around \$600 a month

1 for the care that I need and similar out-of-pocket  
2 expenses.

3 My older daughter and I have both had  
4 health care bills that are currently in collections  
5 and trying to arrange payment plans which currently  
6 -- usually the minimum that they allow you to pay is  
7 \$50 a month. And even that between two people which  
8 is \$100 month, can be really strenuous on a single  
9 household of two children -- having two children.

10 I say all of this to say that I'm still  
11 a single parent, and health care is still  
12 unaffordable. I'm having to choose not to access  
13 some of the health care because of the out-of-pocket  
14 costs. Currently there are services that I need, but  
15 as they add up, I'm not able to do those, whether  
16 it's my physical therapy, you go twice, three times a  
17 week, that's 60 bucks minimum out of your pocket.  
18 You add that up for the month you're talking about  
19 three times four, 12 times 20, that adds up as the  
20 month goes along. And these may be for specific  
21 needs whether ongoing or related to something that  
22 has happened in your life.

23 I am -- today insurers asked for an  
24 increase of 8.2 percent as an average. That's not  
25 necessarily what will be approved, and while many

1 Vermonters, including me, will receive no, or luckily  
2 maybe a standard COLA of three percent this year, we  
3 have heard from many people that even us who live  
4 here are moving out of the state because we can't  
5 find livable wage jobs. And those who are fortunate  
6 enough to have livable wage jobs are being forced to  
7 not take pay increases because of the financial  
8 situations.

9 I listen to this insurer's testimony  
10 today, and there is a lot of language as well as  
11 systems as a whole is hard to understand, and I  
12 wouldn't pretend to understand it all. However, what  
13 I do understand is that my friends, my families and  
14 neighbors and myself are suffering. And that not --  
15 we are not getting the care that we need, that we can  
16 afford. What I do know is that the Green Mountain  
17 Care Board has an authority to quote: "Ensure that  
18 our health care system provides quality, affordable  
19 health care to all Vermonters while reducing the  
20 waste and controlling costs." End quote. And quote  
21 again: "Explicitly responsibility for controlling  
22 the rates of the growth in health care costs and  
23 improving the health of Vermonters."

24 You're in a position to truly help the  
25 people of Vermont. Whether it's the 11,000 that we

1 spoke about who pay that more -- I think I heard  
2 earlier. Or whether I think maybe it's 60,000 who  
3 might not be insured at all. Or whether it's the  
4 77,000 that you talked about who were actually in  
5 this plan right now, or whether it's the plus 600,000  
6 Vermonters who deserve the right to health care.

7 I think as people we have an obligation  
8 to our communities and communities are asking you for  
9 help and this Board. They are asking the Board to  
10 renew and to assure the commitment to its mission.

11 I thank you for the thoughtful  
12 questions today, especially around affordability.  
13 And I'm wondering what is the price of my life, what  
14 is the price of my life when I talk to my children.  
15 If people are not able to afford what they may need  
16 to meet their basic fundamental needs for all of us  
17 to live dignified lives, I believe we are not only  
18 moving -- I believe we are not moving closer to  
19 healthy communities but further away.

20 I truly ask the Board to continue to  
21 work together to move toward Act 48 and truly  
22 universal health care system that's equitably  
23 financed, and it truly makes health care a human  
24 right in the state and to lead the nation. And we  
25 can afford that. I ask you to please decline these

1 insurance hikes and to consider this a social justice  
2 issue and the humanity of our people here in Vermont.  
3 Thank you.

4 MR. GOBEILLE: Thank you, Sheila. Is  
5 there anyone that we missed?

6 (No response)

7 MR. GOBEILLE: Okay. So does  
8 anyone from the Board have anything before we make a  
9 motion to adjourn? Staff? Good. Is there a motion?

10 MS. RAMBUR: So moved.

11 MS. HOLMES: Second.

12 MR. GOBEILLE: All those in favor?

13 THE BOARD: Aye.

14 MR. HUDSON: Thank you to all those who  
15 attended today, and thank you to all of those who  
16 made public comments.

17 (Whereupon, the proceeding was  
18 adjourned at 1:39 p.m.)

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C E R T I F I C A T E

1  
2  
3 I, Kim U. Sears, do hereby certify that I  
4 recorded by stenographic means the hearing re: Docket  
5 Number GMCB008-16-RR at the Second Floor Hearing Room,  
6 City Center, 89 Main Street, Montpelier, Vermont, on July  
7 20, 2016, beginning at 9 a.m.

8 I further certify that the foregoing  
9 testimony was taken by me stenographically and thereafter  
10 reduced to typewriting and the foregoing 206 pages are a  
11 transcript of the stenograph notes taken by me of the  
12 evidence and the proceedings to the best of my ability.

13 I further certify that I am not related to  
14 any of the parties thereto or their counsel, and I am in  
15 no way interested in the outcome of said cause.

16 Dated at Williston, Vermont, this 23d day of  
17 July, 2016.

18  
19 \_\_\_\_\_  
20 Kim U. Sears, RPR  
21  
22  
23  
24  
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