

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.

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

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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: Is 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

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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
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<p style="text-align: center;"><u> </u> \$ <u> </u></p> <p>\$100 203:8 \$2 [2] - 64:1, 118:10 \$20,000 [3] - 182:24, 184:6, 184:17 \$200 201:17 \$225 183:22 \$25,000 183:19 \$3,000 192:7 \$3,500 [2] - 183:16, 184:5 \$325 202:14 \$4,000 [2] - 179:15, 179:18 \$400 [2] - 184:5, 195:24 \$409 179:11 \$50 203:7 \$500 117:25 \$6,500 183:22 \$600 202:25 \$75 67:18 \$975,000 [3] - 30:8, 30:12, 121:21</p>	<p>158:14, 161:7, 161:9, 161:11, 161:25, 162:10, 163:10, 163:15, 170:23, 172:15 1.6 180:9 1.7 68:18 1.9 [2] - 28:17, 45:15 10 [11] - 41:20, 46:9, 46:13, 49:11, 53:7, 73:5, 116:11, 144:24, 144:25, 180:13, 184:12 10,872 68:17 10-fold 188:4 10.1 142:9 10.2 [3] - 116:9, 116:12, 142:3 10.3 142:10 100 [7] - 3:10, 18:3, 23:19, 23:25, 26:20, 37:18, 131:21 107 3:11 10s 134:7 11,000 [4] - 68:16, 68:24, 69:21, 204:25 118,000 69:19 12 [10] - 3:25, 8:13, 87:18, 87:20, 88:10, 89:21, 145:14, 174:19, 202:5, 203:19 12-month 11:5 12.6 116:10 125 184:2 125,000 180:7 129 3:11 13 [9] - 3:24, 8:13, 18:23, 29:5, 29:6, 41:20, 111:6, 133:23, 148:15 131 [2] - 8:7, 21:5 138 3:12 14 [6] - 3:5, 8:12, 39:15, 108:15, 144:18, 153:13 14-15 3:24 140 3:12 144 3:13 15 [9] - 8:13, 39:12, 39:15, 39:18, 72:9, 153:14, 174:19, 182:10, 183:13 15,000 184:1</p>	<p>150,000 179:3 156 144:7 158 3:14 16 [10] - 3:24, 8:12, 14:12, 39:12, 39:18, 45:21, 56:13, 129:21, 132:12, 179:11 163 127:12 164 [4] - 3:14, 53:6, 53:11, 53:18 165 3:15 17 [10] - 3:25, 8:13, 39:12, 45:21, 69:4, 87:21, 87:23, 100:23, 107:11, 167:20 17,000 65:21 17,436,082 167:9 170 3:16 172 3:16 174 3:18 176 3:18 178 3:19 18 [5] - 3:24, 4:21, 8:12, 153:7, 202:5 181 3:19 184 111:9 186 [2] - 2:7, 3:20 187 141:13 188 [2] - 130:25, 138:20 189 3:20 19 189:16 191 3:21 192 [3] - 123:1, 124:23, 139:13 193 3:21 195 3:22 197 [2] - 3:22, 148:14 1:39 206:18</p>	<p>2.8 [13] - 42:24, 160:21, 160:25, 161:2, 161:24, 166:11, 166:20, 168:1, 168:8, 171:13, 171:21, 172:1, 172:2 2/3 [4] - 115:19, 115:21, 116:11, 124:6 20 [11] - 1:7, 1:12, 43:1, 133:23, 182:10, 183:19, 194:16, 202:6, 202:7, 203:19, 207:7 200 3:23 200,000 [2] - 68:20, 69:19 2001 144:14 2002 144:15 2004 191:18 2013 [2] - 11:23, 126:4 2014 [15] - 11:23, 11:24, 34:8, 34:11, 42:23, 43:2, 59:8, 107:15, 108:21, 118:10, 119:4, 126:5, 133:6, 157:3, 191:19 2015 [32] - 11:24, 15:4, 15:9, 15:16, 15:21, 17:10, 17:14, 17:17, 17:23, 18:5, 20:16, 26:8, 26:10, 26:17, 28:14, 29:18, 29:21, 30:5, 34:23, 43:2, 43:6, 51:16, 104:7, 104:10, 119:5, 119:9, 119:19, 120:11, 120:12, 153:1, 157:3, 167:4 2016 [22] - 1:7, 1:12, 4:15, 11:5, 17:14, 17:18, 18:3, 18:7, 21:21, 26:10, 26:22, 26:25, 47:5, 71:25, 131:22, 132:1, 132:8, 150:15, 151:4, 155:15, 207:7, 207:17 2017 [38] - 4:17,</p>	<p>8:19, 10:2, 10:8, 10:18, 15:9, 15:17, 15:24, 16:1, 16:9, 16:12, 17:10, 17:22, 22:24, 26:12, 28:5, 28:12, 30:1, 30:8, 35:10, 38:4, 40:2, 40:9, 40:17, 47:4, 56:18, 57:3, 57:5, 57:17, 58:18, 72:1, 72:6, 114:11, 119:19, 145:12, 151:10, 167:5, 171:14 2018 16:11 202 [2] - 150:7, 150:8 203 [6] - 150:8, 150:13, 152:14, 154:22, 155:11, 156:25 206 [2] - 145:1, 207:10 207 145:2 20s 134:7 20th 4:15 213 147:23 216 153:4 218 [3] - 151:2, 151:3, 170:6 221 56:14 225 14:12 228 100:21 23 195:24 23d 207:16 25 [5] - 65:7, 152:22, 178:22, 179:13, 181:5 26 6:17 29 [3] - 59:10, 63:23, 189:23 29,000 67:23 29.7 136:10 2B 65:10 2nd 1:12</p>	<p>23:5, 24:10, 24:16, 24:18, 25:5, 123:7, 123:10, 158:13, 159:5, 159:7, 160:16, 160:19, 160:21, 166:10, 166:21, 166:22, 168:7, 171:20 30 [4] - 29:21, 37:18, 81:13, 120:11 300 [2] - 63:12, 108:7 32,000 178:18 329 1:22 33 3:5</p>
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