STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-008-16-RR

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

July 20, 2016
9 a.m.
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89 Main Street
Montpelier, Vermont

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

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I N D E X

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

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

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

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

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

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

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

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

MR. GOBEILLE: Can I interrupt?

MR. HUDSON: Sure.

(Phone playing music)

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

Thank you. Sorry to bug you. But I did

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

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

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

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

Could all witnesses who plan to appear

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

(The five witnesses were sworn)

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

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

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

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

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

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

MS. HUGHES: Okay.

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

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

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

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

MS. HUGHES: Okay.

MR. HUDSON: Start with Blue Cross.

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

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

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

So with that, we are prepared to go forward.

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

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

Vermont exchange marketplace beginning next year, January, 2017.

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

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

The 8.2 percent increase far exceeds

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

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

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

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

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

two percent will be reduced.

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

Thank you.

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

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

PAUL SCHULTZ

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HUGHES:

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

A. My name is Paul Schultz.

Q. And what is your position with Blue Cross?

A. I am the chief actuary at Blue Cross.

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

MR. HOGAN: Thank you.

BY MS. HUGHES:

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

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

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

A. Yes, it is.

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

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

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

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

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

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

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

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

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

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

A. Our goal in developing these rates was to

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

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

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

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

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

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

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

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

other taxes and fees.

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

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

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

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

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

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

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

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

A. Yes. They are.

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

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

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

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

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

at the time of the filing.

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

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

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

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

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

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

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

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

A. 3.8 percent.

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

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

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

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

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

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

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

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

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

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

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

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

A. Negative 0.8 percent.

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

A. Negative 0.4 percent.

Q. And what would you conclude about those results?

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

Q. So the overall requested average rate increase

is 8.2 percent; is that correct?

A. Correct. 8.2 percent.

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

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

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

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

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

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

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

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

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

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

But altogether minus 0.8.

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

A. Yes, I am.

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

A. It is Exhibit 13.

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

A. They had one recommendation.

Q. And what was that recommendation?

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

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

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

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

Q. So what was their recommendation?

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

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

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

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

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

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

Q. And are those part of the statutory standards?

A. They are. Yes.

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

A. It's 8.24 percent.

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

A. Yes, I am.

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

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

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

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

Q. And are they unfairly discriminatory?

A. They are not unfairly discriminatory.

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

A. Yes, they are.

Q. And do they meet the statutory standards?

A. They do.

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

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

Q. Thank you.

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

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

THE WITNESS: 44.

MR. HOGAN: 44 percent; correct?

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

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

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

MR. HOGAN: Okay. Thank you.

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

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

MR. HOGAN: I'm done for now.

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

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

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

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

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

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

MS. RAMBUR: Just curious.

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

MS. RAMBUR: Thank you.

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

mobility between plans, how people adjusted their plan choices?

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

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

THE WITNESS: Right.

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

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

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

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

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

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

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

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

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

THE WITNESS: That's right.

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

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

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

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

THE WITNESS: Yes.

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

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

DR. RAMSAY: Right.

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

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

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

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

THE WITNESS: Yes. They is CMS essentially.

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

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

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

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

DR. RAMSAY: Right.

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

DR. RAMSAY: That does drive your need

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

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

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

THE WITNESS: Yeah, that's true.

DR. RAMSAY: That's all.

MR. GOBEILLE: How are you?

THE WITNESS: Well, Al. How are you?

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

THE WITNESS: Yes.

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

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

THE WITNESS: Yes.

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

THE WITNESS: Sure.

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

THE WITNESS: And that's in there.

MR. GOBEILLE: That's in there.

THE WITNESS: That's in there.

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

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

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

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

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

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

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

THE WITNESS: That's correct. Yes.

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

THE WITNESS: Yes.

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

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

MR. GOBEILLE: Of the 90 percent.

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

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

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

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

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

THE WITNESS: That's the commercial?

MR. GOBEILLE: That's the commercial. So I don't want to --

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

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

THE WITNESS: Okay.

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

THE WITNESS: Okay.

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

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

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

MR. GOBEILLE: Right.

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

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

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

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

THE WITNESS: Please.

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

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

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

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

MR. GOBEILLE: That's a big number.

THE WITNESS: It's a big number.

MR. GOBEILLE: Meaning it's very important.

THE WITNESS: It certainly is.

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

THE WITNESS: Right.

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

THE WITNESS: Yes.

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

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

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

MR. GOBEILLE: You do mathematically own utilization.

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

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

THE WITNESS: We do.

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

THE WITNESS: Correct.

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

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

MR. GOBEILLE: That would be helpful.

THE WITNESS: I will do that.

MR. GOBEILLE: Thank you.

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

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

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

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

THE WITNESS: Right.

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

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

MR. GOBEILLE: Thank you.

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

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

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

THE WITNESS: That's a tough question.

MR. GOBEILLE: That's a great answer.

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

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

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

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

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

So most of that shortfall has more to

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

MS. HOLMES: Thank you.

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

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

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

MR. HUDSON: Are you referring to prior auths?

MR. HOGAN: Yes, prior auths.

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

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

MS. GREENE: I can.

THE WITNESS: Ruth can field that one.

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

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

CROSS EXAMINATION

BY MS. RICHARDSON:

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

MR. HOGAN: What was the page number again?

MS. RICHARDSON: 164.

THE WITNESS: Okay.

BY MS. RICHARDSON:

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

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

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

A. .07 percent.

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

longer standing by that calculation.

A. That's correct.

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

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

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

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

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

A. That's correct. Yes.

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

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

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

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

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

MS. RICHARDSON: Thank you.

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

MR. HOGAN: No.

MR. HUDSON: Thank you, Paul.

MR. GOBEILLE: Thank you, Paul.

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

RUTH GREENE

Having been duly sworn, testified as follows:

THE WITNESS: Good morning.

MR. HUDSON: Good morning.

DIRECT EXAMINATION

BY MS. HUGHES:

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

A. Ruth K. Greene.

Q. And what is your position with Blue Cross?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. As Paul indicated earlier, the vast majority

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

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

Q. Thank you.

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

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

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

THE WITNESS: Prior authorization.

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

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

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

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

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

THE WITNESS: Not clinical management.

MR. HOGAN: What would the other elements be?

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

medical care are 40 percent higher.

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

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

THE WITNESS: Yes, I would say it is.

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

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

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

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

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

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

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

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

MR. HOGAN: Sure.

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

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

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

MR. HOGAN: Right.

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

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

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

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

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

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

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

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

MR. HOGAN: I appreciate it. Thank you.

THE WITNESS: Yeah.

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

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

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

THE WITNESS: It's tab one.

MS. HUGHES: Page 51.

MR. GOBEILLE: Page 51.

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

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

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

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

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

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

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

THE WITNESS: Yeah.

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

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

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

MR. GOBEILLE: Yes.

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

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

MS. RAMBUR: That would be very helpful.

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

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

THE WITNESS: The number for the 17 --

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

THE WITNESS: Yeah.

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

THE WITNESS: Right.

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

THE WITNESS: Yeah.

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

MS. HOLMES: Okay. So I think

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

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

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

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

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

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

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

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

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

described. A lot of components there.

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

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

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

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

THE WITNESS: The generic piece has

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

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

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

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

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

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

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

MS. HOLMES: Thank you.

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

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

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

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

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

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

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

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

So I'm just saying that one of those

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

THE WITNESS: Sure, of course.

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

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

auths, and the measurements.

DR. RAMSAY: Measurement burden; right.

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

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

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

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

THE WITNESS: Understood.

MR. HUDSON: Any other questions?

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

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

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

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

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

CROSS EXAMINATION

BY MS. RICHARDSON:

Q. You were describing some of the costs

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes. It does.

Q. And do you incorporate that?

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

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

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

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

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

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

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

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

THE WITNESS: The earnings on

investment portfolio serve to contribute to the RBC.

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

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

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

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

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

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

a large --

THE WITNESS: Yeah.

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

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

(Recess was taken.)

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

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

RYAN CHIEFFO

Having been duly sworn, testified as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

negative impact on risk-based capital and on solvency.

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

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

So I'm happy to take any questions.

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

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

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

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

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

MR. HOGAN: Thank you.

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

MR. HOGAN: Okay.

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

THE WITNESS: Yes, that's absolutely

correct.

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

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

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

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

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

the other, we would absolutely take that into account.

MS. RAMBUR: Thank you.

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

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

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

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

THE WITNESS: That is correct. Yeah.

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

THE WITNESS: I would agree.

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

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

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

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

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

THE WITNESS: No, that's not true.

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

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

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

DR. RAMSAY: And the healthier other indicators.

THE WITNESS: And the healthier other indicators. Exactly.

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

MR. HUDSON: HCA have questions for this witness?

MS. RICHARDSON: Just one follow-up question.

CROSS EXAMINATION

BY MS. RICHARDSON:

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

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

MS. RICHARDSON: Thank you.

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

MS. HUGHES: May I ask a question?

MR. HUDSON: I apologize. Of course.

CROSS EXAMINATION

BY MS. HUGHES:

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

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

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

A. Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

Q. Thank you.

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

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

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

THE WITNESS: That's correct.

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

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

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

THE WITNESS: -- happened to that.

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

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

DR. RAMSAY: Sure.

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

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

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

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

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

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

THE WITNESS: Thank you.

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

MS. HENKIN: Dave Dillon actually.

MR. HUDSON: Representing Lewis & Ellis.

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

DAVID M. DILLON

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HENKIN:

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

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

Q. How long have you worked for them?

A. 17 years.

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

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

Q. Briefly what are your professional affiliations?

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

Q. So your area of expertise is?

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

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

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

Q. Were those review of exchange filings?

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

Q. Over those nine states.

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

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

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

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

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

Q. Is he an actuary also?

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

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

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

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

A. Yes, that's correct.

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

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

some of the questions as we go along.

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

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

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

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

A. Yes, it is.

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

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

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

A. That is correct. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

Q. So excessive is not equated with affordability?

A. Correct.

Q. Kind of terms of art?

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

Q. Did you give a range of member trend?

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

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

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

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

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

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

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

Q. So no recommendations on the trends at all.

A. Correct.

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

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

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

A. Sure.

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

adjustment?

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

Q. That is a federal program; correct?

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

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

put it in the bank.

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

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

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

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

THE WITNESS: I don't remember that.

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

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

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

BY MS. HENKIN:

Q. On its own business?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

Q. And you heard the witnesses today?

A. Yes.

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

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

A. Yes.

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

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

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

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

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

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

MR. GOBEILLE: Can you say that again?

THE WITNESS: -- the bottom third. Therefore there was about 2/3 of the companies that had higher RBCs.

MR. GOBEILLE: Meaning more?

THE WITNESS: More.

BY MS. HENKIN:

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

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

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

check this chart, is this from Blue Cross directly?

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

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

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

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

MR. GOBEILLE: Yeah.

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

BY MS. HENKIN:

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

A. Correct.

Q. How much does that change the rate?

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

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

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

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

A. Correct. Yes.

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

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

Again I want to highlight it is a non-rate

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

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

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

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

A. That is correct. Yes.

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

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

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

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

review.

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

A. No.

MS. HENKIN: Thanks, David.

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

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

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

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

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

MR. HOGAN: Excuse me. Page 16.

MR. GOBEILLE: Can I ask a question?

MR. HOGAN: Yeah.

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

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

MR. HOGAN: That's exactly right.

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

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

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

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

THE WITNESS: No.

MR. HOGAN: Okay.

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

THE WITNESS: Okay.

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

THE WITNESS: Yes.

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

THE WITNESS: Yes.

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

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

2016, yes.

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

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

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

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

DR. RAMSAY: Right.

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

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

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

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

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

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

THE WITNESS: Yes.

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

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

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

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

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

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

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

MS. HOLMES: Okay. Thank you.

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

THE WITNESS: Yes.

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

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

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

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

MR. GOBEILLE: In Vermont.

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

MS. RAMBUR: That was my question.

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

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

MR. HOGAN: Okay.

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

MR. HOGAN: Thank you.

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

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

CROSS EXAMINATION

BY MS. HUGHES:

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

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

of the Medicaid population was 0.1 percent.

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

A. Yes.

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

A. Yes.

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

A. Yes. It does.

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

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

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

A. That is correct. Yes.

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

revealing any confidential information?

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

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

Q. Okay. Thank you.

MS. RICHARDSON: I have --

MR. HUDSON: Does HCA have questions?

MS. RICHARDSON: I have a few questions. The Board asked some of my questions, so that will shorten it.

CROSS EXAMINATION

BY MS. RICHARDSON:

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

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

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

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

A. Correct.

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

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

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

A. I believe that's correct. Yes.

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

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

A. Yes.

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

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

Q. Close to the --

A. Correct.

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

A. Yes.

Q. I don't have any further questions.

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

THE WITNESS: Thank you.

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

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

MS. RICHARDSON: Call Donna Novak as our witness.

DONNA NOVAK

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. RICHARDSON:

Q. Could you state your name and address please?

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

Q. And where are you employed?

A. NovaRest, Inc.

Q. And what is NovaRest?

A. It's an actuarial consultant firm.

Q. And how long have you worked there?

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

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

A. Yes. That's my report.

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

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

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

you referring to page 206 of the binder?

A. It actually starts on page 207. Yeah.

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

A. Yes, it does.

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

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

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

A. Yes.

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

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

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

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

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

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

Q. What procedures did you follow in performing

your review and analysis of the Blue Cross rate filing?

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

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

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

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

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

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

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

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

Q. Yes.

A. Yes. Absolutely.

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

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

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

A. Yes.

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

A. If it should be approved or disapproved?

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

as filed or disapproval?

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

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

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

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

A. Yes. I did.

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

A. Yes, I did.

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

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

comfortable making a recommendation on the risk adjustment.

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

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

A. Yes.

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

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

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

report?

A. Right. On page 218.

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

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

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

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

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

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

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

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

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

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

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

Q. If you could just read it.

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

Q. And you just used the acronym ASO?

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

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

A. Yes.

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

A. Yes.

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

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

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

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

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

A. Yes.

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

A. Okay. "Considering 1.3 percent CTR shown in the Blue Cross Blue Shield of Vermont Q3, 2016 large group rating program filing, the CTR for this filing could be reduced -- could be reduced from..." I think -- sorry -- that should say, but it says to 1.3 percent. "Additionally, since RBC level is at the upper range of BCBSVT's target, and the CTR for the merged market could be less than the other lines of business, the CTR could safely be reduced below 1.3 percent."

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

filing that Blue Cross has testified?

A. Yes.

Q. It's continuing to request?

A. Yeah.

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

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

Q. And for the second sentence you have indicated that you believe that the RBC level could be reduced below the 1.3 percent. And could you explain a little bit more about why you think that that is appropriate?

A. Okay. Again, it's because right now they are already in the upper quartile of the range. And because they are already in the upper quartile of the range, adding, you know, they don't need as much in order to stay at the 600 percent target that they have targeted.

Q. When you say the range, could you be clear about which range you're talking about?

A. I'm sorry, yes. It was what was previously testified to be between 500 percent and 700 percent.

Q. So could you read your conclusory paragraph on page 203 please?

A. Okay. Under conclusions: "Since BCBSVT's solvency level is strong with only a slight reduction from 2014 to 2015, a reduction in the filed CTR would not likely be a threat to BCBSVT solvency and would make the products more affordable."

Q. So you've heard the testimony from the other witnesses today and read the reports from Lewis & Ellis and from Department of Financial Regulation?

A. Yes.

Q. And do you still believe that this conclusion in this report is appropriate?

A. Yes.

Q. Have one final general question about the actuarial review standards that are used. When an actuary is determining whether a requested rate increase is inadequate or excessive, is there a precise number that must be reached in order to use those two phrases? Is there a very precise target?

A. It's a range. And it's based upon a range of assumption -- ranging of assumption that ends up with a range of not excessive but adequate rates.

Q. And in this filing would you say that that's also a possible finding about adequacy and/or inadequacy and excessive rates that there would be a range?

A. Absolutely. I think we talked a lot today

about ranges and different alternatives.

Q. And even within a range an actuary could find that there is an adequate not excessive rate filing?

A. Absolutely.

MS. RICHARDSON: I don't have further questions.

MR. HUDSON: Okay. HCA has concluded its direct. I know we have some questions from the Board.

MR. GOBEILLE: Sure. My first question would be how do I reconcile the fact that Lewis & Ellis and Blue Cross did math to get to an -- I think it was a 3.8 or 3.7 percent contribution in reserve and you got to a 1.3 off of a document. How do I think about that?

THE WITNESS: It's Blue Cross Blue Shield of Vermont's document. It was in their large group.

MR. GOBEILLE: But I mean the math part. Did you do math to figure out what they --

THE WITNESS: I looked at the difference in assumptions. But there was no documentation of the development of those assumptions. So I couldn't -- I can tell the different assumptions that went into the two of them.

MR. GOBEILLE: Let me ask it a different way. Do you disagree with their -- with the way that they did their process? As actuaries?

THE WITNESS: No.

MR. GOBEILLE: So a 3.8 is reasonable.

THE WITNESS: There is a slight disagreement about the 3.8 number, but the process is mine.

MR. GOBEILLE: Meaning if all you had to look at was this filing, and you didn't find document on another product, which way or may not be relevant to this, what math would you have used to determine what contribution for reserve would be appropriate if you're doing this as an actuary? I mean it sounds like Lewis & Ellis did math. And Blue Cross did math. And it sounds like DFR does their math. What math did you use?

THE WITNESS: Okay. I did not include it in my report. But I did an analysis of the increase in claims and the increase in premium, and how much that would impact the authorized control level. And therefore how the authorized control level would change.

MR. GOBEILLE: So did you --

THE WITNESS: Very similar to what was

in the large group, very similar process to what was in the large group filing.

MR. GOBEILLE: Let me be clear. I would be more comfortable if you disagreed with something and said it's a math issue. So you're not taking issue with their math.

THE WITNESS: No.

MR. GOBEILLE: Okay. That's all I have.

MS. RAMBUR: Can I follow up on that? I just wanted to make sure I heard this correctly. So the independent actuary that the Board has hired to help us meet our responsibility to the public of solvency and affordability testified that they concurred that a short-term contribution to reserve of 3.8 was reasonable, if I'm remembering correctly. And but they concurred that an evening out to two was also a reasonable approach.

Do you agree or disagree with the 3.8?

THE WITNESS: When I looked at the calculation of the 3.8 I thought it should be 2.8. But it's just the way it was calculated in the spreadsheet. But I don't disagree with the process. We could look at the math in the spreadsheet, but I thought it should be 2.8.

MR. GOBEILLE: So then that would mean that the math would lead you to a 2.8 percent contribution in reserve.

THE WITNESS: Short term. Yeah. Yeah.

MR. HOGAN: But I'm trying to figure this out. You did testify that the CTR could be reduced to 1.3 percent.

THE WITNESS: Yes. The other filing led me to believe that 1.3.

MR. HOGAN: And then further you indicated that it could be reduced more than 1.3 percent.

THE WITNESS: And that's based on the current solvency level and the impact of reducing it to that amount.

MR. HOGAN: How much further could it have been reduced?

THE WITNESS: I've not done that math.

MR. GOBEILLE: Is there a math that could do that?

MR. HOGAN: That's -- can you -- can that be calculated?

MR. GOBEILLE: Is sounds like the math get us to a 2.8, and some other thing gets you to a 1.3 or lower.

THE WITNESS: You could calculate how much the reserve level currently is over the six -- the mid point. And taking all of the assumptions on trend and everything as true, what the contribution to reserve would have to be in order to hit the six when you take into consideration the solvency level that's currently in existence. You could do that math.

MR. HOGAN: If the CTR were reduced to 1.3 percent, what then would the impact of that be on the rate that Blue Cross has requested?

THE WITNESS: I believe it would decrease it .7 percent. .7 percent.

MR. GOBEILLE: That hasn't always worked that way in a linear fashion in the past. I would --

THE WITNESS: Well that's why I said approximately.

MR. GOBEILLE: No, I mean like last year a three point reduction in CTR was a .5 percent reduction in rate. I don't know what it is because my actuaries didn't come back with that. I don't have that figured out. But basically, and I don't want to start throwing around numbers, but that would -- that math would have to be done and would have to

be knowable.

THE WITNESS: And it could be done, you know, what the impact would be on the premiums.

MR. GOBEILLE: I mean I think that -- all right.

MS. HOLMES: CTR question too. It seems to me from what I've heard CTR is a function of risk.

THE WITNESS: Yes.

MS. HOLMES: So you're using 1.3 which is the large group market as a benchmark for what this could then be. Are you assuming then that the risk is the same across the two pools?

THE WITNESS: No. The filing included the whole market. The 1.3 was calculated on the whole market.

MS. HOLMES: So is the risk the same then?

THE WITNESS: No. The risk is not the same between the large group market and the merged market.

MS. HOLMES: Okay.

DR. RAMSAY: I have a question. So Ms. Novak, you know, the adequacy of the contribution to reserve which we struggle with really plays directly

into the solvency of the company. And we heard from DFR earlier that RBC was not the only factor; their are corporate governance structure, their risk mitigation strategy, their periodic financial analysis which DFR does, claims reserves development, all of those things go into the fact that our DFR says if all those things are good, RBC can fluctuate more. You heard that; correct?

THE WITNESS: Yes, I did.

DR. RAMSAY: But you don't have access to any of that information about corporate governance or periodic financial analysis of the company or the risk by condition strategies, you don't have that?

THE WITNESS: I did not. No.

DR. RAMSAY: Thank you.

MR. HUDSON: Okay. Hearing no further questions from the Board, Blue Cross Blue Shield, do you have any questions for this witness?

MS. HUGHES: I do.

CROSS EXAMINATION

BY MS. HUGHES:

Q. So would you say that the Department of Financial Regulation has more information than you do about the financial condition of Blue Cross?

A. Yes.

Q. At any given point in time?

A. Yes.

Q. And you reached different conclusions than DFR on the CTR request, so is DFR wrong?

A. DFR is more conservative, I believe, in their requirements.

MS. HUGHES: I would like to recall Paul Schultz at this time.

MR. HUDSON: Aside from the question of whether Blue Cross can recall a witness, Ms. Novak is still on the stand.

MS. HUGHES: I'm done with my questions for her. Thanks.

MR. HUDSON: Hold on. Were there any follow-up questions from the Board before -- you want to do redirect?

MS. RICHARDSON: I had one area to ask some additional questions for redirect.

REDIRECT EXAMINATION

BY MS. RICHARDSON:

Q. There have been a number of questions about the calculation of a required CTR factor from Blue Cross Blue Shield which is on page 75 of the binder. Could I ask you to turn to that, please.

MS. HUGHES: This is beyond the cross

examination.

MS. RICHARDSON: If I may, I'm trying to respond to the questions that were brought up by the Board, not just by Blue Cross.

MR. HUDSON: Well it's hard to tell before you ask the question whether it's beyond the scope. So I'll allow it.

BY MS. RICHARDSON:

Q. In answering your questions to the Board you indicated that you thought that the 3.8 percent figure on this chart should be 2.8 percent.

MS. HUGHES: Again I object. This is beyond the scope of cross examination.

MR. HUDSON: But it's not beyond the scope of the questions the Board asked.

MS. HUGHES: That's true.

BY MS. RICHARDSON:

Q. My follow-up question relating to the Board's question is could you explain how you would use the information in this chart and arrive at a 2.8 percent instead of a 3.8 percent figure? And just to clarify, you're referring to the 3.8 percent which is associated with the line that says required insured CTR factor to maintain target RBC; is that correct?

A. Yes. That's calculated by taking the

estimated year-end authorized control level, and I'm assuming that's for the whole company because it's a little bit higher than what the whole company's authorized control level was at the year end 2015. That's an assumption I made. And the year end 2017 authorized control level which I had no documentation of how that was determined. So the difference between those two with some adjustments for investment income, and some adjustments for the tax, resulted in a needed amount of 17,436,082. That amount when I looked at the calculation in the spreadsheet, when I went to the spreadsheet and tried to understand how it flowed, was divided only by the QHP premium equivalent, and not by the total premium equivalent.

And then I went to the large group filing and pretty much the same process was-- it was followed. It was determined a little differently, but in that filing all of the premium for all lines of business were used to determine what the increase was needed as it was done as a premium, so I concluded that the 17 million should have been divided by the total premium shares which is 616 million plus instead of just the QHP. So I just went into the spreadsheet and divided by the total premiums instead of just the QHP premium.

Q. When you did that, did you come up with the

figure of 2.8 percent that you testified to?

A. Yes.

Q. That's how you arrived at it?

A. Yes. Some of my assumptions about what was represented could be wrong.

MR. GOBEILLE: So just to be clear though, your -- if their math leads to a 3.8 and they yield to a two, your math leads to a 2.8?

THE WITNESS: For short term. Yes.

MR. GOBEILLE: Well that would be long term. This is short term.

THE WITNESS: Short term.

MR. GOBEILLE: And then long term is a two.

THE WITNESS: Two.

MR. GOBEILLE: Thank you.

THE WITNESS: And again, that's just on the difference.

MR. HUDSON: Are you renewing your request to call Paul Schultz?

MS. HUGHES: I am. Yes.

MS. HENKIN: I believe that's fair. I know we did not bring that up earlier, but it's relaxed rules under administrative procedure.

MR. HUDSON: Right. There is also

limits.

MS. HENKIN: They will have to be brief based on time constraints.

MR. HUDSON: If there is consensus from the Board, they will allow the recall, and I'll allow it.

MS. HENKIN: No objection to it.

PAUL SCHULTZ

Having previously been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HUGHES:

Q. Can you turn to page 218 of the binder.

A. Yes, I'm there.

Q. You heard Ms. Novak's characterization of that particular exhibit, and did she correctly characterize what that exhibit demonstrates?

A. No. This exhibit was a demonstration of the contribution to reserve that was required only for increases in health care cost trend. This did not contemplate membership increases or any other causes of premium increases.

Q. And was there information that developed after that large group filing was made?

A. Yes. After the time the large group filing was prepared we learned that DVHA -- that the state was going through a Medicaid recertification process. As I testified earlier, that's expected to lead to some pretty significant membership increases on QHP business.

Q. And even though that says 1.3, what was the amount that Blue Cross requested for its CTR in the large group filing?

A. We requested two percent CTR in that filing.

Q. And what did the Board do in reaction to that request?

A. The Green Mountain Care Board approved the two percent CTR in that filing.

Q. And turning to page 75.

MR. GOBEILLE: Page 75 did you say?

MS. HUGHES: Yes.

BY MS. HUGHES:

Q. Did Ms. Novak's assumptions about this page, were they accurate?

A. No. As Ms. Novak testified, she did make some assumptions in coming to her 2.8. I can clarify that the projected 2017 ACL as I testified earlier, was looking only at premium increases in the QHP line of business. It was not looking across all lines of business. So because it's looking only at ACL increases through the QHP line of business, it would be appropriate to divide by the premium of the QHP line of business.

So I would conclude that 3.8 is the correct short-term CTR rather than the 2.8 that Ms. Novak calculated.

Q. And why is Ms. Novak's approach to calculate two percent wrong?

A. Two percent?

Q. 2.8?

A. The 2.8 -- just as I testified, she because of the labeling -- I will say the label was somewhat unclear, so I understand why you had to make some assumptions, but the assumptions that she made was not correct. It was prepared differently than what she had assumed.

MS. HUGHES: Thank you.

MR. HUDSON: Further questions?

MS. RICHARDSON: Just one.

CROSS EXAMINATION

BY MS. RICHARDSON:

Q. You testified that the CTR that was approved for the large group rate filing was two percent, so that was a larger amount than the amount that was determined required to maintain target which was 1.3 percent?

A. Yes. It was larger than the amount required to maintain target relative only to health care cost increase. So we have heard a lot of testimony about what other sort of events may impact a solvency level, including membership increases, including potential adverse events, things like that. So yes, that's correct.

MS. RICHARDSON: Thank you. I don't have any further questions.

MR. HUDSON: Anything further from the Board? Okay. Thank you, Paul.

All right. That concludes the witnesses that we had scheduled to hear from today, who are actual witnesses attached to the party that is.

I would like to take a very brief moment to confer with the Board's rate review staff.

MR. GOBEILLE: I think we are good on all that.

MS. HENKIN: And Noel, I think if they do have a close, we should probably do that before the public comment briefly. And I know that there has been briefing dates already given for the parties.

MR. HUDSON: I agree. So at this point we will move to closing statements.

MS. HUGHES: We will put ours in writing. Thank you.

MR. HUDSON: Thank you.

MS. RICHARDSON: In the interest of making the process go more quickly, we would also reserve comments.

MR. HUDSON: On behalf of the Board I thank all parties.

MR. GOBEILLE: Is it back to me?

MS. HENKIN: I believe the evidence

will be closed, and then we take public comment.

MR. HUDSON: Okay.

MR. GOBEILLE: So is there a sheet for public comment, Jaime?

MS. FISHER: Yes.

MR. GOBEILLE: Does the person on the top of the sheet know who they are? We could start now. I know we are bumping up against 1 o'clock.

MR. NELSON: I believe I know who I am.

MR. GOBEILLE: Perfect.

MR. NELSON: At least right now.

MR. GOBEILLE: Trying to figure out about myself.

MR. NELSON: I'm Wayne Nelson, president of an engineering firm in Winooski. It's a small firm.

We have seen health care costs -- insurance cost increases go up on average of seven percent over the past 12 to 15 years. We have seen engineering salaries go up anywhere from zero to two percent over that same range, and I'm just one of them. I'm representing other companies today.

Company owners are just concerned about the divergence between the cost of health insurance and the salaries which is obviously -- everyone

understands that already. After witness -- I had lots of questions, but after witnessing this I have a whole new understanding of generally what isn't going on. So I was wondering is it possible that there could be a symbiotic relationship between all the organizations where they can communicate ahead of time and develop a system where we can come up with a proactive way to improve health care outcomes, but at the same time reduce health care costs to the consumer? Is that a possibility? To kind of change the way we do our regulation? I don't even know who can answer that.

MR. GOBEILLE: We will take it just as a comment. I don't think anyone can right now, but I think it's a good comment.

MR. NELSON: Okay. And then the next comment I have is assuming that Vermont Health Connect survives the next political situation in the state, what happens when the larger employers like the State of Vermont and maybe some of the other non-health-care employers that do their own health care, health insurance, when they do join if Health Connect survives, what impact will that have on all the conversations regarding cost increases? Now that we are going to have a larger pool of people inputting

into the same system. That's my second question.

MR. GOBEILLE: Thank you. Matt. How are you, Matt?

MR. BIRONG: I'm good. How are you guys? I was planning on saying good morning, but now it's good afternoon. Anyway. My name is Matt Birong. B-I-R-O-N-G.

I am the owner and president of Three Squares Cafe, Incorporated which is actually just a small cafe in Vergennes. I am here as not just a representative of small business but also of a health care consumer.

Since the inception of Vermont Health Connect the Affordable Care Act, I have seen my health care costs personally for my wife and myself increase from roughly the low 500-a-month range to now 925 a month plus deductibles, et cetera, which shockingly matches the first mortgage of my first home.

That being said, seeing this as an expensive business expense and expense of family costs for individuals such as myself, I'm not only seeing it as spiraling out of control but also siphoning money out of our economy that should be circulating through maybe education initiatives,

small businesses, things of that nature. And to see it sort of getting pigeonholed in this other direction is a frustration of mine because I feel like it could be managed better, circulated more effectively.

And one thing I'm also not hearing throughout the course of this entire discussion is words like families, loved ones, neighbors, the people that it's directly impacting. I'm hearing, you know, line item statistics. I'm hearing aged population statistics or risk adjustment transfers. I think we are missing the big picture about humanity, about what's directly being impacted here.

You know, I mean I run a company. I run a hospitality restaurant service industry that runs exceptionally tight margins, so I get you have to operate your business within a realm of profitability. But at what expense? You know, when I have to make adjustments with my bottom line to ensure the success of my business, a lot of times I just can't arbitrarily raise prices 8.2 percent every year. I might have to take a look at administrative costs. I might have to take a look at the functions within my own business to make sure that I'm not taking advantage of my customer base.

That being said, I agree with Wayne. We need to take a look as a greater whole, functioning entities, not combative ones to work together, to find a resolution to this problem. Because it's not going away. It's only getting worse.

So I just ask that everybody kind of maybe take a financial perspective step back for a moment and just take a look at a societal one for a few minutes. I guess that's all I've got for you.

MR. GOBEILLE: Thank you, Matt. Daniel?

MR. QUIPP: Good afternoon. Daniel Quipp, Q-U-I-P-P. I'm going to read my statement because I'm too tired to really think straight.

So I'm a teacher in an alternative school in Brattleboro. I receive a salary of 40,000 annually which equates to about 32,000 after deductions. And my employer doesn't offer health care. My wife's employer can't provide affordable health care to me. My health care premium costs amount to 25 percent of my annual net income. Our gross household income is 75,000. Net -- so after deductions -- is 6,150 -- 61,500 which means that we receive zero subsidy for our health care. A

two-person household such as ours that earns over 50,000 -- 58,000 doesn't receive any subsidy. If our household earned 150,000, we would pay the same price -- I would pay the same price for my health care that I do today. If I earned the same as the CEO of Blue Cross Blue Shield, who I believe is sitting behind me, and he could clarify his salary if he wishes, we would pay the same premium. That's upsetting to me.

When choosing my health care plan I had to make a choice between a cheaper plan such as the Bronze plan of $409 per month which is 16 percent of my monthly take home, or more costly plan such as the Platinum which is 656, which equates to 25 percent of my monthly income. If I chose the cheaper Bronze plan, then I have to come up with $4,000 before the health plan will start paying for any care. And earning the kind of money that I earn, I don't have $4,000 sitting around. So I chose the Platinum plan because it actually does work as health care even though it costs more than my rent, it costs more than my car payments, it costs more than my heat, and it costs more than my groceries each month.

By increasing premiums you're forcing people to make difficult decisions about what they can spend on their piece of mind, because the amount

of money that we spend on our health care has a direct impact upon our, you know, mental health, and that has a real -- I'm sure Dr. Ramsay knows, an effect on our physical health.

So this year I'm going to get a 2.5 percent wage increase. People -- this is from the Bureau of Labor statistics, so 125,000 Vermonters in the most common employment areas are going to receive an annual salary increase of around about 1.6 percent. I've heard four hours worth of testimony this morning about line items. I understand these are complex issues, but the majority of people in this state cannot afford another 8, 10 percent squeeze on their income.

So thank you for your time.

MR. HOGAN: Daniel, we are only supposed to listen, but I'm detecting an accent.

MR. QUIPP: I'm from the U.K.

MR. HOGAN: From the U.K.

MR. QUIPP: Do you want to hear a side note?

MR. GOBEILLE: Can you use more rugby terms like knock on?

MR. QUIPP: I actually have some data on that. I was looking through old paperwork. I

found one of my last paychecks from my last teaching job in London. The deduction from my salary each month was equivalent to about six percent for the stuff that goes towards my free health care in the U.K. rather than 25 percent, and that's post tax, you know. In the U.K. that deduction comes out before tax as well, so it's like I'm being asked to pay for it twice here.

MR. HOGAN: Thank you very much.

MR. GOBEILLE: Can we get a copy of that so we have it in writing?

MR. QUIPP: Yeah, I've got it.

MR. GOBEILLE: Thank you. Mark -- I'm not going to get this right.

MS. RICKS: Dottie. Dottie.

MR. GOBEILLE: Dottie Riggs?

MS. RICKS: Ricks. My name is Dottie Ricks. R-I-C-K-S. And I hope you're not going to ask me about my accent. I know I have two minutes. I'm going to talk as quickly as possible. I have point -- two points of order I would like to present to this Board.

One is I request that you consider having these meetings in the evenings. Working class people have to take off from their work to come here,

and it costs them to sit through four hours of listening, you know, to the business that you really need to listen to. You know, it sometimes is goddledygook to us.

Secondly, I would request -- I know I spoke with you, and I understand the legal, you know, scheduling you have to do. But you did not say that legally we have to wait until the end of the meeting to do our presentations. I'm requesting that you consider having 15 to 20 minutes at the beginning of the meeting, let us give our presentation. And you can spend all day, you know, going back and forth with them. It's a win/win for you because then you can refute, you know, the things that we disagree with. So I would ask that you consider that.

You guys have talked about nothing but statistics, and people are not actuarial figures on a spreadsheet. I am not. I can tell that you have not put on your jeans and your T-shirts and your sneakers and gone down and sat in the farmers' market and talked to people. Because if you did that, you would never sit here and say this is affordable. I have done that. Young people that want to do the right thing, $20,000 a year, have been self-insuring themselves, paying for their insurance. Paying for

their health care needs out of pocket. Now we are asking them to pay 4 to 5,000 above.

They understand insurance. They understand everybody contributing, but do we have to gouge them? I just, you know, I challenge everyone of you on this Board, I challenge you people, to call Heather at the Vermont Workers Center and come down with she and I and walk through -- walk through the street, the farmers' market and talk to people.

I talked to small business people that have said they can't afford Vermont Health Connect, that they can pay less, you know, getting it on their own. So we want to increase it by five to 15 percent. I've talked with retirees that are living off Social Security like me. They are paying -- the problem is that everybody has $3,500 deductible. They never make that deductible, so they are just contributing money into the general fund. That's not fair when they are living off of 20, $25,000 a year.

My daughter -- I had to get Vermont health care for her. The cheapest I could find was $225 a month with a $6,500 deductible. So she doesn't have insurance. I self -- that's out of my pocket. I self fund her.

I was unemployed five years ago. I was

on Vermont health care. I took in maybe 15,000 with earnings and unemployment. I paid 125 a month. That was doable with my savings. So you know, the people we have talked to, none of them have paid less than $400 a month with the $3,500 deductible. If they are making $20,000 a year, that's fully one third of their income, which is what a mortgage is.

What are you thinking about and what -- the bottom line for me is that I read this article, special report: "Despite regulation, hospital profits up. Vermont's hospitals have prospered over the last 10 years more than doubling assets, tripling profits and increasing the amount of cash they have on hand for rainy days." You're funding this, and we are funding this when we pay these increased premiums. Instead of balancing your budget on the backs of people that make $20,000 a year, why not go after these profits and say, no, we are not going to pay you so much. That's going to open up enough money to cover your .4, or your .5, or .8 or whatever deficit which by the way is -- you know, that doesn't sound like a big percentage to me.

Revenue patient care is down to about 2.3 billion annually and yet hospitals charge insurance services and companies for five billion

dollars. I have a disconnect with that. I don't really understand it. But it says to me there is something off and we're overpaying.

Peter Galbraith says what's happening is instead of keeping costs down using the extra revenue, lowering prices so that it focuses entirely on the service, the extra money is going into empire building and these outside salaries. Balance your budget off these people. Okay. Not off of us. People cannot afford health care as it is, and you want to increase it? You know, what are they going to give up? Food. Clothes. You know, we have to have a sense of decency about this. And with profits like this from hospitals where they could be getting their money from, I just don't know how you could possibly, you know, try and do this off the backs of people that can afford it.

And I'm going to chal -- as I said, I'm challenging everyone of you. I'm waiting to hear from Heather which one of you is going to call up and say I've got on my jeans, my T-shirts and sneakers on. I'm going to come down and look these people in the face, see how decent they are. They are committed to doing their share. They pay that because they believe they are doing their share.

They don't want to go to the emergency room and make all of us pay for it. So I hope to hear from you. Thank you.

MR. GOBEILLE: Thank you, Dottie. Mark Tulley.

MR. TULLEY: Hello.

MR. GOBEILLE: Good morning, Mark.

MR. TULLEY: My name is Mark Tulley. I'm a citizen of Brattleboro, Vermont. I'd like to speak to the Board's mandate to serve all citizens of Vermont regardless of their health care and health insurance situation. I myself am not going to see an increase in my health care cost if these rate hikes go through. I am, however, part of a three-person household, one of whom has Blue Cross Blue Shield's health plan before you today.

When I spoke to him yesterday about why I was coming up here, he didn't know about this increase. He has it pretty good. He's got a full-time job, though at minimum wage. Our shared expenses result in a fairly reasonable rent and utility bills. Our house is not particularly struggling, and yet when he heard eight percent, he went to speak, but he began shaking in fear. And his words were strangled, and he just fell silent. So

this stuff is like -- these rate increases are threatening the stability of my household regardless of my direct costs in like going to the doctor. It's actually threatening the existence of my household and so many household like it because folks have got to pool together in group housing. We didn't even know each other before last November, us three.

I'm also part of a peer group of people who have gone through like enormous sacrifice to lower their basic living cost so they can work on building community space and refuge for people who suffer relentless harassment and oppression. And many of these people need care for HIV. And so where they live -- what state they live in depends on what health care system. It took a lot of these people a long time to get to Vermont because of that transition, the necessities of that transition. And they -- and their ability to pursue these aspirations has been -- is challenged by the current system.

This no doubt will take at least two or three key players in these efforts out of the game if not out of the state altogether. And the knock on effects of that are huge.

So I just want to say for every citizen of Vermont whose viability is imperiled, imperils the

viability of many, many more people around them. Many more. And so if there is -- whatever percentage of people this may be creating hardship for it's huge. It's 10-fold, maybe a hundred fold, the viability of communities, the viability of the entire state is at risk here.

And so I understand that it's -- your mandate to take care of people's well being through health care is kind of twisted by also needing to take care of, you know, corporate profit lines. That's really an unfortunate situation. I hope the state changes. But to rely on rate increases -- to even allow rate increases to be the mechanism to address the financial exigencies created by that conflict of interest is unacceptable, and I for one would pay more taxes and take on more responsibilities as a citizen of Vermont to avoid forcing this upon the back of folks who actually need the help the most.

I would just like you to keep that in mind. Thank you.

MR. GOBEILLE: Thank you, Mark. Pete.

MS. PIPINO: Hi. I would like to testify for Pete.

MR. GOBEILLE: Are you Heather?

MS. PIPINO: I'm Heather. Pete had to go to a funeral today and he asked if I would read his testimony.

MR. GOBEILLE: I just thought Pete had a really cool last name.

MS. PIPINO: Yeah, so it's Pete Gummere. G-U-M-M-E-R-E. And my name is Heather Pipino. P-I-P-I-N-O.

MR. GOBEILLE: If you're going to read something, if we could have a copy of it before you go, that would be great.

MS. PIPINO: Certainly.

MR. GOBEILLE: Thank you.

MS. PIPINO: When I use the word I, it's Pete. I had my first job -- I had my first job in health care when I was 19. I have had almost continuous involvement in the health care field since then. Most of that time has been as a non-clinical manager for a not-for-profit and for-profit organizations. During that time I have also taught in a Master's program in health care management at the New School in New York City.

The last 29 years has been here in Vermont. For the past several years the health care costs control focus has been on squeezing the

hospitals. Hospital rates and budgets have been under control for several successive years. Some budgets have come in under targets set by the state. Hospitals that have come in at or under state guidelines have often been asked to squeeze further. Physician reimbursements have also been squeezed. I know physicians that have moved out of state because of the health care reimbursements in Vermont. Yet the state has continually given greater increases to the insurance companies. And it appears that they are simply not under the same kinds of economic pressure that the rest of the industry is.

Now retired, I have the perspective of the senior citizen. However, affordability of health care for all Vermonters remains a serious question of social justice. I know many working people whose health insurance costs have gone up rather than down. Wasn't reducing cost the point of health care reform? It is incumbent upon the state to do the same thing to the insurers that they have done to the hospitals for several years. Just say no to these unreasonable rate hikes, or have the intellectual honesty to admit your own ineffectiveness or unwillingness to do the tough part of your responsibility.

And if anybody would like to go

canvassing and door knocking with me, please be in touch. Thanks.

MR. GOBEILLE: Thank you, Heather. Avery Book. Did I get that right?

MR. BOOK: Yes. I did write it, but I probably need to e-mail it to you. It's not very legible.

MR. GOBEILLE: That would be great.

MR. BOOK: My name is Avery Book. Like it sounds. I grew up here in Vermont, right down the road in Worcester. I currently live in Burlington. I'm currently on Vermont Health Connect with Blue Cross Blue Shield. And I, like many others, many in Vermont, can't afford the proposed rate increase.

The cost of living in Vermont is totally out of control, and health care costs are an enormous part of that. There was a report that Public Assets Institute did that showed from 2004 to 2014 health care costs rose 70 percent. This is at the same time that child care costs, college, location, housing, out of control housing was also rising. In that same period median household income was dropping by seven percent. So I think all this in the context of seeing the insurance executives continue to get six figure salaries -- I agree with

the statement this is a social justice issue.

I'm insured through Blue Cross Blue Shield on Vermont Health Connect and what many people would call under insured where I've -- I'm insured and am relatively healthy, but God forbid I actually need to use my health insurance, because I can't afford that $3,000 deductible. Twice in the last three years I have had to leave Vermont to find work that pays a livable wage. As you can imagine that was an extraordinarily difficult thing to have to do multiple times over the last three years. And uprooting myself from my community, the family I have here to go find a job that just pays the bills. Extraordinarily difficult thing I think a lot of young Vermonters face, the prospect of having to leave the state they love because of how expensive it is to live here.

This fall my contract with the long-term temporary job is up. And I expect my income to drop probably close to half. Half of what it is for next year. The rate increases being proposed here year after year are just simply untenable for me and for thousands of other Vermonters, and I fear if this and other cost of living continues in Vermont, it's going to drive me

and other people out of the state to look for a place where they can afford to live.

I encourage the Board to reject this rate increase. I encourage the Board to do everything in its power to move forward with Act 48. Actually moving toward universally, equitably financed public health care where health care is treated as a human right not as a commodity to be bought and sold. Thank you for your time.

MR. GOBEILLE: Thank you. Paul Langevin. How are you, Paul?

MR. LANGEVIN: Good. How are you?

MR. GOBEILLE: Doing well.

MR. LANGEVIN: Who is talking?

MR. GOBEILLE: I am.

MR. LANGEVIN: I have to put my glasses on.

MR. GOBEILLE: I looked down to write.

MR. LANGEVIN: So yeah, I'm Paul Langevin from Johnson, Vermont. L-A-N-G-E-V-I-N. I wanted to give a short story. I lost my wife to cancer. She died a little over two years ago. She originally had a thyroid cancer. Had surgery. And she was in remission for about five and-a-half years. They said well you're doing great. Well up comes

another cancer that nobody knew about, and she died within two years of it.

So following that, I asked the people at Fletcher Allen how was it that there isn't some type of an assessment, a yearly evaluation to see if there is any other kind of cancer that's growing, especially for someone who is in remission. The answer was that would be just too costly. I want you to hear that silence, because that's what I had to listen to. People should not be equated to price for insurance companies.

During the time we were having chemo, we had to get a pill. Blue Cross Blue Shield -- I had the best policy, denied five times her pills. Shopping around for the cheapest pill. The day my wife died they tossed the pills on my porch, 20 below zero, Mr. UPS guy. This is disgusting. This is unacceptable. I'm an advocate strongly for single payer, because I know if we have government regulated, and I mean regulated seriously, and they don't do a good job, I vote, and I vote them out of office. With insurance companies, they have got tons of lawyers to just dust the story, and you'll never get to the truth. That's all I have to say.

MR. GOBEILLE: Thank you, Paul.

Rachel, and I don't know the last name.

MS. DESILETS: Desilets. D-E-S-I-L-E-T-S. Thank you.

MR. GOBEILLE: Thank you, Rachel.

MS. DESILETS: As a new retiree living on a fixed income, mostly Social Security, my Medicare payments plus my Blue Cross Blue Shield supplemental is greater than what I was paying when I was working. And I'm not sure how much longer I'm going to be able to -- you know, how long I'm going to be able to pay those rates without having to look at other sources of insurance. And I don't know about Health Connect. I don't know what that would cost me. But I'm very concerned. As you know, right now having to pay my own supplemental is more than what I can afford really. And then thinking of Health Connect what I've heard, I'm not very optimistic, and I'm a little concerned about where that's leading me.

With all respect to hospitals, I know that while I was working with victims of crime we would compensate for their medical expenses, and we would see SANE exams that would range between maybe $400 in one hospital and 23 hundred dollars in another hospital. And I wonder how much -- I mean a

SANE exam is a SANE exam. I'm wondering how much of that really goes towards the patient's care and how much of it might go towards administrative. And you know, right now the state pays for some of those expenses, especially if it's going to try to prosecute the crime. But when it goes to the insurance, you don't have that avenue. So -- and that's not the only practice. There is also like prophylaxis, you have some hospitals that would pay for three, they are not cheap. And then you have some that will start off at the onset of treatment with one treatment.

And my experience in talking with women is that they often don't go the full three treatments because they get such an adverse reaction to the treatment. So we are paying for things maybe that, you know, we need to look at. I'm not saying we shouldn't take away the prophylaxis. I'm just saying do we pay for it once, and then have someone have them go back and refill that -- you know -- that prescription.

So I think there are ways that might be wasteful. And I'm wondering if those are being examined. And then also why is there such a divergent cost in care between carriers, and is it --

and I know there are different costs between hospitals. But at the same time, I wonder how much of that is administrative and how much of it is really patient care. Thank you.

MR. GOBEILLE: Thank you, Rachel. Ellen Schwartz.

MS. SCHWARTZ: S-C-H-W-A-R-T-Z. Hi. I'm probably the most fortunate person of people you're going to hear testify today, because I am lucky to be old. Lucky to be -- also lucky to be old enough to be on Medicare. I'm lucky that when I was actually a much younger person our country established Medicare so that nobody in my age group would go completely without medical care, and I'm further lucky that I worked over the border. I live in Brattleboro. I worked over the border in Massachusetts as a public employee, so I'm able to purchase a Medicare extension plan through the Group Insurance Commission of Massachusetts that I can actually afford.

But access and affordability -- access to health care and affordability shouldn't depend on being old enough to get Medicare or poor enough to qualify for Medicaid. Like one of the previous speakers, I did a lot of surveying this winter down

in Windham County, and I also have a lot of conversations -- informal conversations with people about health care. And some of the anecdotes I heard, and this is not statistical, but these are real people, people who were not insured because they said they'd pay the penalty rather than buy -- all they could afford is the Bronze plan -- they would rather pay the penalty, because even if they got the Bronze plan it wouldn't do them any good because they couldn't meet the deductible. So they just pay a penalty. Or people who get the Bronze plan but aren't actually using it, they're just sort of hedging their bets. They are going to have it in case they end up in a real catastrophe. They are not actually using it for primary care or preventive care.

The third set of stories I heard is from people who are on Medicaid, are working in what's increasingly the case in Vermont and elsewhere what we call the gig economy, meaning like they have several different jobs, none of which offer health insurance, or they are not working in any of them for enough hours, or they are freelancing and they are basically watching their income to stay poor enough so they can stay on Medicaid. Because they have

serious medical conditions or chronic medical conditions, and they know that if they got on to Vermont Health Connect they wouldn't be able to actually meet their health needs on the only plan that they could afford. So these are the kind of stories that I'm hearing when I'm out talking to people in Brattleboro.

And to me, that makes absolutely no sense on a medical level. As a state, we should be increasing access to care rather than creating greater barriers to care. Increasing premiums is a barrier to care. Deductibles and copays are barriers to care. They are different pockets of money when you're looking at the insurance industry, but for the person who is paying it, it's all coming out of their pocket.

This morning I listened to this testimony. I heard a lot about statistics, about insurance liability risks, about adverse utilization, decrease -- and decreases and increases in utilization, positive and negative events. All very heady sort of mathematical stuff. But I want to just remind this Board on the other end of each one of these policies is a person who at some point in their life is going to need health care.

And I ask that the Green Mountain Care Board exercise its regulatory authority to deny this rate increase so we don't move further from the goal of health care as a public good for all of us, equitably financed, and not just for people like me who are lucky enough to be old. Thank you.

MR. GOBEILLE: Thank you very much, Ellen. Sheila Linton, I don't know if I'm saying that right. Did I get it right?

MS. LINTON: Yes. Sheila Linton. L-I-N-T-O-N. And I'm actually going to start with just my question, and then I'm just going to say a little story.

So I had a question as I was sitting here for the last almost five hours now, and I was wondering if the insurance increase does happen, how does that affect the subsidies that the state currently gives? And is that sort of like a double whammy for the community? And what I mean by that is that the community talks about how those state subsidies come from people paying taxes, and then there is -- there is going to be an increase which for myself who is on Vermont Connect Blue Cross Blue Shield will be impacted as well. So for those people, I'm just wondering about that of if this was

-- how does that really affect the subsidies that Vermont does give in these plans?

So I would like to start by saying thank you to all the people who have testified today, specifically the people in the audience here. Daniel, Paul, and Ellen had very good points that resonate with my story as well.

Again my name is Sheila Linton. I'm a native Vermonter, and I live in Brattleboro. I'm a single mom with two daughters and currently have Vermont Blue Cross Blue Shield. For the last three years my income has been such that my family no longer qualifies for Medicaid which was a reasonable, affordable system and plan for my family. It was equitable and based on my income, so my income -- when my income went up, my premium went up a little bit, but it never exceeded $200 a month for my family as a whole while having the same or similar care and access to service that I have now.

Over the last three years since being on Vermont Health Connect this has not been the case. I have many concerns. Currently my premium, not including the subsidy, is around 600 out of pocket a month. In the first two years that I have been on Vermont Health Connect Blue Cross Blue Shield I sent

my oldest daughter to college. In addition to college debt, she came back -- my young adult daughter incurred health debt as well. And the health debt was due to the out-of-pocket costs for her as an 18 year old at the time of a 12 hundred dollar deductible, 20 dollar copays for visits, 50 dollars for her inhaler, 20 dollar copays for physical therapy, and that's just right off the top.

So those stories that we hear about our youth are very serious. That story turned into us having to pay that penalty. My daughter last year decided that we couldn't afford that any more. And so she was no longer on my plan. And I was on a single plan. And she took the hit, $325 a month for not being -- having a health plan. Of course she couldn't afford to pay that, so we know where those costs got absorbed, and that was within our household.

So I also have some of my own medical issues. And I currently have a Platinum plan. I have the Platinum plan because of many reasons why people said, it's a lower deductible and I can at least have smaller copays entering into the doctor where I know my medical situation requires me to do that. I'm paying out of pocket around $600 a month

for the care that I need and similar out-of-pocket expenses.

My older daughter and I have both had health care bills that are currently in collections and trying to arrange payment plans which currently -- usually the minimum that they allow you to pay is $50 a month. And even that between two people which is $100 month, can be really strenuous on a single household of two children -- having two children.

I say all of this to say that I'm still a single parent, and health care is still unaffordable. I'm having to choose not to access some of the health care because of the out-of-pocket costs. Currently there are services that I need, but as they add up, I'm not able to do those, whether it's my physical therapy, you go twice, three times a week, that's 60 bucks minimum out of your pocket. You add that up for the month you're talking about three times four, 12 times 20, that adds up as the month goes along. And these may be for specific needs whether ongoing or related to something that has happened in your life.

I am -- today insurers asked for an increase of 8.2 percent as an average. That's not necessarily what will be approved, and while many

Vermonters, including me, will receive no, or luckily maybe a standard COLA of three percent this year, we have heard from many people that even us who live here are moving out of the state because we can't find livable wage jobs. And those who are fortunate enough to have livable wage jobs are being forced to not take pay increases because of the financial situations.

I listen to this insurer's testimony today, and there is a lot of language as well as systems as a whole is hard to understand, and I wouldn't pretend to understand it all. However, what I do understand is that my friends, my families and neighbors and myself are suffering. And that not -- we are not getting the care that we need, that we can afford. What I do know is that the Green Mountain Care Board has an authority to quote: "Ensure that our health care system provides quality, affordable health care to all Vermonters while reducing the waste and controlling costs." End quote. And quote again: "Explicitly responsibility for controlling the rates of the growth in health care costs and improving the health of Vermonters."

You're in a position to truly help the people of Vermont. Whether it's the 11,000 that we

spoke about who pay that more -- I think I heard earlier. Or whether I think maybe it's 60,000 who might not be insured at all. Or whether it's the 77,000 that you talked about who were actually in this plan right now, or whether it's the plus 600,000 Vermonters who deserve the right to health care.

I think as people we have an obligation to our communities and communities are asking you for help and this Board. They are asking the Board to renew and to assure the commitment to its mission.

I thank you for the thoughtful questions today, especially around affordability. And I'm wondering what is the price of my life, what is the price of my life when I talk to my children. If people are not able to afford what they may need to meet their basic fundamental needs for all of us to live dignified lives, I believe we are not only moving -- I believe we are not moving closer to healthy communities but further away.

I truly ask the Board to continue to work together to move toward Act 48 and truly universal health care system that's equitably financed, and it truly makes health care a human right in the state and to lead the nation. And we can afford that. I ask you to please decline these

insurance hikes and to consider this a social justice issue and the humanity of our people here in Vermont. Thank you.

MR. GOBEILLE: Thank you, Sheila. Is there anyone that we missed?

(No response)

MR. GOBEILLE: Okay. So does anyone from the Board have anything before we make a motion to adjourn? Staff? Good. Is there a motion?

MS. RAMBUR: So moved.

MS. HOLMES: Second.

MR. GOBEILLE: All those in favor?

THE BOARD: Aye.

MR. HUDSON: Thank you to all those who attended today, and thank you to all of those who made public comments.

(Whereupon, the proceeding was adjourned at 1:39 p.m.)

C E R T I F I C A T E

I, Kim U. Sears, do hereby certify that I recorded by stenographic means the hearing re: Docket Number GMCB008-16-RR at the Second Floor Hearing Room, City Center, 89 Main Street, Montpelier, Vermont, on July 20, 2016, beginning at 9 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 206 pages are a transcript of the stenograph notes taken by me of the evidence and the proceedings to the best of my ability.

I further certify that I am not related to any of the parties thereto or their counsel, and I am in no way interested in the outcome of said cause.

Dated at Williston, Vermont, this 23d day of July, 2016.

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Kim U. Sears, RPR

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