STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER 9-18-rr

IN RE: BLUE CROSS BLUE SHIELD OF VERMONT
2019 VERMONT INDIVIDUAL AND SMALL
GROUP RATE FILING

July 23, 2018
9 a.m.
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115 State Street
Montpelier, Vermont

Rate Review Hearing held before the Green Mountain Care Board, at Vermont State House, Room 10, 115 State Street, Montpelier, Vermont, on July 23, 2018, beginning at 9 a.m.

P R E S E N T

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Robin Lunge, JD, MHCDS
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A P P E A R A N C E S

Blue Cross and Blue Shield of Vermont

Jackie Hughes, Esq.

Health Care Advocate

Jay Angoff, Esq.
Kaili Kuiper
Eric Schulteis
Mike Fisher

I N D E X

MR. MULLIN: Good morning everyone. I'm about to call this meeting to order. In advance I just want to apologize to everyone for the close quarters. I know everybody would like a little more space. We moved back several months ago to a new building and it's a great building for us to get our work done in, but the one fall back is we don't have our own board room so we're at the whim of the open spaces to hold hearings at, and in this particular case the larger room across the hall which we will be in tomorrow is not available today. So hopefully everybody will get to know their neighbor and be polite, and at the beginning I'm going to ask anyone that has not signed in that wishes to testify at the end of the day to please sign in with Agatha at the back of the room, and do we have a general sign-in for who's here, Agatha?

MS. KESSLER: No we don't.

MR. MULLIN: So why don't you have a pad passed around the room so we can get everybody to sign in. With that I am going to turn this hearing over to our Hearing Officer for today Judy Henkin and Judy will be running the day's proceedings.

MS. HENKIN: Good morning everybody. I'm Judy Henkin. I'm going to be Hearing Officer by

designation from the Board Chair as you just heard. It is July 23rd, 2018. This the docket number GMCB 9-18-rate review. If you have a cell phone, can you please turn off the sound now so I don't have to look at you with -- glare at you later.

We have Blue Cross here today. It's the first day of two days of hearings. Jacqueline Hughes -- Jackie Hughes -- I'm going by Jackie -- is representing Blue Cross Blue Shield of Vermont. We're doing a little bit of a different setup for their witnesses today if you have been here in the past. We are going to have all four of their witnesses sit at the witness table together and that way the Board and the HCA can ask questions as a panel. We in the past had to call people back because it was the inappropriate witness for the question that was asked. This should make our time more efficient. We're going to try to be efficient today. Also we have a long day ahead. Blue Cross will be taking up most of the morning, if not all of the morning, with their witnesses with the cross examination and with questioning from the Board Members.

We have a court reporter here today so this will be transcribed, and we'll be asking for an

expedited transcription of this. So that will be done and it will be posted to the web site after it's done. The Board has jurisdiction over this matter under Title 18 Section 9375(B)(6), Title 8 Section 4062(A) that deals with rate review, and Title 8 Section 4512 that's specific for Blue Cross. I want to welcome everyone. It's going to be a little warm in here and it's a little bit of an intimate setting for this hearing, but welcome. If you are here to comment, there is a sign-up sheet. We will be taking comment at whatever time the hearing evidence is concluded. So I don't have a time certain for that, and tomorrow night there is also public hearing from -- beginning at 4:30. I believe we have a 6:30 stop. We will try to get everyone accommodated. I know that's been pretty widely disseminated for that public comment to be heard and it's at City Hall tomorrow night. Written public comments are also being accepted to I believe the 28th.

The HCA is here today -- the Office of Health Care Advocate, and we have a new face on the panel here. Jay Angoff is here representing -- Angoff. Sorry.

MR. ANGOFF: Angoff.

MS. HENKIN: Is that misspelled?

MR. ANGOFF: Yes it is misspelled. I'll just change my name.

MS. HENKIN: I looked at that and said boy I'm wrong. Thank you. So Jay is here today, the Health Care Advocate's office, and he is joined by Kaili Kuiper whose name I'm sure I mispronounce every time, and Eric Schulteis whose name I think I'm getting right. Mike Fisher, the Chief Health Care Advocate, is here at the table also. I want to remind the parties today and the Board that there are confidential documents that are within this filing. The Board has been privy to those because they are -- may be material to a decision, but I do want to caution everyone when they are speaking about documents they are clearly marked in the packets and to please be very aware and I'm going to also state that to the witnesses.

I think at this time there are -- if we could -- I'll introduce also we have our actuary who will be testifying this afternoon, and David Dillon from L&E is in the back of the room and we will have him testify. We also have the Department of Financial Regulation and the Commissioner is here with their General Counsel in the front row and we'll hopefully get to them this morning, but they will be

presenting testimony after we hear from Blue Cross and get through that whole morning.

While we're at it if we can swear in all of today's witnesses at once so we get that completed, I'll ask the court reporter to please do that.

(All witnesses were duly sworn.)

MS. HENKIN: So again I want to talk about the procedure a little so everyone has this clear. We will have Blue Cross presenting first. After they present their direct testimony the Office of Health Care Advocate will have an opportunity to ask questions. The Board will then have an opportunity to ask questions following the HCA. After that we will hear from the Department of Financial Regulation. We'll also have opportunities for the carrier, for the HCA, and for the Board to ask questions of the Department of Financial Regulation. The testimony from Lewis & Ellis, we will have our general counsel, who I have not introduced -- not general counsel. He's our staff attorney, he's assistant counsel here, Sebastian Arduengo will be leading the direct for our actuary, and we will again allow for the HCA, for the carrier, to ask questions, and if the Board has follow-up

questions also there will be time for that, and last will be presentation by the HCA.

I would like to first, before we commence anything, deal with there was a motion in this and there was a motion concerning the testimony of Michael Fisher. There's an expert report that is at issue -- it is at issue and I will note in both matters, the MVP and the Blue Cross, and the same arguments were made concerning the admissibility of it. In Blue Cross was there a response to that -- to the motion?

MR. ANGOFF: We didn't file a written response. Blue Cross filed their motion I believe late Thursday night. We would like to argue it now with your permission.

MS. HENKIN: I'll leave a few minutes for that and get that out of the way. So, Jackie, I'll let you just briefly present what's in your motion and it's a written motion. I have reviewed it. We have reviewed the other one. Do you have anything to add?

MS. HUGHES: I do have a couple things to add. One is to clear the air. There was a press report on the motion that I think mischaracterized what the motion is all about. This hearing is a

contested case and is the equivalent of a trial, but the Board is the judge. The Vermont Rules of Evidence do apply to this proceeding, and our Motion in Limine was squarely based on the technical Rules of Evidence that apply and addresses the question of whether certain testimony could properly be admitted as expert testimony under those rules. Our motion was not about whether the Health Care Advocate should participate as a party and play their statutory role in the process. Our motion was not about whether the Health Care Advocate can cross examine our witnesses, can cross examine the witness for the Green Mountain Care Board, can cross examine the Commissioner, and it's not about whether the Health Care Advocate can advocate on behalf of consumers. It was noted earlier whether the Vermont Rules of Evidence permit the type of evidence the Health Care Advocate sought to admit as evidence. However, the Green Mountain Care Board rules -- we respect the role of the Health Care Advocate in this process and we're not trying to say that they are not a participant.

I believe my motion fairly states our legal grounds. There is one procedural ground that I mentioned in the motion but didn't highlight and that is the fact that the opinion was not signed. That

was required under the scheduling order to be signed and it was not, and so I add that as another procedural ground.

MS. HENKIN: And that was in your written motion as I recall.

MS. HUGHES: Yes.

MS. HENKIN: Mr. Angoff.

MR. ANGOFF: Madam Hearing Officer and Mr. Chair and Members, we're surprised at the opposition to this. It's not that earth shattering. The case is not going to rise or fall with all due respect on Mr. Fisher's testimony, but we believe that Mr. Fisher, even if this were a federal court proceeding, under the technical Rules of Evidence would be permitted to testify, but let's be clear this is not a federal court proceeding. This is an administrative proceeding. In a federal court we don't have four people as a panel responding to questions, and this body has its own rules and one rule is that evidence is admissible if it's of the type commonly relied upon by reasonably prudent people in the conduct of their affairs. I would like to think that anyone would agree Mr. Fisher's testimony does fit in that rule.

In addition, the statute expressly gives

the public advocate -- I'm sorry, the Health Care Advocate the right to testify at the proceeding. So we think that it's allowed under the technical rules that would apply in federal court. Even if it's not, it's clearly allowed under the rules that apply here, and, number three, the statute expressly gives the Health Care Advocate the right to testify in this proceeding. So we think that the motion should be denied.

MS. HENKIN: I have reviewed the law on this and we did receive this early enough and have notice that this was an issue in the case and I recognize it's an important role for the Health Care Advocate in this proceeding. It is provided for in statute. It is provided for in our rule. They are an integral part of this proceeding in providing their -- in participating by suggesting questions. They are allowed to provide a public comment under Section 4062 of Title 8. They are a party in the proceeding, however, that doesn't confer expert status to their witness in this instance.

The document that was provided by the Health Care Advocate is in its essence not based on any type of technical or other expertise of Mr. Fisher as a legislator. It is a recitation of his

recollection and his research into the legislative history of Act 48, and it doesn't involve specialized knowledge for what he has provided there and would not be anything that adds to the case or be evidence or a fact at issue. It's well settled law that the opinion of one legislator is not representative of the legislative intent of the statute.

The Board does have the opportunity to look at legislative history and look at and do research behind the Act, however, here the gist and the core of what was provided is that the concepts -- the review standards of affordability, access to care, and quality of care are separate and distinct from the actuarial standards. It does not appear to dispute they are not. Those are expressly provided for in the statute. The Legislature did put those into the statute as a separate requirement. They are part of the rule and based on the plain language of the statute those do not need additional construction through the legislative research that was provided by the Health Care Advocate, and the response in the MVP I believe was that these do have some meaning. I don't believe that that will need -- the terms were inserted advisedly into the statute. That's the presumption. So yes they would have some meaning.

So we have looked at Rule 72. We looked at our rules. This is patently inadmissible as an expert statement, but we are going to exclude that from the hearing and the related testimony.

MR. ANGOFF: Madam Hearing Examiner, may Mr. Fisher then testify as a fact witness, not as an expert witness but simply describing what he saw as a fact witness?

MS. HENKIN: What he saw at the Legislature would -- no that is what was in the expert testimony. So the opinion of one legislator is not representative of the intent behind the statute. I don't think that there is much in what was written that is necessarily not open to inclusion in your memorandum that follows. There's a lot of legal construction of an ultimate conclusion of law that the Board is going to make, but I do not believe that that is something that Mr. Fisher should be allowed to testify and I'm going to exclude that testimony.

Moving on we have stipulated to materials. I believe everyone here has a similar binder, but there were some materials that were not included. We had a late amendment from Blue Cross and I do not believe that's been put into the binders

and I would like Blue Cross to please explain that -- what's going on if that's to be discussed because it is part of your filing.

MS. HUGHES: Right. We did not put it into the binder because the binder only includes matters that have been stipulated that can be admitted into evidence, and I have asked the Health Care Advocate's Office whether they would stipulate to it. They said they didn't have an adequate opportunity to review it yet, but we fully intend to present it as part of our case today. So we did not -- we didn't presume to put it in the binder without it actually being stipulated to.

MS. HENKIN: But you will offer that into evidence?

MS. HUGHES: Yes we will.

MS. HENKIN: And we have copies here if in fact -- you have enough copies?

MS. HUGHES: We have copies.

MS. HENKIN: All right. We will get going then without much more discussion here. Any other preliminary issues that we need to review? I would --

MS. HUGHES: I believe there is one other and that is the parties have worked to develop

a list of things -- facts that can be administratively noticed. I believe there was a letter that was filed last night by part of the HCA team. The letter, though, did not have the attached documents and so we would like the opportunity -- there was at least one where we want to have the opportunity to look at the final document. We agree in principle that all of those things can be noticed by the Board. They may take administrative notice and I will let the Health Care Advocate argue why they should be administratively noticed, but I did want to point out the fact that there is I think sort of a technical glitch in that we don't have the final documents that will be provided to the Board.

MS. HENKIN: And we did have a discussion before about putting together all of the actual documents or links to them. I want to at least say right now that the stipulated exhibit list, these are exhibits 1 through 16, are entered into evidence so they do not have to be entered in singularly, and I also want to point out that I did receive that list of documents and my understanding is they are in fact stipulated to as far as they can -- we can take administrative notice of those; is that correct?

MS. HUGHES: You may if the Health Care Advocate convinces you that they are relevant and meet other standards. Yes.

MS. HENKIN: And I'll go back, and my understanding was we did have this discussion earlier that the carrier did not oppose the Board taking administrative notice of those at this time.

MS. HUGHES: We do not. We do not.

MS. HENKIN: Okay, and we have reviewed the list and the Board will take administrative notice of all of those items. So those do not have to be again individually discussed and debated at this point. I'll allow each party to do a brief opening statement before we get to the first witness.

MS. HUGHES: Great. Thank you. Good morning. As Judy said earlier, I'm Jackie Hughes and I'm here representing Blue Cross. This is Blue Cross's sixth individual and small group rate filing formerly known as the QHP filing.

We and the Health Care Advocate have stipulated to the admission of the materials that you found in your binder -- that you find in your binder, and this year exhibits 2 through 12 display the broadest list of questions that we've received to date on any of our filings, and time constraints will

not permit us to go through all of those so we have to rely on you to have reviewed them and absorb them.

In this hearing we plan to highlight some of our -- the contents of our filing, but not necessarily each and every piece of it. We will also present an amendment to our filing that was filed last week. We don't normally file amendments, but this year several events made it clear to us we must in order to fully fund the 2019 rates. We will highlight important solvency concerns that are applicable to Blue Cross as well as the multi-faceted operational realities of our business.

Blue Cross has long been an active participant in Vermont's individual and small group markets. In some years and in some markets we've been the only participant. Blue Cross has also actively collaborated on state health reform initiatives starting more than two decades ago and that promote the public's access to affordable high quality health benefits, and in some of those initiatives we've been the only non-government participant or we have taken on a disproportionate share of the burden.

This filing reflects our holistic efforts to transform Vermont's health delivery system

to one in which every Vermonter has health care coverage and receives timely, effective, and affordable care. In order to support our efforts we need to be able to invest in health care reform initiatives with some investments seeing no return on investment and others with long delayed or disappointingly low returns. If Blue Cross is crippled in its health reform efforts due to lack of investment capital, health care in this state we believe will become less affordable, less accessible, and of lower quality.

Everyone wants health care that is high quality, accessible when needed, and affordable, and the very difficult and complex work required to make the cost of health benefits and, therefore, the rates more affordable cannot be done by Blue Cross alone. Nor does it make long term or short term sense to deplete Blue Cross's financial position to the point that it can no longer afford to protect its members from financial ruin when they need health services. That is the trajectory we are currently on and despite that we remain committed to this market.

The rates we present here for the 2019 benefit packets reflect the product of Vermont consumer protections and health care reforms to date

together with the associated savings and costs that go along with those. The rates also reflect the many millions of dollars of annual savings achieved by Blue Cross through its own care management and reform initiatives.

We do thank Dave Dillon and the team at L&E for their efforts to conduct a thorough review of the filing. Once again L&E's opinion makes clear that Blue Cross's developed rates applying rigorous actuarial standards so the requested rates are adequate but not excessive or unfairly discriminatory, and I realize L&E has not yet looked at the amendment and passed judgment on it, but their original opinion does confirm that our original filing meets those standards.

Our approach, however, is not just to meet the actuarial standards. It is to meet all of the standards. Our filings have always been about meeting all of the standards. The filing supports our payment obligations for necessary health services that are of high quality and to provide access for our members at the right time in the right amount and in the right place while being as affordable as the various mandates and other requirements allow.

The rates are designed to allow us to

pay for the increased costs and the increased utilization of the provider services, hospital stays, prescription drugs, and other medical supplies and equipment which comprise over 90 cents of every premium dollar. The filing as amended will produce rates that are reasonable in relation to the benefits that are to be provided in 2019 while not being inadequate, excessive, or unfairly discriminatory.

We also thank Commissioner Pieciak for his solvency report and the sense of urgency it conveys. The Board's decisions over the last few years have taken Blue Cross in an unsustainable direction financially. We do not agree with that direction and we think the rate approved by the Board should cover the expected costs of the medical care and drugs that we pay for on behalf of our members. The rate should also cover the taxes and the fees that will be paid and they must also cover the cost to administer the plans. That means adjudicating, processing, and paying the millions of claims we receive each year to help providers manage our members care, to help our members access timely and effective care, to assure that care delivered meets high quality standards, and to provide for the maintenance of the policy holders' reserve fund.

This reserve fund is for member protection. It allows Blue Cross to make investments in health care reform, it allows Blue Cross to keep pace with technological challenges that we face while also allowing us to meet the unexpected events which have and will continue to occur.

It bears repeating underfunding Blue Cross's rates is not payment reform and it is not cost contained. It just -- and it does not make the rates more affordable. It simply postpones the day of reckoning and hampers Blue Cross's ability to engage in health care payment reform with other interested parties including the Board.

Finally, during this hearing we will present the Board with the evidence and support for what it is going to take for Blue Cross to have adequate funding to deliver the 2019 plans for tens of thousands of Vermonters. We hope the Board can see its way clear to give Blue Cross a rate that will allow it to continue to serve in this market. Thank you.

MS. HENKIN: Mr. Angoff.

MR. ANGOFF: Thank you. My name is Jay Angoff. I'm with the law firm of Mehri & Skalet in Washington, D.C. I represent the Health Care

Advocate's Office. I appreciate the opportunity to be here today.

We don't believe that Blue Cross has carried the burden that it is entitled to this increase or any increase under the controlling statute, and we'll be questioning Mr. -- the Blue Cross actuary and others and going into a lot of detail. Hopefully it won't put you to sleep, but we will be going into a lot of issues, but let me just address three right now.

First, the most significant is the windfall that Blue Cross gets this year and next year and next year and the year after that under the Trump tax bill. I've got a particular interest in this law because the Trump tax bill raises my taxes. I live in one of those high cost Maryland suburbs and there's a cap on local state and local taxes so it raises my taxes, but it gives Blue Cross a tremendous windfall. Blue Cross gets 16 million dollars back in 2019 as a result of the Trump tax bill making the taxes that Blue Cross has paid for about the last 20 years refundable.

In addition, the tax bill, which is called the Tax Cut and Jobs Act, also eliminates Blue Cross's obligation to pay federal taxes in the

future. Not just this year, but for ever and ever. Now I'll be questioning the Blue Cross actuary on exhibit 5 in their rate filing, and exhibit 5 goes through all the provisions that raise -- in Blue Cross's estimation that Blue Cross thinks are going to raise the amount that it's going to have to pay out next year. Those are estimates. Some we agree with, some we think are reasonable, some we think aren't, but on the one hand Blue Cross includes what it thinks it will have to pay out next year and it totally disregards what it's getting back from the Trump tax bill. You don't see that any place in exhibit 5. So it's all one way stuff. They raise the rates because of things they think are going to happen next year. They don't know but they think, but they refuse to reduce their rates not just based on a projection but based on actual money that they know is being returned. So that's number one. That's what I think the Board should really focus on.

Number two, and I have a little sympathy for Blue Cross on this issue -- not on the Trump tax bill issue, but this issue. Blue Cross has always taken the position that they are just a passive punch taker, that whatever the hospitals say the rate is the rate is and they don't negotiate, and it's true

obviously Vermont's a small state, the hospitals have market power, but Blue Cross has market power. Blue Cross is the dominant insurer by far in this state. Hospitals cannot afford to do business if they don't accept Blue Cross insured payments. So we think Blue Cross can do more.

I know that the Board, I think quite correctly, has put in previous orders that we expect -- we reasonably expect Blue Cross to be tougher with the hospitals. The Board's absolutely right about that, but I think the Board should consider at least doing a little more than just saying we expect and actually reducing the rate, not a lot, but reducing the rate some in order to really give Blue Cross an incentive to get tough with the hospitals. It's a cost plus percentage of cost business. It's really in Blue Cross's economic interest, as ironic as that might seem, to have costs be a little higher because 2 percent of a hundred dollars is less than 2 percent of 101 dollars. So the higher the underlying costs are the more Blue Cross makes. They need a real incentive to cut those -- to get -- to negotiate more stringently with the hospitals.

Third, Blue Cross reads the term affordable and the term quality of care and the term

promote access to health care out of the statute. Blue Cross's actuary says that the rate is not excessive, inadequate, or unfairly discriminatory. We disagree with that and we think we have a compelling case and will show why that's not the case. We think the rate is excessive, but let's assume Blue Cross is right, that their actuary is right. In most states -- in virtually all states that's enough.

I used to be the Insurance Commissioner of Missouri and in Missouri, like all other states, the only test is -- for whether or not a rate is lawful is, is it excessive and inadequate and unfairly discriminatory, and if the company can come in and demonstrate that it's not excessive, inadequate, or unfairly discriminatory, it's lawful. Then Blue Cross would be right if they were in any other state, but Vermont is different.

The Vermont statute says that you all must determine that rate not just is not excessive, inadequate, or unfairly discriminatory, but you have also got to determine whether or not it's affordable, whether or not it promotes quality of care, whether or not it promotes access to care, and Blue Cross's actuary doesn't do that. Blue Cross doesn't carry

the burden on that, and I'm not criticizing Blue Cross's actuary. That's not what an actuary is trained to do, but Blue Cross has not submitted any evidence demonstrating that this rate they are proposing is affordable.

So those are the three issues we'll get into in the cross examination period. There are many more, but based on that we don't think Blue Cross is carrying its burden; and then the -- finally just two points -- two more points. One, the Blue Cross amendment to the filing was filed -- we got notice of it at 6:46 p.m. on Wednesday. Blue Cross filed in this case on May 11th. There was no reason Blue Cross could not have amended this much earlier. Even if they could have amended this earlier, it's unfair to us, much more important it's unfair to you, and most important of all it's unfair to the people of Vermont for Blue Cross to come in two days before the hearing and say oh yeah we're asking for another two and a half percent. So I don't think it's proper to consider that amendment and we recommend the committee -- the Board reject that; and then finally let's not forget the Blue Cross statute -- the enabling act. Blue Cross has an obligation under the statute to provide insurance at minimum cost under

efficient and economical management. MVP doesn't have that obligation. Blue Cross does. It says they have got to provide insurance at minimum cost; not at some point in the midpoint of an actuarial range, but at minimum cost. So Blue Cross is in a unique position. They haven't carried their burden, and we ask and will show during this hearing that Blue Cross is not entitled to the rate increase they propose. Thank you.

MS. HENKIN: Thank you. You can call your first witness.

MS. HUGHES: Great. I call Paul Schultz, Ruth Greene, Josh Plavin, and Andrew Garland.

MS. HENKIN: Witnesses and everyone have taken their oath.

MR. MULLIN: Again we apologize for the lack of space.

MS. HENKIN: Before you start I do want to state that we had a discussion about the procedure before this hearing and you will be asking questions of each of these four and then the HCA will be asking questions I believe was the agreed upon process and then the Board will ask questions after that.

PAUL SCHULTZ,

RUTH GREENE,
JOSHUA PLAVIN, M.D.,
ANDREW GARLAND,
Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HUGHES:

Q. Thank you. My first set of questions are directed to Paul Schultz. Mr. Schultz, what is your position with Blue Cross?

A. (Mr. Schultz) I am the chief actuary in Blue Cross, and before I go any further I'll notice the witness microphone is on the board table. I don't know if it would be helpful to have it over here or if you guys can here us loud and clear.

I'm chief actuary in Blue Cross. In that role I have oversight of the actuarial services and underwriting departments. That includes a number of things including pricing and preparation of rate filings for all of our products including the individual and small business products.

Q. And is your curriculum vitae part of exhibit 15 pages 318 and 319?

A. (Mr. Schultz) Yes. That's correct.

Q. Can you tell us what your professional

credentials are?

A. (Mr. Schultz) I've been a Fellow of the Society of Actuaries since 2001 and a member of the American Academy of Actuaries since 2000.

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

A. (Mr. Schultz) I am. It was prepared under my supervision and I certify it meets all actuarial standards and also that it complies with all federal and state rules and regulations.

Q. And is that exhibit 1 of the binder?

A. (Mr. Schultz) That is.

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

A. (Mr. Schultz) Sure. As with any pricing exercise there are many component parts. The largest and most meaningful of those is a projection of allowed claims costs. So to do that projection we start with 2017 calendar year experience for the QHP population. That's over 800,000 member months within those plans.

We then trend that -- excuse me. We trend that claims experience forward to 2019. We adjust for any anticipated or known population changes as well as any known regulatory changes, and finally we apply a set of what are called allowed factors or allowed adjustments to

translate allowed claims to paid claims. Paid claims are amounts paid by the health plan as opposed to those paid through member cost sharing that go to providers for providing care to members of these plans. So that projection of claims accounts for about 90 percent of the premium dollar.

To that we add a number of components. Administrative costs come in at just under 7 percent of premiums. Again for those we start with 2017 as our base year for experience. We remove any one time items that are not expected to recur and then we trend that forward. For that we use inflation and wage growth to trend those numbers forward to 2019. We also have to add taxes and fees to that total. That's about 1 percent of the premium this year. That's lower than it has been in the past because of the one year hiatus of the federal insurer fee. So one percent there, and then at the direction of management we added one and a half percent for a contribution to member reserves.

Additionally we add 0.1 percent for what we call the cost of bad debt which is essentially members who drop their coverage during the year and sometimes haven't paid their premiums until that time. So uncollectible premiums arise worth 0.1 percent.

Q. And does that contribution to reserve include

profit?

A. (Mr. Schultz) No. There is no profit. We are a local Vermont non-profit company. We don't have a parent company. We're not beholden to Wall Street. There's no profit in these rates.

Q. Did Blue Cross file an amendment to its original filing?

A. (Mr. Schultz) Yes we did. We filed an amendment on July 18th.

Q. And why did Blue Cross do that?

A. (Mr. Schultz) There were a number of changes. There were two statutory changes in Vermont that affected 2019 -- or will affect 2019 benefits and, therefore, rates. There was also regulation that was promulgated by the federal government after the date of the filing regarding association health plans. The Vermont Department of Financial Regulation is expected to promulgate emergency guidance also with respect to AHPs. Because of these changes we needed to make an amendment to our rate filing.

Q. And are you familiar with the contents of the amendment that was provided to the Board?

A. (Mr. Schultz) Yes I am. I also supervised the preparation of that amendment.

Q. And would you describe the contents of the

amendment?

A. (Mr. Schultz) Yes. So we actually started with the Lewis & Ellis recommendations which we do not oppose. So that formed the starting point of our amendment. From there we added the cost of two new Vermont state laws which impact 2019 benefits, one having to do with chiropractic co-pays, the other having to do with breast imaging. Those two things combined added an average of about 0.1 percent to rates. Not a huge amount.

We then layered on top of that a factor for association health plans. We do expect there to be a pretty significant migration of small groups from qualified health plans to association health plans in 2019 because of these recently released federal and expected state rules. Those changes increased the rate by about 2.1 percent on average.

Q. And does this amendment include any change for the recent federal actions regarding the risk adjustment program that's headlined in the news?

A. (Mr. Schultz) No. There's nothing in the amendment for that. So the federal government has suspended payment of risk adjusted amounts for 2017 and that's expected to impact 2018 as well. However, we do not believe that will have any impact on 2019 risk adjustment, therefore, we did not include anything in the

amendment for that.

Q. So I'm going to show you what has been marked exhibit 17 for the record. Mr. Schultz, can you identify for the record what exhibit 17 is?

A. (Mr. Schultz) That is the rate amendment that I just summarized at a high level.

Q. And was this amendment provided to the Board, to Lewis & Ellis, and counsel for the Health Care Advocate on July 18th?

A. (Mr. Schultz) Yes. That's right.

Q. And was that the first that the Health Care Advocate knew that we were interested in filing an amendment?

A. (Mr. Schultz) Honestly I don't know the answer to that.

MS. HUGHES: So I move for admission of exhibit 17 into the record.

MS. HENKIN: Mr. Angoff?

MR. ANGOFF: We object. We think it's improper. If it is going to be admitted, we would ask for a substantial extension of all the deadlines so we can review it and challenge it.

MS. HENKIN: I have reviewed the document and the justification for the document as to the timeliness of the information and the timing of

the filing of the initial -- the initial rates through SERFF. I'm going to admit the document. I do understand not only has the HCA not had the opportunity to really review the document, the board members have not, our actuary has not. We do have a provision that allows for up to 30 additional days for the Board's decision. This hearing today we will leave this issue open while we await some responses from the carrier on the amendment. We can discuss it today, and if we have to reopen this hearing for open discussion we will do that also, but we do have up to an additional 30 days, and I am not going to extend any deadlines at this moment and we will discuss that at the end of today's testimony.

MS. HUGHES: Thank you.

MS. HENKIN: So exhibit number 17 of Blue Cross is admitted into evidence.

BY MS. HUGHES:

Q. Just some light reading. So, Mr. Schultz, in your professional opinion was this amendment necessary?

A. (Mr. Schultz) Yes it was because of subsequent actions taken by the Vermont Legislature and also subsequent regulation that was released by the federal government and is anticipated to be released by DFR. This amendment was necessary to meet with all the rules around

this rate filing. Specifically rates would have been inadequate in the absence of this amendment.

Q. So as you developed the filing and the amendment what was Blue Cross's objective?

A. (Mr. Schultz) Our objective was to return a contribution to member reserves of our target of one and a half percent, and to do that while using actuarial assumptions that are reasonable both individually and in the aggregate and also in complying with all state and federal regulations and rules.

I want to expand on that a little bit. I want to make it clear we've talked about ranges of reasonable assumptions. I want to make it clear we are not filing at the high end of the range of reasonable assumptions. We are not filing to try to recover the CSR dollars that were defunded in late 2017 and through 2018. Those are in the past. None of that is part of this rate filing.

We are filing for an one and a half percent contribution to reserves which is the amount which is necessary to maintain reserves at an adequate but modest level of solvency that our solvency regulator has insisted that we maintain.

Q. So can you give us an overview of the assumptions other than trend that went into the filing and the subsequent amendment?

A. (Mr. Schultz) Yes. There are a number of those so I'll start with population changes and that had a number of component parts. There was a very small change for newly insured members. There was a much larger adjustment for members who left us from 2017 to 2018. There was a fairly significant migration away from Blue Cross and it turns out that the healthier members are the ones who left us. So that has an increase on our claims cost. That increase was almost perfectly offset by an expected increase in risk adjustment receivable.

Additionally, we took a look at continuing members and for continuing members we've observed over time that the risk pool -- the single risk pool in Vermont has been aging at a pace that adds about a half percent per year to claim costs and so we've reflected that in our assumptions, and finally we include an assumption for selection which is members tend to make financial decisions that are in their best interest. We need to reflect that in our rates. So all those assumptions are in there.

Beyond that we had to make assumptions for a number of new federal regulations. The first of those I mentioned, the defunding of CSR benefits which are cost share reductions available to low income Vermonters. The federal government no longer funds those. In response

Vermont passed what we referred to colloquially as our silver solution. So we are loading the silver on exchange plans with the cost of those CSR benefits. Premiums are higher for those plans, but members in those plans are protected from premium increases because the federal premium subsidies will increase at the same pace.

We also have now silver reflective plans which are exchange plans that look almost exactly the same as the on exchange plans but are available at rates that are more coordinated with what the rates have been in the past. So they don't include the cost of those CSR benefits. Because of all these changes we needed to include assumptions as to how members would migrate from plans that are becoming silver loaded into some of these other plans, whether that's reflective plans or they might stay on the exchange and choose a bronze plan or a gold plan that will have really close to the same price tag as the silver plan. So there will be a lot of membership movement. We had to reflect that.

Additionally the federal government also had a couple other things I mentioned. AHPs that's part of our amendment. For association health plans as of 2014 Vermont decided -- I'm sorry. Vermont decided that as of 2014 associations would no longer be able to offer health plans to small groups. Small groups could only purchase

insurance through the exchange. Recently federal regulations have kind of changed that paradigm. They have stated that small groups who ban together in an association can be treated like a large group for rating purposes. So with that new regulation a number of associations who used to offer health plans prior to 2014 and have continued to operate, they have continued to exist as associations to offer many other benefits other than health benefits to their employer members, they have approached us with an -- and expressed great interest in getting back into the health benefit market. They want to offer these association health plans starting in 2019. So our sales department worked with these associations to develop reasonable membership assumptions based on expected pricing differential between qualified health plans and association health plans. We expect about 8,000 of our QHP members to migrate to AHPs -- I'm sorry, association health plans in 2019.

We did make -- we basically said those people will come from all across the small group spectrum with one exception. We did take note that there are a number of small groups that offer only platinum coverage to their employees. This is similar to prior to 2014. There were some associations out there that offered very rich coverage. Typically that's also augmented by HRAs or

HSAs. We believe that these small groups who only offer this very rich coverage will not be interested in association health plans that are expected to have much leaner plan designs than the platinum plan. For that reason we think these platinum groups as we're terming them will remain on the exchange, but these 8,000 members will come from across all the other benefits, including individuals who are in platinum plans but weren't in a group that offered only platinum plans, we assumed all these folks would migrate to AHPs.

Q. Did you in any way address the repeal of the individual mandate?

A. (Mr. Schultz) Yes. Thank you. We did also do that as part of the changes due to federal regulation. The penalty associated with the individual mandate which was appealed at the federal -- I'm sorry, was made zero at the federal level. The mandate exists at the federal level. The penalty that exists with it is now zero. So as a result of that we expect there to be a number of healthy individuals who drop their coverage in 2019. To come up with these assumptions we looked at historical experience for members who had no or very low claim costs and we assumed these members would make a decision to drop coverage -- or many of these members would make a decision to drop coverage in 2019.

Vermont has recently passed a law with an individual mandate specific to Vermont that starts in 2020. It will have a yet to be defined penalty associated with it. We do not believe that this will impact anyone's decision in 2019 because members can drop their coverage in 2019 and then reenroll in 2020 with no penalty. I also want to point out that the assumptions that we made are in line with best estimate assumptions that were developed by an actuarial study that was published by the Board.

Q. And do we know more about the risk transfer program after the filing was made?

A. (Mr. Schultz) We do. So there were a few other assumptions that went into the filing. Risk transfers are one of them. At the time of filing we had an assumption based on the information we had available at the time. After the filing more -- knew more about the 2017 risk adjustment. This was part of our amendment and part of the L&E recommendations. So it was included in the amendment. We also had to make some assumptions as to administrative costs, how are those going to trend forward over time. We included a 3 percent assumption for wage increases and a zero percent assumption for all other items.

Q. And did you consider paid to allow factors for the plans?

A. (Mr. Schultz) We did. That's another set of assumptions. So I mentioned we start with allowed claim costs paid to allow adjustments. Take us from allowed costs to paid costs. So paid claims are the portion paid by the benefits that we offer as opposed to member cost sharing. So there is a pricing actuarial value. I want to make sure we distinguish that from the metal level actuarial value. The metal level value is based on a federal calculator with a nationwide set of experience data within it and that defines whether a plan is bronze or silver or gold or platinum. The pricing actuarial value is developed specifically based upon Vermont utilization within QHPs, and that calculates how much of a given plan design will be paid by the Blue Cross benefit as opposed to member cost sharing. Also as part of that there's a benefit richness adjustment and that basically reflects that members in richer plans tend to use their benefit more frequently. That particular assumption is based upon federal factors.

Q. So that was the non-trend assumptions. Can you describe your trend assumptions for the Board?

A. (Mr. Schultz) Sure. So trend is probably the most meaningful assumption that we make and I'll discuss medical and then pharmacy trend. Medical trend we split into two pieces. We have utilization trend and unit cost

trend. As part of utilization trend that not only includes the number of services it also includes the mix or intensity of those services. So to develop a utilitization trend we look at past and emerging patterns of care, and in doing that we developed a utilitization trend assumption of 2 percent. That 2 percent has been corroborated by Dr. Plavin, our chief medical officer, in terms of the drivers of that 2 percent trend, and those include a few main ones that I want to go through.

So pharmaceuticals dispensed in a medical setting have increased by about 15 percent from 2016 to 2017. So it's a pretty huge jump. These are similar to specialty drugs on the retail pharmacy side that we know are also increasing at a very fast pace. Some of these are life saving medications, but they are very expensive. So these include things like cancer drugs, rheumatoid arthritis drugs, immuno deficiency drugs. All these are wonderful things for our members. They in some cases cure diseases or increase quality of life, but they are expensive and they are driving up the utilization trend.

The second thing we noticed was an increase in office visits and preventive care. Those went up 4 and 7 percent respectively from a utilitization perspective. This was primarily driven by an increase in mental health professional services which we see as driving care to the

correct setting and getting people the care they need and that will prevent higher claim costs in the long run. We also saw a pretty significant uptick in colonoscopies which also is a good thing. The evidence actually does not indicate that this will reduce costs in the long run, but it will identify cancers earlier and it will save lives. So for that reason it's important that folks get their colonoscopy screenings. So we see that again as a positive development even though it is driving utilization upward.

Finally we saw increase in diagnostic services; x-rays, labs, imaging. We think that's associated with the increase in primary care and office visits that we saw. So that's utilization trend.

Unit cost trend consists of a few pieces as well. A portion of that, about a little over 50 percent of medical costs, are for facilities that fall under the jurisdiction of Green Mountain Care Board in their hospital budget review process. So for those facilities we made the assumption that increases would match those from last year except unless a facility had made a public commitment to a commercial rate increase that was lower than what they had last year. In that case we worked it into our projection.

We also have other providers with whom Blue

Cross directly contracts and we have out of area providers that are accessed through our blue card system. We don't directly contract with those out of area providers. So where we contract we included anything we know about, ongoing contract negotiations and our unit cost trends and for everything else we provided -- I'm sorry -- we relied upon Blue Cross Blue Shield Association trend survey that demonstrated how costs are increasing elsewhere in the country.

Q. And how about pharmacy trend is that one of the trends that you were -- that you included in the filing?

A. (Mr. Schultz) It is. Yes. So the pharmacy trend used a similar approach to what we did with medical utilization trend looking at past and emerging patterns of care, but we tempered that in a few ways. One thing we did was to look specifically at drugs that are losing their patent protection and moving from brands to much less expensive generic utilization. So that became part of our trend.

We also took a look at specialty medications. These are similar to the medications that are dispensed in facilities and they are very high cost but often life saving drugs. They make up almost the entirety of the drug pipeline. Almost every drug that you will see come

out over the next few years will be a very high cost specialty medication. These are curing previously incurable diseases in some cases and in all cases they are greatly improving quality of life. We cover those for our members. It has a pretty profound impact, however, on the pharmacy trend. So with all those considerations pharmacy trend in total is 13.3 percent. We did separately consider our negotiations with our pharmacy benefit manager in terms of pricing. So 13.3 percent is without those pricing considerations, and we add in those, that pricing, it has the impact of reducing the 13.3 percent trend down to about 9.9 percent.

Q. And did you make any subsequent amendments to trend to reflect Blue Cross initiatives?

A. (Mr. Schultz) We did have another change that impacts trend. I want to avoid I think the use of the word amendment. This was not part of our amendment, but in our original filing we included the impact of a cost containment effort that we're implementing in conjunction with our providers and in conjunction with OneCare Vermont and this effort has two primary goals. One is to reduce hospital admissions by 4 percent by reducing readmissions. Two is to reduce emergency room visits by 5 percent, and we're going to achieve those things through a collaborative care coordination process that in some cases

directs care more appropriately to primary care providers. This initiative is expected to have an impact on trend, if you include it within trend, of about 1.1 percent. So it will reduce our trend from 2 percent utilization trend for 2018 to 0.9 percent utilization trend for 2019. That in turn has an impact of about 0.8 percent on premiums.

Q. Did L&E offer any opinion on your trend assumptions?

A. (Mr. Schultz) They did. They opined that both our medical and our pharmacy trend assumptions matched their best estimates. They are at the midpoint of their expected ranges.

Q. And do you agree with that portion of their opinion?

A. (Mr. Schultz) I don't. I think it's misleading for L&E to have included our cost containment strategy as part of trend. That's a separate initiative. Trend is a look at how costs have been changing in the past and are expected to continue to change in the future in the absence of some sort of external event that acts upon them. So when they looked at utilization trend they agreed that 2 percent was the best estimate and they provided a range of 1.6 percent to 2.4 percent. They similarly agreed that 2.7 percent was our best estimate for cost trend. When you put those things together you

get a range of 4.2 percent to 5.2 percent. That's different from the range they published in their report because in their report they threw the cost containment into there.

So the distinction I want to draw is that Blue Cross is moving trend from an expected range of 4.2 percent to 5.2 percent. In 2018 we are at the midpoint of that at 4.7 percent. In 2019 we are moving that down by the 1.1 percent, I mentioned, for the cost containment efforts. So our 2019 trend is 3.6 percent. That's well below the 4.2 percent to 5.2 percent range. In fact, it's even below the range that L&E published in their report that I think is misleading because it did incorporate those efforts already.

So we are making efforts to reduce trend below the high point of the range. In the past the Board has made adjustments to trend to move it to the low point of the range. That would be clear error this year because Blue Cross is already taking the initiative to implement programs that will move that trend line below the low point of L&E's range.

Similarly on pharmacy trend I noted that the 13.3 percent trend which L&E agrees is best estimate is before Blue Cross contracting efforts. Those contracting efforts will have the impact of moving that trend down to

9.9 percent which is far below L&E's best estimate.

Q. What contribution to members reserve was requested?

A. (Mr. Schultz) We filed a 1.5 percent contribution to member reserves that is a long term assumption that is -- that's the minimum long term assumption necessary for us to keep pace with the increase in medical claims as well as unforeseen adverse events.

Q. And can you give us examples of unforeseen events that have actually occurred?

A. (Mr. Schultz) Yes. We actually answered that question as part of the Q&A. That's in section 9 of the binder starting on page 258. We provided quite an enumeration of the number of unforeseen adverse events that have actually happened to us over the past five years. It's a long list. I don't want to read the whole thing for you, but I do want to highlight a few of these just to show kind of the variety of unforeseen events that can occur. So I'll kind of just pick one from each year.

So federal regulation has been fairly dynamic shall we say under the Trump Administration. We kind of never know what we're going to get. In some cases we're able to react to that and build it into rates. In other cases we are not. CSR defunding occurred in late 2017. We were not able to build that into rates. As a result,

we expect about a 7 million dollar hit to surplus for us living up to the promises we made to members and covering them for those cost share reduction plans. Those monies will not be refunded by the federal government. It will come out of surplus. It's about 7 million dollars.

If we look at 2017, the Green Mountain Care Board made explicit cuts to utilization trend that are below the recommendation of their actuaries. That lower utilization trend did not materialize and we will have to use about 4 million dollars of reserves. We did in fact use about 4 million dollars of reserves to cover those additional claims beyond what we were able to put into rates.

In 2016 within the large group line of business we covered premature twins who were born in late 2016 and required several months of intensive care. They were eventually discharged and we paid a medical bill of about a million dollars for those twins. Obviously we can't include that sort of thing into rates. So that million dollars essentially comes out of surplus.

If we go back to 2015, actuarial projections can be challenging in a time of significant change or uncertainty. In other words, we're not always right. So when the ACA was first implemented once we were able to look at experience we noticed that individuals were making

plan selections that were right for them financially, but our rates did not include that within premiums. We therefore needed to make an adjustment moving forward. We started making that adjustment with our 2016 rate filing. That's the selection adjustment I mentioned earlier. It's still in our filing today, but because we didn't recognize that, that adjustment needed to be made for 2015, that cost us about 7 million dollars. So again that means money comes out of reserves.

The final one I want to point out, if we go to 2014, because of issues with the rollout of Vermont Health Connect in early 2014 we had a number of members who did not yet have their ID cards. So what Blue Cross did is if members showed up at the pharmacy they didn't have an ID card but they said that they had tried to enroll through Vermont Health Connect and into a Blue Cross plan, we covered their medications free of charge. So that program was about $200,000, which is not the largest number that I mentioned, but we can only implement those sorts of programs to help see Vermonters through difficult changes in their health care if we have an adequate level of reserves.

Q. So what is Blue Cross's average requested rate increase?

A. (Mr. Schultz) Our average requested rate

increase is 6.7 percent -- I'm blanking 6.9.

Q. 6.9.

A. (Mr. Schultz) Thank you and that is the amount that Vermonters will actually feel. Okay. So when you think about loaded plans those rates are going to be going up by 20 percent very nearly on average, but because federal premium subsidies will go up at the same amount at the same pace, or in our case probably even at a faster pace than that, Vermonters wouldn't feel that change. So concentrating only on what individuals and small businesses will feel we're at 6.9 percent. That's after the amendment that we filed.

Q. And since 2014 what is Blue Cross's actual realized contribution to reserves for this business?

A. (Mr. Schultz) For this line of business it's negative 1.2 percent.

Q. And what did Blue Cross expect after regulatory action for the same time horizon?

A. (Mr. Schultz) We expected positive 0.7 percent.

Q. And what was the Green Mountain Care Board's approved CTR for this period?

A. (Mr. Schultz) An average of about 1.2 percent.

Q. So why doesn't the approved CTR match the expected CTR?

A. (Mr. Schultz) The Green Mountain Care Board sometimes orders reductions to assumptions below those that were recommended by their actuaries. In that case we absolutely implemented them in the rates, but we don't build them into our forecast of expected results.

Q. And are those the CTR or are you talking about other assumptions?

A. (Mr. Schultz) Talking about other assumptions -- trends and assumptions other than that.

Q. And what do you conclude about those results?

A. (Mr. Schultz) Well I think it's clear that our rates have been inadequate over the past four years. I would also say that it's very clear that since actuarial results have been an average of 2 percent lower than expected results that our assumptions have not been at the high end of the range. In fact, if anything, they have been too low.

Q. And can you walk us through the numerical components of the 6.9 percent?

A. (Mr. Schultz) Yes. So as with any projection or any assessment of how rates change from year-to-year we need to start with actual experience. So if we look at 2017 experience and compare it to the 2017 experience, implicit in last year's rate filing we find that they are almost exactly equivalent which is good news. We also

find that risk adjustment was significantly higher in terms of the receivable to us than what we expected. So in combination those things drive a reduction of rates of about 1.3 percent.

Far and away the biggest driver of the increase in rates is trend. Trend increases rates from '18 to '19 by about 7.3 percent. That consists of all the different components I talked about earlier. So for utilization trend, as you recall the Board last year reduced utilization trend from 2 percent to 1 percent. We reexamined that this year. We continue to see evidence of a 2 percent utilization trend. So in restoring that to a 2 percent level and projecting it forward another year that impacts premiums by about 2.3 percent for utilization trend.

For unit cost trend those increases drive premiums up by about 2 percent. Pharmacy trend, which I indicated was 13.3 percent before our contracting efforts, drive an increase of about 3 percent of premiums. So those three things together are about 7.3 percent.

We had a number of other factors. I talked about the population adjustments that we made. There were also some benefit tweaks that were made to the plans including the recently enacted statutes. All those things combined increased rates by about a half percent.

Looking at CTR, restoring CTR to an adequate level increased rates from 2018 to 2019 by one and a half percent. Administrative expenses and other fees increased rates by about 1 percent. That includes 0.6 percent in terms of an increase for Blue Cross administrative costs. So to kind of frame that in a somewhat different way if we were not projecting any increases in claims and we did not have to restore CTR to its adequate level, we would be looking at a 0.6 percent rate increase as part of this filing.

Finally we talked about the number of federal changes that we had to take into account. One was good for premiums. The federal insurer fee was suspended for a year. That lowers premiums by 2 percent. The other two unfortunately were not helpful to qualified health plan premiums. The individual mandate had the impact of increasing costs by about 2.2 percent -- increasing premiums I should say about 2.2 percent, and association health plans coming on the market and giving small groups an alternative to QHPs is expected to increase the cost of premiums for QHPs by an additional 2.1 percent.

So it's a lot of numbers. If anyone was keeping a running a tab, what you get is an 11.6 percent rate increase. I testified our actual filed rate increase is 6.9 percent. The difference between those two are rate

mitigation actions that were taken by Blue Cross Blue Shield of Vermont. There are a number of these. First we made good on our promise to Vermonters that all realized benefits of tax reform would be passed along to them. So we lowered premiums by 1.1 percent in recognition of tax reform.

Secondly, in terms of pharmacy contracting we worked very closely with our pharmacy benefit manager to do two things. One is to significantly improve our discounts at retail pharmacies and mail order pharmacies. Also our discounts on specialty drugs. Additionally we worked with them to maximize the rebates that we received from drug manufacturers. All those things together benefited rates about 2.3 percent, and finally it was discussed earlier the cost containment efforts that were undertaken in conjunction with providers and with OneCare Vermont on the medical side those items decreased rates by another 0.8 percent. In total that's 4.2 percent of rate mitigation that Blue Cross has worked hard to achieve over the past year which is about 16 million dollars in rate reductions.

Q. So, Mr. Schultz, do you have what has been labeled exhibit 18 in front of you?

A. (Mr. Schultz) I do.

Q. And can you please identify that for the

record?

A. (Mr. Schultz) Yes. This is a graph showing the components of average filed Blue Cross premiums over the past three years. This is -- this was prepared under my direction from information that's readily available in each of last -- in this and the previous two rate filings before the Board.

Q. And is it a summary?

A. (Mr. Schultz) It is.

Q. And what is it a summary of?

A. (Mr. Schultz) So this is a summary of the various components of average filed premium and I can describe those. So we have -- does everyone have this in front of them?

MS. HUGHES: So I would ask that exhibit 18 be admitted into the record.

MS. HENKIN: We have not seen them up here yet. Mr. Angoff.

MR. ANGOFF: No objection.

MS. HENKIN: No objection. Exhibit number 18 is admitted into evidence.

BY MS. HUGHES:

Q. So, Mr. Schultz, can you briefly describe the contents of the graph starting with the axes?

A. (Mr. Schultz) Yes. So the vertical axis is

average premium in dollars per member per month. The horizontal axis is time. Each of our three years that we observed. The various areas within the graph, at the bottom the blue area represents administrative expense and contribution to member reserves that we filed in each of these three years. The green area above that is representative of claim costs for each of the three years. At the very top we have a red area. That shows the taxes and fees that were inherent in each filing. You will notice that kind of varies from year-to-year. The big difference being the federal insurer fee was in place in 2018. It was not in place in 2017 or 2019, and, finally, there's this yellow triangle at the top. This shows the impact on 2019 rates of various federal regulation that has come out over the past year. So that's not -- that's association health plans. That's also the removal of the penalty for the individual mandate. That also shows CSR defunding. This is prepared -- while I talked about the impact held by Vermonters in my previous testimony, this is the overall average increase. So it does include that's the silver load. So that's what's in the yellow triangle.

Q. So what does this graph show in terms of average filed premium increases?

A. (Mr. Schultz) So what it shows is that the

vast majority of average filed premium increases 90 percent as I testified earlier is due to the -- because of payments made to provider for care that they provided to Vermonters in these plans.

Q. And you're familiar with the recommendations prepared by the Board's actuary?

A. (Mr. Schultz) Yes I am.

Q. And is that exhibit 13 of the binder?

A. (Mr. Schultz) That is exhibit 13 of the binder.

Q. And how many recommendations has Lewis & Ellis made?

A. (Mr. Schultz) There are five recommendations.

Q. And can you describe the nature of the first four recommendations?

A. (Mr. Schultz) The first four were recommendations for changes to actuarial assumptions having to do with population changes.

Q. And do you oppose any of those recommendations?

A. (Mr. Schultz) We don't oppose any of them. In fact we incorporated all four of them into our amended filing.

Q. And what about the fifth recommendation?

A. (Mr. Schultz) The fifth recommendation was

that the Green Mountain Care Board should consider hospital budget submissions as part of their decision as well.

Q. And are you familiar with the hospital budget submissions that were recently filed with the Green Mountain Care Board?

A. (Mr. Schultz) Yes. I've reviewed a summary of the commercial rate increases included in those submissions that was prepared based on information publicly available in the Green Mountain Care Board web site.

Q. And what impact would those hospital budget submissions, along with any other known contracting changes, have on your unit cost trend assumptions?

A. (Mr. Schultz) We would need to increase our unit cost trend from 2.66 percent to 2.99 percent. I can split that out a little bit. We would need to increase our unit cost trend for providers under the purview of the Green Mountain Care Board hospital budget review to 3.2 percent and we would decrease the unit cost trend for other providers to 2.8 percent.

Q. And what about UVMMC?

A. (Mr. Schultz) Right. So the largest driver of that is UVMMC. They publicly committed to a 0 percent commercial rate increase and that's what you'll find in

our filing. Their hospital budget submission includes a 4 percent commercial rate increase.

Q. And was that commitment made to the board in February?

A. (Mr. Schultz) It was. Yes.

Q. Do you intend to resubmit the filing to reflect the increase in unit cost trend represented by these changes?

A. (Mr. Schultz) No we don't intend to. They were not included as part of our amendment either. We believe that the Board will be able to manage the unit commercial rate increases for these hospitals down to the level that was included within our filing.

Q. And are there any areas of disagreement between you and the Board's actuary with respect to their explicit recommendations?

A. (Mr. Schultz) They were none with respect to their recommendations. As I mentioned earlier we do have a disagreement with them in terms of how they presented their range for trend.

Q. So turning again to the binder that's been provided to the Board and contains the exhibits that have been admitted into evidence are you familiar with exhibits 2 through 12?

A. (Mr. Schultz) Yes. These are all responses we

provided as part of the Q&A process, questions submitted by either Lewis & Ellis, the Board's actuary, by the Board themselves, or by the Health Care Advocate.

Q. And were you involved in drafting the responses to those questions?

A. (Mr. Schultz) I was. I actually signed the responses to 2 through 8 and to 11 and 12, and I was involved with the responses included in the binder as 9 and 10 and I'm familiar with their contents.

Q. So exhibits 1 through 12 and 17, all of which are now in evidence, does that comprise the complete filing that the Board has under consideration?

A. (Mr. Schultz) Yes. That's correct.

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

A. (Mr. Schultz) Yes I am.

Q. And in your professional opinion are the rates as filed, including the amendment, adequate?

A. (Mr. Schultz) Actuarial standard of practice number 8 provides guidance to health care actuaries who were submitting rates as part of a filing and review process. Within that standard of practice they define rates as adequate if they provide for payment of claims, administrative costs, taxes, regulatory fees, and a reasonable contingency or profit margin. These rates are

not inadequate.

Q. And are they excessive?

A. (Mr. Schultz) Neither are they excessive. The same standard of practice defines excessive rates as those that exceed what's required to pay for the things I just mentioned; claims, administrative expenses, taxes, fees, and a reasonable profit or contingency margin.

Q. Are they unfairly discriminatory?

A. (Mr. Schultz) They are not.

Q. And are they reasonable in relation to the benefits that will be provided in the 2019 plans?

A. (Mr. Schultz) Yes they are reasonable.

Q. And are you familiar with the other statutory standards that apply to this filing?

A. (Mr. Schultz) I am. They include affordability and promoting access to care and promoting quality care.

Q. And do the rates as filed meet the standards of promoting access to care and promoting quality care?

A. (Mr. Schultz) They do meet those standards. We did provide some of those responses within the Q&A that has been admitted into evidence and my colleagues will expand upon those standards in their testimony.

Q. And are the rates affordable?

A. (Mr. Schultz) That's an interesting question.

So to address that I would like to first turn to exhibit 18 again. I want to address some lines on this exhibit that I did not address earlier. There are three dotted lines on the page and I'll start from the bottom and work my way up.

The bottom dotted line is the blue line above the blue area of the graph. This shows the maximum administrative expense and CTR, combination of those two things that carriers are allowed under federal and Vermont laws. What's notable here is that our actual admin and CTR is about 60 percent lower than that maximum. If you go other jurisdictions, you will find for profit carriers in those jurisdictions filing rates that are much closer to that maximum dotted line.

Similarly if we move up to the gray dotted line that's before the red area, that shows what premiums would have been had we filed at the maximum allowable sum of admin and contribution to reserve. The rates are about -- that we did file are about 10 percent lower than that gray dotted line.

Finally, there's a purple dotted line at the very top of the graph. The difference between the gray and the purple lines are Blue Cross Blue Shield care management and fraud waste and abuse efforts. Notably these efforts in 2019 reduced premiums by about 8 percent.

They would be about 8 percent higher if we didn't have those programs and they weren't part of what we do. Notably that 8 percent is very close, in fact it's within a dollar, of the administrative costs and contribution to reserve that we include in the filing. So, in other words, we essentially pay for ourselves through our care management and fraud waste and abuse efforts.

I also want to consider as part of this graph -- again I want to return to the green which represent, along with the yellow -- the green plus the yellow represents payments to providers for care they provide to Vermonters. Again this is 90 percent of the total premium. Since these rates are not excessive they can only be unaffordable if the underlying cost of care represented by this green area is unaffordable.

Now when the Green Mountain Care Board makes cuts to rates that are below the recommendation of their actuaries they are effectively requiring Blue Cross fund the difference out of surplus and in doing so are creating a conflict between affordability and solvency. In the absence of such rate cuts that conflict does not exist. The Department of Financial Regulation has opined that solvency is the most basic aspect of consumer protection. In fact, I would say that solvency is the most basic tenet of affordability.

Q. And can you explain some of the policy choices that have been made that affect affordability or the cost of the benefits and the payments that are being made to providers?

A. (Mr. Schultz) Absolutely. So affordability really can't be assessed in the absence of looking at policy and Vermont has made a number of policy decisions over the last several years that do impact affordability. Notably Vermont decided that at the onset of the program that members making less than 300 percent of federal poverty level the premiums would not be affordable for these members, therefore, they implemented the Vermont premium assistance and additional cost share reductions for members below 300 percent of FPL. Notably they did not implement similar programs for members making more than 300 percent of PPL.

As the Board is aware the state has convened a working group that has been looking at a 1332 waiver that would leverage federal dollars as well as state funding to make premiums more affordable for everyone. Blue Cross has been a very active participant of that work group.

I want to address age rating. Vermont does not allow age rating. There's only one other state that does not allow age rating. We're all familiar with those depressing studies that come out every year from the

Kaiser Family Foundation that showed generally speaking Vermont has the second highest rates for a 40-year-old non-smoker. Those come out every year. If Vermont allowed age rating as almost every other state does, rates for a 40-year-old would be more than 200 dollars lower than they are today. That would completely change the dynamic. In those studies Vermont would show not at the top of the premium list but in the bottom quintile of states for affordability for a 40-year-old. Let me explain that a little bit differently.

Vermont's decision and policy was to make this one of the very best states to purchase insurance if you're older than 55 or so because younger members are required to subsidize the costs of older members. Of course the flip side of that policy decision is to make this among the very most expensive states in the union to get insurance if you're younger than age 45 or so. The break even is about age 52. So circling back a little bit if those studies looked at the average 52-year-old instead of the average 40-year-old, Vermont would be in the 10 most affordable states to purchase health insurance for an individual. So Vermont could very easily make this coverage more affordable for young families if they decided to allow age rating. The policy decision on the other hand was to make this -- make these rates very, very

affordable for individuals who are nearing retirement.

Q. So those things that you just described can you relate them to the green area on exhibit 18?

A. (Mr. Schultz) Yes. For each of those three they don't really change the size of the green area, but they do change who pays the premium for that and it makes it more affordable or less affordable for a segment of the population or for the whole population.

There is one other policy consideration I want to address and that's the cost shift. Because Medicare and Medicaid do not fully fund what they pay providers, in other words, provider costs are not fully funded by what Medicare and Medicaid pays them, those costs need to be shifted to private commercial payers. That includes individuals, small businesses, and large groups. It's arguable that large employers have the deep pockets that are necessary to bear the burden of the cost shift and continue to pay a substantial portion of the premium on behalf of their employees. It is arguable as to whether individuals and small groups who are paying these costs out of their pockets can or should also bear the burden of the cost shift.

Q. So can the Green Mountain Care Board influence the green in the hospital budget process?

A. (Mr. Schultz) Yes. So policy isn't the only

way to make this more affordable. We can also take action to actively reduce the size of this green area. The Green Mountain Care Board is a key and valuable player in that both through your hospital budget review process, through your oversight of payment reform and many other initiatives. Blue Cross is also a key player in this through our own cost containment efforts, through our own payment reform initiatives, and in fact it is -- all we do everyday is work hard at reducing the green and the blue bars. We have every motivation to do so. It's part of our mission to do so. So we do everything we can to reduce that while still maintaining access to care.

So I think there are two ways that we can make this more affordable. One is by prioritizing affordability over access to care and my colleagues will describe that in a little bit more detail. The other way is to create policy change and change that regulatory and statutory environment. Blue Cross is ready to and willing to lead with the Green Mountain Care Board in making those changes happen just as we have worked hard over the past year to include 16 million dollars of rate mitigation in this year's rates.

Q. Thank you, Mr. Schultz. I would like to reserve calling Mr. Schultz in rebuttal if necessary. Probably won't be necessary, but I just wanted to reserve

that right.

MS. HENKIN: See how our time is going. We should have time to do that.

MS. HUGHES: Thank you.

BY MS. HUGHES:

Q. So, Ms. Greene, could you identify your position at Blue Cross?

A. (Ms. Greene) Yes. I'm Ruth Greene. I'm the treasurer and CFO at Blue Cross Blue Shield of Vermont. I've been there about five and a half years and I'm responsible for all the financial management functions of the company including treasury function, financial reporting and controls, as well as the actuarial and pricing function.

MS. HENKIN: Ms. Greene, can you speak up a little? Maybe we'll turn this mike around also. Thank you, Kevin.

BY MS. HUGHES:

Q. And is your CV attached as part of exhibit 15 pages 320 through 322?

A. (Ms. Greene) Yes it is.

Q. So have you read the solvency opinion that has been submitted by the Department of Financial Regulation?

A. (Ms. Greene) Yes I have.

Q. And is that tab 14 of the binder?

A. (Ms. Greene) Yes it is tab 14.

Q. And as CFO and treasurer of Blue Cross what are the key points that you take from that opinion?

A. (Ms. Greene) This year as I read the DFR's solvency opinion it's clear to me that the Commissioner has escalated his message and concern. Three key elements in particular stuck out to me. First, the Commissioner makes clear that the primary tool or fundamental element of maintaining an insurer's solvency is to consistently charge adequate premium rates. Blue Cross Blue Shield knows this. Each and every year we have submitted proposed rates that are designed to be adequate. Each year the decision of the Board has reduced those rates making them inadequate. This is not sustainable clearly.

The second point that came from the opinion in my view this year very clearly is that the Blue Cross Blue Shield Vermont RBC ratio is trending down -- downward. This is true. Each and every year when Blue Cross Blue Shield of Vermont submits rate proposals again they are designed to be adequate and include CTR that's intended to maintain our reserve level. Each and every year the Green Mountain Care Board reduces that rate making it inadequate and thereby putting pressure on our RBC ratio. This is also not sustainable.

The third point that I'll draw out is the

Commissioner outlined in some detail the unprecedented uncertainty in the federal health reform environment. This creates increasing financial risk to us as an organization, and clearly the solvency opinion this year was a comprehensive walk through of how this trend is continuing. So each and every year Blue Cross Blue Shield of Vermont has done its level best to navigate these changes. The federal changes happen on short notice and in ways that have not been foreseen and we do our level best to navigate these choppy waters each and every year. The Board when they cut their rate -- cut our proposed rate it weakens our reserves and our ability to sustain those hits, if you will, and so I would like to draw attention to the overall message that I took from the solvency opinion was that something has to change.

Q. So what is the recent history of rate adequacy for Blue Cross rate filings under the Board's jurisdiction?

A. (Ms. Greene) In its recent decisions the Board -- for example, in last year's qualified health plan rate filing they pointed out that their task is to strike a balance between the lean as possible rates and protecting the insurer's solvency or financial health. I don't believe that there's a -- it's a misnomer that a balance can be had there. The fundamental tenet of adequate -- or

fundamental tenet of solvency is that we're consistently charging adequate rates. So it really is inconsistent to think that you can chip away at the rate and maintain financial health. You can't do both.

Further, the Board has consistently cut our rates believing they are incentivizing us to be more efficient and to negotiate better rates with our providers. The truth is that we do everyday focus on efficiency and everyday negotiate and bring our market share to bear on our provider negotiations. However, it is clear that our rates have been inadequate over the last several years. From the period 2014 to 2017 we have lost 16 million dollars in this market segment.

Second, it was part of the prehearing Q&A on tab 12 page 282. One of the questions that was asked of us is to provide a calculation of what the RBC would be for the QHP business only. The illustration that we provided is just that, it's an illustration, because RBC is not a tool that's used for a particular stand alone line of business it's used for the whole company. However, it was instructive in that illustration that the approximate RBC for the QHP business only decreases from 2014 -- 2013 -- sorry -- to 2017 the QHP business RBC would have declined 239 percentage points. So clearly the rates have not been adequate to sustain the reserves that

are needed to navigate the choppy waters both today and into the future.

Q. So just with QHP business alone, if that were our only business, would the level of surplus be within the Commissioner's range for surplus that he's determined to be reasonable?

A. (Ms. Greene) It would not. It would have fallen below the target range.

Q. And how do you know that Blue Cross is operating efficiently?

A. (Ms. Greene) Blue Cross has demonstrated to the Board through many information sessions that we work everyday to continuously improve our operating efficiency. A couple of data points I'll draw your attention to in this rate filing is that L&E included in their report in section 13 of the binder a reference on page 303 that Blue Cross Blue Shield's Vermont administrative costs are lower than 95 percent of the other Blue Cross Blue Shield plans nationwide, and this is notable in the sense that we are much smaller than many of those plans and much economic theory holds that we would lack scale, but we have worked very hard on making our administrative cost ratio one of the best.

We also have answered in some of the prehearing Q&A questions relating to the operating

efficiency, and again that's on tab 12 and this one is on page 276. I won't go through it in all the detail that is in the response that's there for you to read, but clearly on the bottom of page 276 we've shown that our operating expenses per member per month are well below the rates available benchmark median.

In particular, the small group and individual insured book of business is $35.50 per member per month and the benchmark median is $41 a month -- $41.02 on that exhibit. So we know we're efficient. We work really very hard at it. It's part of everything we do, and having the Board feel the need to cut a rate below the level that is adequate to incentivize us is really -- we have no need to be further incentivized. We have to compete for our customers and they expect us to spend as little as possible on our operating expenses.

Q. Does Blue Cross serve all of its markets in the same way?

A. (Ms. Greene) Yes. We compete in several Vermont markets. We're one of the only carriers who competes across both the small group and individual market, the large group insured, and self-funded market. We also offer Medicare supplement products and we also have our Medicare Part D product. In all of our offerings we compete for the business that we have and we are

motivated to make sure that each of our segments are operating as efficiently as possible.

Q. So are the rates that Blue Cross is proposing affordable, provide quality care, and promote access to health care?

A. (Ms. Greene) Yes they are. I wanted to draw attention, as Paul mentioned, to the answer to the prehearing questions in tab 9. So if you could turn to page 235 tab 9, we were asked to provide support for the extent -- to the extent that it exists that Blue Cross Blue Shield of Vermont is proposing rates that support affordable rates, promote quality of care, and promote access to health care.

I'm not going to go through the answers in detail here. We had a lot of examples that we went to some length to make sure the Board understood and see how the connection was made specifically, but I would like to just draw attention to our introduction on page 236 of that answer. The three interrelated standards of affordable, quality, and access to care are intended to work together. There's a tension between those three things, and the goal for Vermont and Blue Cross Blue Shield of Vermont is to find a balance between those three competing goals of often if you achieve more results on one of the goals oftentimes one of the other goals will

suffer. So Blue Cross Blue Shield of Vermont in this answer here we were focused on these objectives and our goal was -- is a transformed health care system in which every Vermonter has health care coverage and receives timely, effective, affordable care. That's in our vision. It was in our vision long before the Green Mountain Care Board was created and we continue to pursue those objectives working with the stakeholders in the health care system in Vermont.

The challenge is when you pursue one of those objectives to the detriment of one of the other of the so-called triple aim sometimes you have a less than optimal situation on the one that's being out of balance. So Vermont has frequently pursued access and high quality care. We get very high marks for the quality of health care available in Vermont and often times that will come at a higher cost for health plans.

Q. And has the Board ever expressed its opinion on the triple aim?

A. (Ms. Greene) Yes. I believe, and it's in the decisions that we have had over the years, that the Board shares that goal of working to find that optimum place where the tension between those three things can be brought to bear in the Vermont market.

Q. So what is Blue Cross's contribution to

reserve philosophy?

A. (Ms. Greene) Blue Cross Blue Shield of Vermont's contribution to reserve philosophy is one that we like to set a long term objective and stick with it so that we avoid any fluctuations that are unnecessary in our rates in delivering premium rates to our customers. We did outline that philosophy in some detail this year. It's somewhat new. It is part of the rate filing itself in tab 1. We outlined on pages 180 through 181 the approach that we're using coming up with an appropriate contribution to reserve, and again I won't go through that in detail. It's there. We outline it on page 180, our CTR philosophy, just so it would be clear for everyone.

A couple of points I would like to draw your attention to is the long term assumption had been 2 percent for many years, and with the Tax Cuts and Jobs Act that came into play at the end of December we were able to reduce that 1 -- the 2 percent CTR long term assumption to one of 1.5 percent, and that is directly a reflection of passing the fact that Blue Cross Blue Shield of Vermont no longer pays federal corporate income taxes. We have passed that along in the rate through that CTR assumption. It was to be -- it used to be 2 percent. It is now 1.5 percent.

Q. And what is Blue Cross's adequate long term

level of RBC risk based capital?

A. (Ms. Greene) As in the past we've mentioned to the Board that our target RBC range is 500 to 700 percent and we believe that this range has served us in the past. This range was put into place over 10 years ago, very much before the advent of the recent volatility in the federal health care reform environment. So with the recent market volatility and regulatory changes this is very much an adequate but clearly not excessive target range.

Q. And if Blue Cross were to go to the bottom of the range, what is the upshot of that?

A. (Ms. Greene) So clearly if the Board continues targeting to the low end of the range, say 500 percent or somewhat above that, it's implicitly taking on more risk than -- in today's environment than it might have 10 years ago. If the rates go below the range, our CTR philosophy is such that we have to increase our long term assumption in a particular rate filing from the 1.5 percent to something higher in order to move our surplus back into that range. Clearly that sets off a possible rain of events where we're increasing our rates, we become less competitive, we have to compete for our business, we'll lose business potentially, and then that has the further detriment that we might not be able to serve all the markets in Vermont that we are capable and currently

believe in serving.

I would like to point out too Lewis & Ellis in their report on tab 13 on page 304 -- just to put the Blue Cross Blue Shield of Vermont's RBC range into context on page 304 L&E both opine that they felt our long term assumption of CTR of 1.5 percent was reasonable. They also reviewed our level of RBC relative to the other Blue plans nationwide and they found that over half of the Blue Cross Blue Shield plans nationwide have actual RBCs higher than the maximum of our range. Our range is clearly not excessive.

Q. So we heard a little bit about the alternative minimum tax credit in Mr. Angoff's opening. Does that credit provide for increased RBC for Blue Cross today?

A. (Ms. Greene) It does not provide for increased RBC today. The AMT credit is a function of the Tax Cut and Jobs Act. It eliminated the corporate AMT and the result is that beginning in late 2019 and over five years from that time Blue Cross Blue Shield of Vermont will be able to recover our AMT. We did answer a question. We provided details about that in our rate filing, and we also answered a question on tab 4 page 210 where we outlined -- it's the last page on that tab. We outlined that the 16 million -- assuming that the results in our tax filing for the 2018 year are consistent with the

estimates we're making today, we estimate 16 million will be refunded from the IRS in late 2019 and then we'll receive 7.9 in 2020, 2.6 million in '21, and another 2.8 in 2022. So this recoverable is out on the horizon. It's a great thing. We're happy about it. It's one of the federal changes that HCA's lawyer has said that it is a positive, but it hasn't happened yet. It will happen in late 2019 at the earliest. It is subject to assumptions around what will be sequestered in terms of the IRS payments, and we also recognize that federal payments have not necessarily been as reliable as we might think they have been over the last 20 years. We have very current examples of situations where the federal government has withheld payments. The cost share reduction payment was completely halted on October 12, 2017. Overnight our premiums were underfunded, and we also have the recent notification from CMS that the risk adjusted payments for the 2017, which is a program that's a fundamental piece of the ACA, and the co-payments which are significant are frozen at the moment. So even though the AMT is very much a positive thing we will record it and reflect it in the financials when we receive it.

Q. And if you do receive it, how will you use it?

A. (Ms. Greene) As we have said in our comments about the impact of the Tax Cuts and Jobs Act, all of the

benefit of those changes will be passed on to policy holders and members for all of our businesses, not just the QHP business. When those tax AMT refunds come to us they will come into surplus, and to the extent that our surplus position is within our target range it will serve to mitigate future increases to members.

Q. Perhaps backfill some of the other changes?

A. (Ms. Greene) Exactly. Just to be really specific about it in late 2019 when we receive the 2016 payment the way I would be thinking about that it would first go to cover the 2018 CSR defunding that is sitting as an empty cover in our member surplus. So when we get to late 2019 to the extent that our surplus is in good shape we would have the opportunity to mitigate rate increases.

Q. So what is Blue Cross's goal with this rate filing including the amendment?

A. (Ms. Greene) Blue Cross Blue Shield's goal is clearly to have funded premium rates. As I mentioned, in observing the Commissioner's solvency opinion the fundamental tenet of maintaining our solvency is to have consistently funded premium rates, and so we're here today to outline that is for 2019 a rate increase proposal of 6.9 percent. That's what we need.

Q. Thank you. My next questions will be directed

to Andrew Garland and Mr. Garland's CV is not in the binder, but he was noticed as a fact witness. So I would like to ask him a little bit about his background and experience because you don't have it in writing.

MS. HENKIN: Go ahead, please.

BY MS. HUGHES:

Q. Thanks. So, Mr. Garland, where do you currently work?

A. (Mr. Garland) Blue Cross Blue Shield Vermont.

Q. And what is your position there?

A. (Mr. Garland) I'm the vice president of client relations and external affairs.

Q. And how long have you held that position?

A. (Mr. Garland) For a little over three years.

Q. And before that position where were you?

A. (Mr. Garland) I was at MVP Health Care for three years as the vice president of payment reform and network strategy.

Q. And before that?

A. (Mr. Garland) Blue Cross Blue Shield Vermont back to 2002.

Q. And did you start your career in insurance in 2002?

A. (Mr. Garland) No. In 1998 with Kaiser Permanente Health Care in Oakland, California.

Q. So you have heard -- or I should say I have read some of the Green Mountain Care Board decisions and does the Green Mountain Care Board need to provide Blue Cross with incentive to be more efficient and to lower the cost of care by cutting requested rates?

A. (Mr. Garland) No. The marketplace provides that incentive. I think it's very important to rearticulate that every market we participate in, in Vermont is highly competitive; the individual and small group markets, the large group market both insured and self insured, the Medicare supplement and Part D markets, we have extremely strong and many times aggressive competitors in all of these marketplaces.

As Ruth mentioned, we're a small company. The same infrastructure serves all of those markets. So our efficiency, our effectiveness in the small group market is the same efficiency and effectiveness essentially that we're selling in the large group space or in the Medicare space, and all of the clients we serve demand the lowest possible administrative cost and the highest value in return. Everybody wants the high value evolving health plan at the lowest possible cost. That pressure is what drives our business everyday, and when you think about -- I think it might be worth taking a moment to just think about the value and the services that we're talking about.

It is not just paying claims and enrolling people and doing those things quickly and effectively and accurately. That's a part of it, but it's also providing comprehensive data and analytics across a whole range of services; medical care, RX, prescription drug care, lab, mental health services, all those brought together so that our clients can understand what's happening with their benefits.

It involves things like claims management and fraud waste and abuse that Paul talked a little bit about. A tremendous amount of money flows through our organization billed to us literally by thousands of hospitals and providers of many different types. It's extremely important that we understand what's happening with all of those dollars and they move through and make sure that the expenditures are appropriate and accurately represent what care was delivered and what care should be paid for. We are expected to provide tools to help our members get the most from their benefits. Vermonters are not looking for low access, cheap fly by night health care products. They buy benefits for their employees or for themselves because they want the best possible care and they expect us to provide expertise, services, and tools that help their members access that care. So that's part of what we do.

They want and expect a compassionate and caring customer service team. Even with the best tools and the most well meaning providers the system is extremely complex, and when Vermonters get in trouble with medical bills in front of them they call us and ask us to explain what's happening here, help me solve that problem, and they need smart knowledgeable highly trained people that are putting the time and caring into solving those problems for them.

Above all they want access to great care. I can't emphasize this enough. It must be so different from other regulatory environments where we're talking to insurers about how to get them to pay for more things. In Vermont we don't have that challenge. Every client we serve wants the fullest most robust care that's possible and they want the best care managers at the plant to help them when they are in trouble to help. So all these goods and services are expected to be provided by us at the lowest possible cost by all of our clients, and if we fail to do that we fail to compete in the marketplace, and I think it's so important to emphasize our clients have options. In the individual and small group market MVP is a strong competitor. In the large group market CIGNA and Aetna and United push hard to try to take business and moving it to their books.

In the Medicare market Aetna and MVP again work very, very hard to take that business. Our members, our clients have options. If we're not efficient and effective in all that we do, we lose business and we fail as an organization. So my -- my short answer to the question is that's what we do. That's what we're about. Our mission, our purpose is going to work everyday is to be as efficient and effective as we possibly can. That's why we exist. There's no further incentive that the Board can provide that the market hasn't already provided for us.

Q. So you have mentioned a whole basket of activities. What about the management team at Blue Cross?

A. (Mr. Garland) Thank you. This is an extremely important part of what we provide. The system is complex and problems occur, but our members certainly and our clients expect that we have a professional, aggressive management team that's working to stop those problems from happening in the first place.

Q. Does Blue Cross use its purchasing power in negotiating leverage to lower the cost of care through unit cost negotiations?

A. (Mr. Garland) We absolutely do. We have direct contracts with I think 201 hospitals now with a hospital in Massachusetts recently directly contracted

with us. We negotiate actively with every one of those hospitals. Most of them we negotiate with every year. This is a very mature process.

In 2008 I took the position of director of provider contracting for Blue Cross of Vermont so I have been participating in that process directly or very closely for a decade. I can assure you that, again, it is a well developed systemic approach negotiating with all those providers. We collect cost data and utilization data using all the information that we have about the claims that are being paid. We look at the budgets that are submitted to you gleaning as much as we can about what's happening with the commercial spend relative to the Medicaid spend. We sit down with the hospitals. We let them know what we know, what we see, how what we pay for services at their facilities compared to the cost of services at the other facilities that we contract with, and we push as hard as we can. I would say given the constraints of our lack of competitive marketplace on the hospital side and our regulatory infrastructure that's a very successful process. We produce results through that work.

We have a second process that's closely aligned to the negotiating which involves a very similar -- a fair amount of overlap that focuses on payment

policy. This is the team that looks at how services are changing and the billing of those services is changing over time and they enact policies to manage the way we pay claims. So this work very closely affiliated with fraud waste and abuse work is essentially meant to correct for new codes that come into the market that may permit reimbursement of things that shouldn't be paid for whether they are technical challenges, billing problems, or liberal billing practices which occasionally occur. That team, which has also existed for more than a decade, is working constantly to make sure that we're managing the dollars through the door.

We also manage directly fee schedules for those where services are negotiated. These are the professional fee schedules. I believe they were talked about before, the primary care and specialists who don't receive payments from us through a hospital contract. I can assure you that our management of those fee schedules has been very, very thorough and has made us no friends in the provider community, and you have heard a number of sort of public outcry. Some of the providers went on those fee schedules which I think offer some evidence they have been very, very thoroughly managed to make sure that we're not overspending for those services.

There is one other lever that we could pull

that we don't. It's the only one I can think of as I was preparing to speak with you today. I think of this as the nuclear option. This is the option where we allow a provider in a hospital to go out of network because we refuse to come to terms with them on a contract. If we were operating in a different marketplace, say suburban Maryland where we had three, four, five hospitals competing with each other in any community, I suspect this would be one of the sharpest tools in our toolbox. That is not the case in Vermont. We don't have significant competition in any service area, but we do have access standards. We have standards to notify members when their providers go out of network. We have many requirements to pay for care regardless of whether or not we can put a network in place.

So I imagine what it would be like to exercise the nuclear option and I would encourage you to think about that as well. It starts with a letter to 30, 40, 50,000 people saying effective x date your provider is no longer in our network. Let's help you find care somewhere else. To me that is a scenario that is likely to cause a tremendous amount of damage and waste. Whether we look at the amount of money we would spend on public relations and legal fees, the damage we would do to our provider relationships, the number of members that we would

confuse, frighten, lives that we would possibly endanger frankly as a result of that confusion, and fright, and the amount of money we would spend on out of network care that we would have to pay for anyway probably at a significantly higher rate, we don't see it as being a value add process except in the most extreme sort of circumstance, and even then we may just be underfunding or moving underfunding from our books on to someone else's at least if we start with the assumption that by definition any hospital budget has already been approved by the Board so it's adequately funded. If we were to take it down significantly from funding that you approve, we would be underfunding it.

So that's an option that is certainly I would say here today has not been taken off the table to us, but it's not one we would rush to. There's fair and dire consequences thinking about that.

Q. So Blue Cross is also in a contract with OneCare, Vermont's ACO. Would they be included within the remarks that you just made?

A. (Mr. Garland) Yes. We do have a contract with OneCare for the small group and individualized. We also have a contract with them now for a self-insured pilot and we're working with them to extend that contract to include more lives, but that's a good example of the type of

activity that we're able to do and that we frankly turn our attention to as an alternative to a nuclear option, and that is to work with public and private stakeholders, providers, regulators, policy makers on alternatives that create more value through our network, and this is also work that, as you mentioned in your opening remarks, goes back a very long time.

Before there was a director of payment reform for the Green Mountain Care Board I was the director of provider contracting for Blue Cross Blue Shield of Vermont, and I brought to our executive team a proposal we start working on something back in 2008 called payment reform. There's this new thing happening in the industry we need to be a part of that. As the Green Mountain Care Board and others in the state have pushed payment reform and other value add initiatives we participated in every one of them. Every pilot that Richard Slusky brought to the table we came and sat down and said how can we make this more valuable.

We've worked with the Blueprint. We've worked with the state's immunization billing pilot. We've been part of dozens of work groups sponsored by the legislature and others to try to come up with better ways to pay for care, to solve problems, that we're making administrative ways for the provider system. When other commercial

payers have been scarce or frankly most of the time nonexistent at those meetings or as part of those pilots, we've been there trying to find a way to make even more value out of our provider network than we can through direct contracting. We've been highly successful.

Q. Thank you. I would like to transition to Dr. Plavin and this is his first time before the Board in this capacity in a rate hearing and his CV is in exhibit 15 pages 323 through 325 -- no, 327. Sorry. So can you tell us what your position -- first identify yourself and tell us what your position is with Blue Cross?

A. (Dr. Plavin) Sure. I'm Josh Plavin. I'm the chief medical officer at Blue Cross and essentially that means I oversee our care coordination programs in relation to this discussion.

Q. Okay, and how long have you been doing that?

A. (Dr. Plavin) That position just under two years, with Blue Cross for just under four years, physician in Vermont for 18 years.

Q. And where did you practice medicine before you came to Blue Cross?

A. (Dr. Plavin) I was at Gifford Health Care which is a critical access hospital and now a FQHC. Led the efforts into it becoming a FQHC.

Q. So tell us more about your role at Blue Cross?

A. (Dr. Plavin) So as I alluded to I oversee our care coordination programs, primarily all of our clinical programs. As Paul had mentioned, cost containment -- clinical cost containment activities. We feel these are vital because they really support evidence based care and certainly utilization monitoring, but most importantly help people navigate a complex health care system both here in Vermont but regionally and nationally, and so we have those connections. You know we're uniquely positioned in Vermont because our goal is to ensure that our members receive the best care available at the lowest cost from all of our providers and we receive information from health care provided, some information about prices, certainly about outcomes, and we work strongly with our provider network. Our care managers are local Vermont care managers who have in depth knowledge of the best care available on a very personal level.

The National Academy of Medicine and Institute of Medicine have published studies where they estimate that about 20 percent of total health care services that are provided really don't improve people's health; wasted medical resources, needlessly increasing costs, and so cost containment certainly is a piece of what we do. That can be achieved through many different ways. While we did mention 9.7 million in savings in the binder at page 278

that was for prior approval alone across our different initiatives.

In our other initiatives our estimate is about 1.9 million in development. We achieved 18.1 million savings for this population -- individual and small group population in 2017. This cost avoidance is reflected in the claims experience that Paul has provided and, therefore, made our premiums lower than they would have been without those efforts.

Q. So that's care management overall. Can you talk in more detail about case management, what does that mean and what is your role in that?

A. (Dr. Plavin) Sure. Again it's a component of our overall care management and I'll just comment care management/case management the definitions of those are in the view of the individual. So we can argue about semantics, but basically case management is about the individual relationship between a nurse and/or a social worker, mental health counselor, pharmacy, Blue Cross, and individual members, and we focus on those who have high complex and chronic conditions as well as rare disease and those with catastrophic events like trauma.

So we have a team of doctors and nurses, pharmacists and social workers, and because of our partnership with Brattleboro Retreat and mental health is

integrated fully in our system and we engage with our members on a very personal level. Our engagement rates in fact are over 50 percent, whereas, the industry benchmark is 27 percent, and our member satisfaction exceeds 96 percent. So once people are engaged who need our help they really get the help that they need, and member feedback is overwhelmingly positive for those whose lives we touch.

I want to give you a case example. This is really care management in general, but certainly this one comes from our work as it were. So we're working with a gentleman, 46-year-old man with diabetes and hypertension. Had come up as a high utilizer and diabetes, and he had had a regular primary care provider, but his chronic disease was really poorly controlled, and so we made an outreach to him and we developed a relationship with him, and as part of that we screened him for everything that can affect our care -- an individual's care. This includes social determinants which is kind of like a look into your personal circumstances that can be a barrier, and we found that he was widowed the year before and then he had had an estranged actually child in the family, and so had a tense relationship with the family which was really affecting his overall well being and his own self management of his disease state.

So through building that relationship, which is based on trust, we were able to find him a mental health provider who could actually see him in a timely manner, helped him to make and keep his appointments and provide him kind of health education resources so he can better manage his own care. He was able to rebuild his family relationships, he had treatment for his depression, and his chronic disease was incrementally controlled, and yes he is reconnected with his family and very thankful for our services. That's just one of many examples we get these routine testimonies from our members.

One of the things that limits us is information and we have made and will make technology investments to enhance our programs, and starting in 2019, for example, we're including realtime admission discharge transfer information, which as you can imagine a claims system has a delay of as many as 60 days before we're notified something happened. This system would bypass that and actually give us immediate access.

Lastly, I want to just talk about care management and kind of its impact on cost containment. Certainly improves quality of care, improves access, but also saves money. What we found in our population is that members who are identified for care management, who are engaged versus those who are identified and for whatever

reason don't engage are actually 25 percent less costly because we're able to navigate that system for patients, get them into the right care, right place at the right time, and mitigate that cost at the same time as improving their experience.

Q. So utilization management is that different from the two types of management you just discussed?

A. (Dr. Plavin) Utilization management is a little part and parcel, but -- and we've discussed this in the detailed response in the binder on pages 247 and 248, but basically what we're trying to do is guide members towards evidence based proven therapies before the use of either ineffective or potentially investigational while research is going on therapies. This is about not just waste but harm in patient safety, and we feel relatively strongly about that, and so one of the ways we intend to promote use of these therapies is through administrative processes that you're familiar with; medical, pharmacy, radiology, appropriate use criteria, using national guidelines in which essentially is what you might call prior approval process, all of that can be instituted in other innovative ways which we're looking into.

MR. ANGOFF: Excuse me, Madam Hearing Examiner. I hate to do this. I've been patient. I know the Board's been very patient, but what does all

this have to do -- this is a hearing on whether this rate increase meets the statutory standard and I just don't understand the relevance of any of this.

MS. HUGHES: Well the relevance is, and I believe the HCA has asked these very questions, does Blue Cross promote quality care, does Blue Cross promote access to care. Dr. Plavin is in charge of the very programs that promote quality and promote access and he is almost done.

MS. HENKIN: I'm going to allow the questioning and they are very much related to some of the questions that were asked by the HCA and by the Board through this filing. You can proceed.

A. (Dr. Plavin) I'll finish up quickly. I apologize. I tend to talk. Just a comment about the pharmacy opioid epidemic. Through instituting guidelines and standards we have seen a decrease in actually close to 40 percent in opiate abuse in our population, which is really good, and the prior approval process is streamlined and evolving, and so now over 50 percent of our prior approvals are automated reducing burden, providing realtime approvals in an automated fashion. We constantly evolve them and we retire policies and we have new policies and we work with our providers.

So one of the examples is the institution of a

policy around a non-invasive treatment for prostate enlargement as opposed to surgery. This was brought forward by our providers for better care, better access, lower cost, and we've instituted that policy.

So, in summary, we have smart and targeted care management for our members. We focus on evidence based utilization monitoring, management, and evolve that over time, and we often implement programs with our provider partners, including the ACO, to maximize resources, preventing duplication and collaborating, magnifying all of our strengths.

MS. HUGHES: Thank you.

MS. HENKIN: As it's just about 11:30. I am going to give a very short break and I think it's for the benefit of the witnesses and those who are looking at me anxiously out there. 10 minutes and we'll be back in the room at 20 until, and we will proceed with these witnesses and the questioning from the HCA. So 10 minutes.

(Recess.)

MS. HENKIN: Let's get going again and we have just finished up the direct testimony and the HCA may question the witnesses.

MR. ANGOFF: Thank you, Madam Hearing Examiner. I'm happy to begin except somebody took my

microphone.

MS. HENKIN: We were missing one key person here and now you have a microphone right on time.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Thank you very much. Good morning. It's almost afternoon, but good morning, Mr. Schultz.

A. (Mr. Schultz) Good morning.

Q. Blue Cross it will get 16.6 million back from the federal government in late 2019, right?

A. (Mr. Schultz) Yes.

Q. Then another 7.9 million in 2020, right?

A. (Mr. Schultz) Ruth is more familiar with those numbers.

Q. And 3.6 million in 2021?

A. (Mr. Schultz) Yes.

Q. And another 2.8 million in 2022?

A. (Mr. Schultz) Right.

Q. Turn to page exhibit 5 in your rate filing which is page 16 of the rate filing page 80 of the PDF.

A. (Mr. Schultz) I'm there.

Q. Could you tell the Board where -- and that's the index rate calculation for 2019, right?

A. (Mr. Schultz) Yes. That's correct.

Q. Could you tell the Board where on that whole page where you calculate the index rate where is the 16.6 million dollars for 2019 reflected?

A. (Mr. Schultz) I can't tell you that because it's not part of the index rate. CTR is part of the adjustments that are made subsequently to the buildup of the index rate.

Q. So when you say -- I understand CTR is part of the adjustments. So -- and don't dispute that, but then what, if any, relationship does that -- does the CTR have to the 16.6 million that you'll get in 2019 -- late 2019?

A. (Mr. Schultz) I can answer that the CTR has -- Ruth testified was reduced from 2 percent to 1.5 percent to reflect tax reform.

Q. To reflect that 16.6 million?

A. (Mr. Schultz) Well it does not reflect the 16.6 million because we haven't received it yet.

Q. Okay. Then could you turn to -- could you turn to the unified rate review please which is page 48. Are you there?

A. (Mr. Schultz) We're there.

Q. And so you're saying the 16.6 million that I believe you said that you reduced your CTR from 2.0 to 1.5 based on the change in the tax law -- based on the benefits you will receive under the tax laws?

A. (Mr. Schultz) At management'S direction we reduced our CTR from 2 percent to 1 and a half percent. Management wrote a memo that was included -- that was included in our filing that addresses a number of issues including the AMT credits.

Q. Okay. Could you look then at the line that's about 60 percent -- all the way down the page in pretty small print it says profit and risk load.

A. (Mr. Schultz) Yes.

Q. Okay, and then across from that it says profit and risk load is equal to 1.60 percent. Do you see that?

A. (Mr. Schultz) Yes.

Q. By the way what you guys call CTR is what the federal government calls profit and risk load, right?

A. (Mr. Schultz) Well no it's not profit. It's contributions to policy ordinary service.

Q. I'm not interested in what it is or isn't. I'm just saying what I want to make clear is what the federal government characterizes there as profit and risk mode is what you characterize as contribution to reserves?

A. (Mr. Schultz) That's where we put our CTR in this federal tab.

Q. Say again?

A. (Mr. Schultz) That's where we put our CTR.

Q. You put your CTR in profit and risk mode in

the URRT, correct?

A. (Mr. Schultz) That's correct.

Q. And so that profit and risk load equals the 1.5 that you characterize contribution to reserves plus .1 for bad debt, right?

A. (Mr. Schultz) Correct.

Q. Okay and that's equal to how much in dollars? That 1.5 or 1.6 profit and risk load is equal to how much in -- how much in dollars?

A. (Mr. Schultz) The projected period total on the URRT is 5.9 million dollars.

Q. Okay. So that 1.5 percent -- so that means that a point is how much a point?

A. (Mr. Schultz) A point is around a little shy of 4 million dollars.

Q. Okay. So a point is a little shy of 4 million dollars. So the Trump tax bill gives you more than 16 million dollars in 2019 alone, but you're reducing -- because of that 16 million you're reducing your CTR only from 2 to 1.5 which is just 2 million dollars. Aren't you?

A. (Mr. Schultz) Let me be specific. We're reducing our contribution from reserves to 2 percent to 1.5 percent to reflect the fact that moving forward the AMT has been abolished and we will no longer pay 20

percent federal taxes. You will note that a reduction of 2 percent to 1.5 percent is a 25 percent reduction. Our tax rate was 20 percent. So based on management guidance we reduce from 2 to 1 and a half because of our change of our tax status.

The 16 million dollars that we'll receive in 2019 Ms. Greene testified that when that money comes in we will use it for a number of things including reestablishing our reserves for the defunding of CSR. We will take a look at where our reserves are at that time and if they are adequately within our targeted range, we will provide additional rate relief to Vermonters at that point.

Q. Then are you saying that the 16 million bucks that you're getting in refunds you're not reflecting that at all in the 2019 -- in your 2019 rates, but rather you're saving it for a rainy day? You'll decide what to do with it in the future, but you're not reflecting that in any way in this filing?

A. (Ms. Greene) If I can answer that question --

Q. If you don't mind, I'm questioning Mr. Schultz.

MS. HENKIN: One of the things I would like to point out we did choose and discuss this panel discussion because not every person on this

panel will have the correct answer. So while you may direct this to Mr. Schultz, if he does not have the answer, if you choose we can get that answer from another witness and it would be more efficient. We tried to do this for efficiency, and I just want to remind you that there are some answers that you may not get from the person you choose, but you may get the answer elsewhere on the panel and we have discussed that and so please proceed.

MR. ANGOFF: As the actuary I believe Mr. Schultz is qualified to provide that answer, but I think if he's not, I'm happy --

MS. HENKIN: Let's try the question again and we'll see.

A. (Mr. Schultz) Would you mind repeating the question?

Q. Yeah. Do I understand you correctly to say that the 16.6 million dollars that Blue Cross will receive in 2019 is not reflected in the rate for 2019?

A. (Mr. Schultz) As the actuary who prepared this filing I received a memorandum from senior management instructing me to file a 1 and a half percent contribution to reserves for 2019. That memorandum discusses a number of issues including the AMT credit. So the decision to file one and a half percent was not mine, and I believe

Ms. Greene would be able to give you more details about that decision if you care to direct your question to her.

Q. Yes I will, but before I get to that then I just want to make sure that you as the actuary then are assuring me that the 16.6 million is nowhere to be found -- that is the 16.6 million that you will receive as a result of the Trump tax bill in 2019 is nowhere reflected in your rate filing?

A. (Mr. Schultz) I will reiterate that it was part of the management process in considering what CTR to file for this rate filing. It was part of the consideration.

MS. HENKIN: Excuse me. Can I get just a yes or no on that? Was that included in the filing? I'm trying to follow this also.

MR. SCHULTZ: Mr. Angoff seems to be implying that we should be able to find a line item that says negative 16 million dollars. We won't find that line item, but the AMT credits were considered in deciding what CTR to file in this filing.

MR. ANGOFF: That's not a yes or no.

MS. HENKIN: Well I would like to know is the 16 million included in this rate for the year or if it's more appropriate that Ms. Greene answers that I will direct it, but it is a yes or no. I

would be interested in hearing that.

MS. GREENE: I would like to answer, if I may. We testified that our CTR philosophy takes a long term view on what the rate CTR is to sustain reserves over time given fluctuations. We outlined that in pages 180 to 182 in the rate filing. Paul is correct that the move from 2 percent to 1.5 percent was due to no longer being subject to corporate income tax.

The AMT credit, should it come to us in late 2019, it's projected at this point in time to be 16 million dollars. Our guidance to Paul was to include -- stick with our long term CTR assumption of 1.5 percent given that there are a lot of -- there's a lot of uncertainty and volatility in the federal environment right now, some of which are reducing our reserves in the AMT which when it gets to us will increase reserves.

So in light of all of that we recommended a 1.5 percent consistent with our long term assumption. We didn't increase when we lost the CSR defunding and we didn't decrease because of the estimated 16 million that we might receive in late 2019.

BY MR. ANGOFF:

Q. Okay. So the 16 million makes it more likely in the future you will be able to prosper with a 1.5 rather than 2?

A. (Ms. Greene) Right.

Q. Very good, and we agree, don't we, Mr. Schultz, that a point that you all call CTR and what the federal government calls profit is worth about four million?

A. (Mr. Schultz) Yes.

Q. By the way, either Mr. Schultz or Ms. Greene, do you know how this provision got into law? That is how the provision that gives Blue Cross this refund got into the law?

A. (Mr. Schultz) No I don't.

Q. And could you explain for the Board what the AMT is? Either one of you.

A. (Ms. Greene) So we've shared with the Board when the tax law change became known some of the background, but it goes back to laws that are in place -- tax laws that are in place for Blue plans and this special provision for our tax provision, and if you met certain requirements you didn't pay any federal income taxes, but if you did you had to pay taxes under this alternative minimum tax, and so Blue Cross Blue Shield of Vermont for many years did pay corporate federal income taxes under

the AMT law.

Q. Okay, and are there other Blue Cross plans in the country that also get this benefit? Do you know?

A. (Ms. Greene) There are -- my understanding is that some do some don't. In order to have -- you have to have paid taxes in the past. There's a threshold that tests whether or not a Blue plan has excessive reserves, and if they do, then they are required to pay regular corporate income taxes, and it is only under the alternative minimum tax that we were required to pay taxes because our reserves were well below the threshold for requiring the full tax.

Q. And the other benefit that the tax bill gives Blue Cross is that it repeals the federal tax going forward -- the federal income tax going forward, correct?

A. (Ms. Greene) Correct.

Q. And in the past couple years that's varied between four or five million down to nothing. In fact I think in one year you got a little back; is that right?

A. (Ms. Greene) When we lose money we don't pay taxes. We tend to get a refund.

Q. So in calculating in reducing the CTR profit, whatever you want to call it, from 2 percent to 1.5 percent you did that based on the fact that you were not paying tax -- you knew you weren't going to be paying

federal income tax in 2019?

A. (Ms. Greene) Right.

Q. Okay, and did you -- in this filing did you make an assumption -- did the fact that you will get more tax refunds in succeeding years affect this filing at all?

A. (Ms. Greene) More tax refunds?

Q. That you will get 7.9 million in 2020, 3.6 million in 2021, 2.8 million in 2022, were those things -- were those amounts incorporated in this filing in any way?

A. (Ms. Greene) It was incorporated in our decision to submit a 1.5 percent long term assumption of CTR.

Q. Okay, but, Mr. Schultz, it is not reflected in the rate filing?

A. (Mr. Schultz) It is reflected because it was considered in our decision.

Q. No. Fine. Show me in the rate filing where it is reflected.

A. (Mr. Schultz) It's the 1.5 percent CTR.

Q. Show me in the rate filing where the refunds you will get under the Trump tax bill are reflected in the rate filing?

A. (Ms. Greene) If you go to attachment C of the rate filing, it's on page 180. We outlined our rationale for the 1.5 percent and in that document we also talked

about the Tax Cuts and Jobs Act, that impact. We also talked about the federal CSR payment on page 182, 7 million dollars.

Q. This is your memo, right? This is your memo. This is not Mr. Schultz's rate filing that he --

A. (Ms. Greene) This is in the rate filing. It's part of the rate filing. It is not part of the federal template.

Q. Okay. Mr. Schultz, could you turn please to -- back to exhibit 5?

A. (Mr. Schultz) Sure. I'm there.

Q. About 8 lines down under population risk morbidity there's a line reading impact of removal and penalty for the individual mandate. Do you see that?

A. Yes I do.

Q. Okay and you calculate that will raise -- and then you see the number on the right-hand column 1.0200, right?

A. (Mr. Schultz) Yes.

Q. So that means you are raising rates by 2 percent based on the removal of the individual -- removal of the penalty for the individual mandate?

A. (Mr. Schultz) Very close to that. I'm raising the index rate by 2 percent.

Q. Stand corrected, and the reason you're doing

that is that your book of business -- the people you insure as a whole are going to use more services because the people who are insured are going to be on average less healthy, right?

A. (Mr. Schultz) I'd rephrase that a little bit. The people we continue to insure will continue to use the same amount of services we would have projected in the absence of this. What's happening is that we project that some healthy members will choose to forego insurance in 2019 due to the lack of a penalty. So when you're removing members from the denominator and you're keeping the claims more or less constant in the numerator when you divide that out you get an answer that's 2 percent higher.

Q. Sure. So on the average the people you insure are going to have more claims because you're eliminating -- because you're eliminating the healthy people who have relatively few claims?

A. (Mr. Schultz) Yes. We're assuming they will drop coverage.

Q. Making the universe of people you insure relatively less healthy than they were last year, right?

A. (Mr. Schultz) Yes.

Q. Okay. Can you go down to the last line two lines below that which says changes in pool morbidity.

A. (Mr. Schultz) Yes.

Q. For changes in pool morbidity you're raising rates another 2.3 percent, right?

A. (Mr. Schultz) Again raising claims, yes.

Q. Isn't changes in pool morbidity the same thing? Aren't you saying the same thing the people we insure are going to be less healthy this year so we've got to raise rates?

A. (Mr. Schultz) Yes. There are two reasons for this. This change in pool morbidity reflects the members that we can observe to have left us from 2017 to 2018. We can see factually what they spent on average in 2017 and we therefore make an adjustment for those people who have actually left us by 2018. You do want to note as well that 1.0231 was the source of one of Lewis & Ellis's recommendations. We don't oppose that recommendation and that changes the numbers to 1.0101 if I recall correctly.

Q. Okay, and the rationale for changing the 1.02 to 1.0101, whatever it was, was what?

A. (Mr. Schultz) We -- in response to one of the questions that Lewis & Ellis asked we agreed that we should have normalized that adjustment for plan design -- for benefit design. So, in other words, there's another adjustment on this page that goes into the plans that are chosen by individuals in the projection year versus the experience year. We should have normalized that out of

the selection factor. We agreed that would be a better methodology and so we incorporated it into our amendment.

Q. So there was a little double counting there?

A. (Mr. Schultz) There was some unintentional double counting that we corrected there. Yes.

Q. If you can go down to other changes in demographics, you're raising rates because of changes in demographics by 1.01, correct?

A. (Mr. Schultz) Yes.

Q. Okay, and aren't you saying the same thing there people are going to be older, our book is going to be older, more female, therefore less healthy, so we've got to raise rates?

A. (Mr. Schultz) It's a similar category. Gender has nothing to do with it, but as I testified we looked at a number of different population changes. This one reflects the changes in population due to the continuing population. So the one we previously addressed were members who left us. The first one we addressed are members who were expected to disenroll because of the lack of a penalty for the individual mandate. This one impacts members who have been on our books and will continue to be on our books. We expect them to continue to get older and as a result we include this factor in here. Yes.

Q. Okay. So you would agree with me, wouldn't

you, that all three of those; the removal of the penalty for the individual -- for the individual mandate, changes in pool morbidity, and changes in demographics one way or another mean the people that you're insuring are going to be less healthy and, therefore, they are going to have more -- your book is going to have more claims?

A. (Mr. Schultz) Yes. That's right.

MR. ANGOFF: Okay. Madam Hearing Examiner, this is embarrassing, but my hearing aid went dead and so if you don't mind, could I just take a 30 second recess to change the battery?

MS. HENKIN: I think that's kind of necessary. 30 second recess. I also want to remind everyone about the time and we did discuss scheduling and time constraints. We hopefully will be able to take a very quick lunch break, but it may be a very brief break at all. So we will keep moving forward in the afternoon, without the testimony of Mike may make up for that, and if anyone is here who has not signed up for comment and wishes to comment at the end of the hearing, please sign up with Agatha who is in the back by the door.

(Recess)

MR. ANGOFF: I apologize to the Board, I apologize to you Mr. Schultz, and the panel and to

you, Jackie.

MS. HENKIN: You may proceed.

BY MR. ANGOFF:

Q. Then under trend factors there's cost utilization trend. You also raise rates, don't you, by 3.2 percent for utilization trend because people are going to use more services, right?

A. (Mr. Schultz) Yes.

Q. And the reason people are going to use more services is that that's less healthy?

A. (Mr. Schultz) No. Those are completely separate factors. Once we adjust for population adjustments that gets us to the projected population for 2019. Now trend is going to continue. Medical cost trend is not going to stop just because we've identified the population that will be enrolled. So for that population that will be enrolled we expect their costs to be higher not because of the change, but once we have identified that population we've settled on a population we're looking at their 2017 claims, we're projecting 2019 claims, we expect those claims to be higher because of medical utilization trend.

Q. So medical utilization trend has nothing to do with the health status of the people that are being insured?

A. (Mr. Schultz) No. In fact, when we develop medical utilization trend we normalize for that. We normalize for age and gender. We normalize for benefit plan. We do that so there is no double counting when we calculate the utilization trend.

Q. Don't people use more services because they are less healthy?

A. (Mr. Schultz) That is one reason they will use more services. There are many others. For example, there are -- I testified extensively on the new miracle drugs that have been released both on the retail pharmacy side and for -- dispensed in a medical setting. People will use those drugs even though they are very expensive because they cure previously incurable diseases or they vastly improve their quality of life. So yes there are things that may continue to drive up utilization for any given individual other than their health status.

Q. Okay. So when you raise rates by 2 percent because of the removal of the penalty of the individual mandate, another 2.3 percent because of changes in pool morbidity, another 1.01 percent because of changes in demographics, and another 3.2 percent because of increased utilization, your position is there's no double counting among them?

A. (Mr. Schultz) There is no double counting now

that we have corrected the changes in pool morbidity for the unintentional double counting that existed there. Other than that there is no double counting. We have normalized all the other factors to account for the ones that came before it.

Q. Okay. Let me ask you now about your assumption that the removal of penalty for the individual mandate would raise rates by 2 percent. In coming to that conclusion you assumed, didn't you, that all the healthy people who are unsubsidized would leave you? Correct?

A. (Mr. Schultz) Yes.

Q. And you assumed that all the unhealthy people who are unsubsidized would stay?

A. (Mr. Schultz) Correct.

Q. Aren't both of those assumptions unrealistic?

A. (Mr. Schultz) That's a good question. Do I expect literally that to play out? No. I think some people will make choices that maybe aren't in their best benefit, but I do believe that the resulting impact of 2 percent is reasonable both based on my own actuarial adjustment and because it matches the best estimate of a report that was a public joint study by the Department of Financial Regulation and the Green Mountain Care Board.

Q. By you agree that among all the people who are healthy and unsubsidized some of them are going to stay,

right? Some of them are going to be rich and they are going to keep their insurance?

A. (Mr. Schultz) Yes.

Q. And some of them aren't going to know about the appeal of the individual mandate, may not have known of the existence of the individual mandate to begin with, so they are going to stay, right?

A. (Mr. Schultz) That's possible.

Q. And some people who are -- who are not healthy for one reason or another are going to leave?

A. (Mr. Schultz) That's true. I mean there's a wide range of population here. We go from people with no claims and preventive only to people with catastrophic claims. The folks with catastrophic claims are clearly going to keep their insurance, but within that wide range I'm sure, as you suggest, there will be some people who have a low level of claims well below the average who don't believe they are going to get the utilization out of their benefits that makes it a good decision for them to keep their coverage. They don't have to pay a penalty. Some of those people will leave as well.

So I will concede we made a simplifying assumption in coming up with this estimate. The means we took to do that was opined as reasonable by Lewis & Ellis. It matches the report that was published by the Green

Mountain Care Board and by the DFR, and I'm satisfied that estimate is a good actuarial estimate.

Q. Even though you grant that the assumptions are unreasonable?

A. (Mr. Schultz) No the assumptions are reasonable. Will they perfectly model exactly what will happen in 2019? No absolutely not. I will never say that is true, but I believe it is reasonably estimated.

Q. Fair enough. You also agree, don't you, just because somebody had claims last year doesn't necessarily mean that that same person will have claims the next year?

A. (Mr. Schultz) That's right.

Q. And conversely you also agree, don't you, just because somebody had no claims this year doesn't mean they are going to have no claims next year?

A. (Mr. Schultz) Correct.

Q. So those would also affect your calculation -- what you just granted would also affect your calculation, wouldn't it?

A. (Mr. Schultz) It would be also a reasonable methodology to use to come up with an estimate. When the report that was published by the Green Mountain Care Board was prepared the authors of that report had far more information at their disposal than I did. They were able to -- so both Blue Cross information and the MVP

information. They were able to work in information that was provided to them by the state to take a look at this.

So yes there are many different methodologies we could have used. I could have landed on an assumption that more people would leave because people with some small to medium amounts of claims may well make this decision as well. Perhaps not all of the people with no claims would make the decision. Perhaps some people with chronic conditions could make the decision, although I wouldn't make that decision, but I would concede that's very unlikely.

So yes there are many different methodologies that could have produced this estimate. The methodology I chose produced an estimate that was in line with a different methodology that was published by another source and in my professional opinion that result is reasonable.

Q. Okay. Would you agree with me though that your estimate of 2 percent is a guess? It's an educated guess, but it's a guess?

A. (Mr. Schultz) No. Actuarial science is not guess work.

Q. So you think your 2 percent is going to be perfectly accurate?

A. (Mr. Schultz) No. I didn't say that. I don't think it's going to be perfectly accurate, but I do think

it's a reasonable assumption.

Q. It's an educated guess?

A. (Mr. Schultz) It is not. It's an assumption based upon my professional judgment as an actuary with over 20 years of experience in the health care field.

Q. Okay, and as an actuary, Mr. Schultz, you've not given an opinion on whether or not the proposed rate is affordable, are you?

A. (Mr. Schultz) I testified to some extent to whether I believe this proposed rate is affordable given the statutory and regulatory framework.

Q. Okay. You're not a lawyer, are you?

A. (Mr. Schultz) I'm not.

Q. You're not an expert on statutory interpretation, are you?

A. (Mr. Schultz) That's correct.

Q. You don't know what the rule against surplus is, do you?

A. (Mr. Schultz) I don't.

Q. So what was your opinion then as to whether or not the proposed rate is affordable?

A. (Mr. Schultz) My opinion is two-fold. If the rate is not excessive, then it can only be unaffordable if the underlying cost of health care is unaffordable.

Secondly, my opinion is within the statutory

and regulatory framework that we have, not meaning the law, the things you discuss and those things, but in terms of no age rating, in terms of the existence of the cost shift, in terms of that structure these rates are as affordable as they can be.

Q. Okay. Let me ask you this then and, Ms. Greene, you feel free to chime in because I think you said it a little more baldly than Mr. Schultz said it, but are you both saying that if somebody doesn't have enough money to be able to pay for insurance that doesn't mean the insurance is unaffordable for that person. It means that the insurance that that person can't buy because she doesn't have enough money is too comprehensive? Is that what you're saying?

A. (Ms. Greene) What I testified to was that Vermont has made policy choices to balance the triple aim of affordability, quality, and access and Vermont has very high marks in terms of access and quality, and I think we testified that will tend to mean that the health plans are more expensive. Paul testified that there are other policy choices that come into play there as well.

Q. And, Ms. Greene, let me just make sure I understand what you're saying. Would you mind turning to exhibit 9 pages 18 of exhibit 9?

A. (Ms. Greene) Page 252 of the PDF.

Q. Yes, page 252 of the PDF, and could you read the -- before the last paragraph there just the last sentence said slightly differently -- that begins with says.

A. (Ms. Greene) Says slightly differently adequate and not excessive rates are not unaffordable unless the care which the premium pays for is too comprehensive.

Q. Okay. So aren't you saying there exactly what I said? Maybe not eloquently, but aren't you saying there that if somebody just doesn't have the money to pay for insurance, it's their fault?

A. (Ms. Greene) That's not what this says.

Q. Sorry. Aren't you saying that if somebody doesn't have the money to pay for insurance, it's not unaffordable. What it means is he or she should buy cheaper insurance that covers less?

A. (Ms. Greene) That is a possibility in some jurisdictions.

Q. What is a possibility?

A. (Ms. Greene) Having a range of health plans that cover different services.

Q. Oh sure, but what I'm asking you, though, is that your definition of affordable that -- are you saying that just because somebody doesn't have enough money to

pay for insurance that doesn't mean it's unaffordable?

A. (Ms. Greene) That's not what we're saying.

Q. What are you saying?

A. (Ms. Greene) We're saying that as Vermont pursues the triple aim of balancing affordability, quality, and access those things will land in different places depending on the policy choices.

Q. What things will land at different places?

A. (Ms. Greene) Affordability, quality, and access. We had -- part of our amendment is that we had two more mandates passed since our rate filing and that is a choice to increase access and quality care that will have a small but yet specific impact on race --

Q. Okay.

A. (Ms. Greene) -- as an example.

Q. Do you have another -- would you like to offer another definition of affordability other than what you have said in your exhibit 9 in your June 28th letter?

A. (Ms. Greene) If you read exhibit 9, tab 9 in its entirety from the beginning to the end for the questions outlined on -- beginning on page 2 of that exhibit, we walk through Blue Cross Blue Shield of Vermont's contributions to affordability, quality, and access of care.

Q. I know Blue Cross Blue Shield has made

tremendous contributions. Do you have another definition of affordable?

A. (Ms. Greene) I don't believe there is a definition of affordable.

Q. Very good. Mr. Schultz, we talked earlier or you all talked earlier about negotiating with hospitals and how difficult -- and there's no getting around the fact, is there, that hospitals have tremendous bargaining power in Vermont. It's a small state. There are very few markets, sub markets, whatever. There are very few areas in the state where there's competition among hospitals, right?

A. (Mr. Schultz) I agree with this and that is the primary direction of Mr. Garland's testimony so he may be the best witness to direct questions to. I will be happy to answer for the actuarial questions.

Q. Very good. Mr. Garland, you agree with that the hospital has tremendous bargaining power?

A. (Mr. Garland) Yes.

Q. But Blue Cross also has tremendous bargaining power, doesn't it?

A. (Mr. Garland) To an extent it does.

Q. You both need each other?

A. (Mr. Garland) Correct.

Q. And the consumer is not a bottomless pit. The

consumer just cannot keep paying these increases, correct?

A. (Mr. Garland) Presumably.

Q. Wouldn't it be to Blue Cross Blue Shield's advantage to be able to go to the hospitals who we all agree have tremendous bargaining power and say listen we've got to get together on this. We can't just keep -- you guys can't keep raising your costs -- raising your rates. We can't keep paying for them because there's got to be something done?

A. (Mr. Garland) Absolutely and that conversation is had every year with every significant hospital in our network talking at multiple levels. My level, the team reports below that. That includes all the contracting folks who do the day-to-day work. Even the level above me. I think our most senior leaders are in frequent contact with our hospital partners and conveying exactly that message.

Q. Can any hospital in Vermont long survive without Blue Cross business of any kind?

A. (Mr. Garland) Long survive? It would be very difficult for me to opine on the financial health of the hospitals in Vermont. From what I have seen looking at filings some of them have significant reserves. Frankly, far in excess I think of what we have.

That being said, I also can't clearly assert

that we would not have to continue to pay those hospitals as much or perhaps even more than we're paying them now were they to fall out of our network. As I testified there are network access standards that we have to live up to, and in many cases hospitals or providers going out of network simply means that health plans end up paying even more to those providers because the care has to be provided for. So we lose all of the gains we've made over decades of negotiations and end up paying very, very, very high book rates or a small percentage off those book rates. So it can be a losing proposition.

Q. You agree you need each other?

A. (Mr. Garland) Yes.

Q. And you're not going to unilaterally disarm?

A. (Mr. Garland) I'm not sure I know exactly what that means.

Q. Okay. Let me say I was somewhat troubled by your announcing here that under no circumstances are we going to not have a hospital be in our network. I mean obviously I think no one wants that, but to announce that aren't you giving up some potential -- aren't you giving up bargaining power by right upfront saying whatever happens no matter what you guys say to us we're going to keep you in our network?

A. (Mr. Garland) Well if that's what I said, then

I misspoke and we could check I believe what I said. It's a step we are unlikely to take because it would have extremely severe repercussions for our members, for the hospital, for the health of our community, for the health care system which we work very hard to improve.

I certainly -- for those from the hospital community who are sitting behind me -- would not say that this is impossible we could get to that point. I think the business case has not been there in the past and something extreme would have to happen for us to find enough value from that to make the case in the future, but if it were there, we would go down that road.

Q. Mr. Schultz, can we talk about Blue Cross's administrative costs?

A. (Mr. Schultz) Yes we can.

Q. Okay. You raise the rate in two ways with respect to administrative costs, right? You raise administrative costs -- you assume administrative costs are going to go up and incorporate that into the rate in two ways. You assume that administrative costs are going to go up by 3.4 percent because Blue Cross is going to have less business, right?

A. (Mr. Schultz) I don't have the numbers in front of me, but that seems right.

Q. Okay. Go to the rate filing. It's -- the

discussion of administrative costs is on pages 30 to 32.

A. (Mr. Schultz) Okay.

Q. So you do assume administrative costs are going to go up by 3.4 percent because you're going to have less business, correct?

A. (Mr. Schultz) On a per member per month basis that's correct. We're assuming administrative costs will go down because we'll eliminate variable costs that support those members, but on a per member per month basis the resulting calculation leads to an increase, yes.

Q. Okay, and you also seem -- administrative costs are going to go up by 2.5 percent because of trend?

A. (Mr. Schultz) Because -- primarily because of wage growth, yes, that's right.

Q. Okay. I understand the increase of 3.4 percent because you're going to have fewer -- 3.4 percent per member per month because you're going to have a smaller book. You're going to have fewer insureds. I understand that. I don't understand the additional 2.5 percent for trend though. Isn't that already incorporated in trend in general?

A. (Mr. Schultz) No. No.

Q. Okay. Explain that then.

A. (Mr. Schultz) Yes. This is a completely separate trend. I don't know that I really necessarily

call it trend. Trend is normally associated with claim costs. These are projected increases in our administrative costs over time primarily driven by the fact that we do generally see wage increases from year-to-year both within our building and among our vendors.

Q. Okay. So the fact that you are accustomed now -- to a greater extent more accustomed to doing this business and therefore there's an argument, isn't there, that administrative expenses should go down because you just -- you're better at what you do. Do you buy that?

A. (Mr. Schultz) And we have made -- as Ms. Greene testified and could probably answer better than I can, Blue Cross has made enormous strides over the last ten years in reducing our administrative expenses.

Q. So you've got to increase your admin by 2.5 for trend and 3.4 because you are going to have fewer insureds, right?

A. (Mr. Schultz) Yes.

Q. Okay. You also agreed because you're going to have fewer insureds you can have a lower what you call contribution to surplus and what the federal government calls profit, right?

A. (Mr. Schultz) In total, yes. As a percentage, not necessarily.

Q. And why is that as a percentage not necessarily?

A. (Mr. Schultz) Because Blue Cross's philosophy for contribution to surplus is to -- given all the considerations that Ms. Greene outlined earlier that we filed in attachment C of the memorandum, our approach is to continue to file a long term assumption that will allow us to maintain our target range as long as we're within that target range and that long term assumption is one and a half percent that we filed.

Q. Could you turn to exhibit 16 which is your annual statement?

A. (Mr. Schultz) Sure.

Q. Are you there?

A. (Mr. Schultz) Yes.

Q. Could you turn to page 26-- 25 which is part of the notes to financial statements section?

MS. HENKIN: There's page numbers in the binders. I think you were provided binders. If you could give us those, it would make it easier for us to follow.

MR. ANGOFF: It's page 377 of the PDF.

BY MR. ANGOFF:

Q. Do you see note 25 there?

A. (Mr. Schultz) Yes I do.

Q. Change in incurred claims and adjustments?

A. (Mr. Schultz) Yes.

Q. What you're saying there in note 25 is, isn't it, that you reserved too much money in the past? That it turns out now more information has come in you really didn't have to pay out as much as you originally projected, correct?

A. (Mr. Schultz) I'm glad you asked that question. I want to draw a distinction between estimates that are prepared for the financial statements versus statements that are prepared for rate filing.

For the financial statements I, as an actuary, am required to use a conservative estimate. When we get to the pricing you might think well is Blue Cross starting with that conservative estimate and the answer is no we are not. We remove the margin from our reserve estimates that is inherent in the year-end estimates when we do the pricing. So that conservatism, that extra margin, is not in our pricing. It is in our financials because it is required to be and I would expect us to restate downward in most years. If we don't, I'm not doing my job correctly as the valuation actuary.

Q. What you say then in note 25 has nothing to do with your rate filing --

A. (Mr. Schultz) That's correct. I don't know if

I'll be able to find it quickly, but we do address this in the actuarial memorandum. We say that uses factors before explicit margin for conservatism.

Q. And then similarly I guess if you look down at the same page on note 28 health care receivable, do you see that?

A. (Mr. Schultz) Yes.

Q. Okay, and going back to 6/30/2016 starting with going forward in each quarter your estimated rebates are significantly less than your actual rebates. Do you see that?

A. (Mr. Schultz) Yes I do.

Q. Okay, and is that reflected in your rate filing? Is the difference between your estimates and your actual rebates reflected in your rate filing?

A. (Mr. Schultz) Yes it is. So I'll give the same answer there for financials. We are required to be conservative in those estimates and we are. For the purposes of rate filing we start with actual rebates and we trend those forward based upon our best estimate of prescription brand trend. So again the answer is yes we start with actuals. We do not start with the conservative estimates in our financials.

Q. Could you turn to the five-year historical data page in your annual statement which is page 386 of

the PDF, page 29 in the rate filing, and, Mr. Schultz, could you go down there to line 12. Do you see that net income?

A. (Mr. Schultz) I do.

Q. Okay. You see Blue Cross's net income then in 2017 was 7.6 million as opposed to 2016 where it was -- where you lost money, okay, and my question is does that 7.6 million in net income affect your rate filing in any way?

A. (Mr. Schultz) Inasmuch as that 7.6 million in net income either covers or fails to cover increases in the required reserves -- so there's something called the authorized control level risk based capital which is a measurement. It's the denominator in the RBC calculation. You can also find it on this page. Inasmuch as that increases, net income needs to cover that in order to keep RBC within our targeted range. So the 7.6 does come into play again in that management memo wherein I was directed to use a 1.5 percent contribution to reserves in that 7.6 million will help define what our RBC level is at any given year-end.

Q. And you don't reflect investment income in your rate filing, right? There's no line item where you say here's how much we made in investment income and here's how it's going to affect the rate?

A. (Mr. Schulutz) Again that is not a specific line item, but it does play into both where we are in terms of risk based capital and -- which is one measure of solvency and it does play into whether we file a CTR equal to our long term assumption or some other number.

Q. Sure, and so all things equal investment income will raise your surplus?

A. (Mr. Schultz) Yes.

Q. Take a look at line 13. You see net cash from operations there?

A. (Mr. Schultz) Yes.

Q. Okay, and so in the last two years you had pretty good years. You made more than 20 million in 2016. More than 21 million in 2017. Are either of those numbers -- in any way do they affect the rate filing at all?

A. (Mr. Schultz) I'm going to have to defer to Ruth on that one.

Q. That's fine. Ms. Greene.

A. (Ms. Greene) Yes. So the net cash from operations is a reflection of the cash flow and it's affected by a large federal insurer, fee payments, and other large claim payments. A lot of times our stop loss coverage will have cash flow that comes and goes. So the cash flow is an important metric for us to pay attention to, but it does not measure the amount of income that's

coming into the RBC.

Q. Mr. Schultz, have you ever heard that Blue Cross has a legal duty to provide insurance at minimum cost under efficient and economical management?

A. (Mr. Schultz) Yes.

Q. And how, if at all, do you believe you operationalize that legal duty in your rate filing?

A. (Mr. Schultz) Dr. Plavin testified to that extensively as did Mr. Garland. I also testified to it in that we are incorporating 16 million dollars of rate mitigation into this particular filing in part due to the new cost containment programs that we're establishing in conjunction with providers and with OneCare Vermont in part due to increased efforts and continual efforts on negotiations with our pharmacy benefit manager that will lower prices at the pharmacy and will increase rebates. So yes I think there are many examples of how Blue Cross accomplishes this.

Q. If you could turn to page 36, the last page of your rate filing. In the PDF would be page 44.

A. (Mr. Schultz) I'm there.

Q. Okay. Could you -- the second full paragraph that begins in my opinion, do you see that?

A. (Mr. Schultz) Yes.

Q. Okay. Just leave out the first phrase for a

while that begins with projected index rate and start with has been developed. Do you see that?

A. (Mr. Schultz) Yes. So --

Q. Can I ask the question?

A. (Mr. Schultz) I'm sorry. Please do.

Q. So when you say that the index rate has been developed in compliance with the applicable actuarial standards of practice you're certainly -- whether people agree with it or not or think you made reasonable assumptions or unreasonable ones, as an actuary that's certainly a judgment you're qualified to make, correct?

A. (Mr. Schultz) Yes.

Q. Okay, and similarly when you say that in your opinion the index rate is reasonable in relation to the benefits provided and the population anticipated to be covered, again whether people think your assumptions are reasonable or unreasonable as an actuary that's a judgment you're qualified to make, correct?

A. (Mr. Schultz) Correct.

Q. And similarly when you say the rate is neither excessive nor deficient you're qualified as an actuary to make that judgment, correct?

A. (Mr. Schultz) Yes.

Q. But if you go back to the first phrase which we left out and you say that the index rate's in

compliance with all applicable state and federal statutes and regulations, you don't know that, do you?

A. (Mr. Schultz) I do. I certified to it.

Q. Do you know all the statutes and regulations that govern this rate filing?

A. (Mr. Schultz) That are pertinent to this filing, yes. I have reviewed what I believe are the applicable statutes.

Q. Whether they use actuarial terms or not?

A. (Mr. Schultz) I have reviewed what I understand to be all applicable state and federal regulations with respect to developing the projected index rate. Yes.

Q. Okay. You're familiar with the rate review standards in this case?

A. (Mr. Schultz) Yes I am.

Q. There's no actuarial principle that governs what affordable means, is there?

A. (Mr. Schultz) There is not.

Q. And there's no actuarial principle which based on which you evaluate quality of care, correct?

A. (Mr. Schultz) That's true.

Q. Then how can you say that you're certifying here that this rate is in compliance with all federal and state standards when there are standards which you agree,

and it's no criticism, you're an actuary, but there are standards which you have acknowledged you know nothing about?

A. (Mr. Schultz) Well I think it's a bit extreme to say I know nothing about them.

Q. Good point. I went too far. I don't say that one.

A. (Mr. Schultz) And I may have relied on some of my colleagues in terms of whether we provide -- promote access to care, whether we promote quality care, and I believe that we do.

In terms of affordability again that standard has not been defined. So based upon my interpretation of what that means because these rates are not excessive they can -- the only way they can be unaffordable is if the underlying cost of care is unaffordable, and while I do some pretty good actuarial work along with my team that supports me, I unfortunately cannot wave the magic wand and make the cost of a hospitalization less. Blue Cross does a lot in terms of negotiation with providers in terms of care management and we do all of these things in order to make care more affordable.

Q. There is no actuarial standard that governs the meaning of affordability, correct?

A. (Mr. Schultz) That's correct.

Q. And there's no actuarial standard that governs the meaning or prepares you to evaluate the quality of care, correct?

A. (Mr. Schultz) That's correct?

MR. ANGOFF: No further questions.

MS. HENKIN: I will open it up to questions from the Board at this point. Chair Mullin, would you like to start?

MR. MULLIN: Sure. Looks like it's going to be a late lunch. So I'll begin my questioning with Mr. Schultz about the filing of the amendment.

MR. SCHULTZ: Yes.

MR. MULLIN: Five days before hearing, less than three real business days before hearing, what prompted you to do a late filing? What was the exact event that said this should be filed now?

MR. SCHULTZ: There were three things -- actually four things that drove the timing of the filing. One is the very late enactment of the two new Vermont mandates. I don't have the exact dates for those in front of me, but they were in late June I believe.

Second, the bigger impact was the promulgation of federal regulations on association

health plans which came out in late June as well. It took some time for us to review and assess that. We also continued to learn additional information such as the Department of Financial Regulation's decision that they would be working on emergency guidance that would come out within a week or two from today. These all were very late developments.

The fourth thing is we wanted to look at Lewis & Ellis's report. There was an element of our amendment that I did not discuss because it had no impact on rates. We didn't change rates for this, but we were waiting to see if Lewis & Ellis had recommended any sort of changes to our competitor's filing because of the market imbalance that exists if you look by metal level within the plan. So we did take a look at what we consider to be a market structural defect in the hopes in the Lewis & Ellis opinion it would be addressed. It was not so that was another very late piece of the puzzle, but even without that piece the association health plans those rules and regulations came out so late that we had little choice but to start working on that amendment as soon as we can and get it to you as soon as we could which unfortunately was last week.

MR. MULLIN: So isn't it accurate that a

discussion of association health plans has been occurring for quite some time?

MR. SCHULTZ: Yes.

MR. MULLIN: And it appears that it's recent events that have triggered this particular filing. I thought I heard in earlier testimony that you had also been approached about being involved in the association health plans?

MR. SCHULTZ: Yes.

MR. MULLIN: Tell us when you were first approached to be involved in association health plans?

MR. SCHULTZ: I don't personally know the answer to that. I'm sure it was well before the federal final regulations. Our point of view that we expressed both in the original filing and in subsequent questioning was that federal regulations and state regulations would not be promulgated in enough time for there to be a 2019 market for association health plans. That was our assumption going in. That's why we assumed nothing in these rates originally for association health plans.

We were -- frankly the federal guidance came out well in advance of what we were expecting and Vermont is reacting to that very quickly. So

it's become very apparent from late June until today that our thought that this would not be a 2019 market impact it's now very clear that it would be a 2019 market impact.

MR. MULLIN: As far as an association approaching you have there been multiple associations which have approached Blue Cross Blue Shield or is it a single?

MR. SCHULTZ: Multiple associations.

MR. MULLIN: Okay, and the company has in the filing stated they believe it's going to be 8,000 lives, correct?

MR. SCHULTZ: Correct.

MR. MULLIN: Of those 8,000 lives you are making an assumption about the health of those lives, correct?

MR. SCHULTZ: We are making an assumption in one way, yes. We are assuming that groups that offer coverage will offer only platinum coverage to their members. Many small groups offer full employee choice. Members can choice whatever plan they want often from whatever carrier they want, but there are a smaller number of groups who do not offer that. In fact, offer the platinum plan only through Blue Cross because we do not believe

association health plans will meet their needs. We don't think any of those members will shift from a platinum plan to an association health plan. Other than that we assume members will come proportionally from all plans and from all different health statuses.

MR. MULLIN: So your assumption is that it will be proportionate to health status that 8,000 migration?

MR. SCHULTZ: Yes. Setting those platinum groups aside, yes, we assume the rest would come from all different health statuses in proportion to the way they are enrolled with Blue Cross today.

MR. MULLIN: And have you made an assumption about what proportion of that 8,000 is strictly Blue Cross members migrating?

MR. SCHULTZ: The 8,000 is specifically for Blue Cross members. We assumed that MVP members will also migrate.

MR. MULLIN: What number is that assumption?

MR. SCHULTZ: 4,000. So it's pretty proportional to our current small group enrollment.

MR. MULLIN: And couldn't you likely assume that based on previous risk adjustment

payments that those migrating from MVP to Blue Cross Blue Shield may be healthier?

MR. SCHULTZ: Migrate -- I'm sorry. We're not assuming any of them will migrate to Blue Cross. We have not been selected as the carrier for AHPs. We're in a competitive situation there. We hope to be, and if and when we are selected as the carrier for AHPs, we'll have to develop rates for AHPs. At that time we'll consider both the Blue Cross migration and migration from outside sources like MVP or currently self-funded plans.

MR. MULLIN: So it's your testimony then that the Green Mountain Care Board should be looking at the rates in other Blue Cross Blue Shield rate plans at the time of a AHP migration to that?

MR. SCHULTZ: I think we have to wait for DFR rules to come out on that. I don't know if AHPs will fall under the jurisdiction of the Board. If they do, I think the Board should take notice of those rates and should investigate them thoroughly.

MR. MULLIN: Okay. Appreciate that. Let's move to pharmacy. You talked a lot about the trend in pharmacy being related to very high priced drugs. One of the examples you used was oral oncology and all the assertions made prior to the

approval of oral oncology drugs. There were assertions that there would be savings and other aspects of medical costs specifically of cutting down on nausea, cutting down on side effects of radiation, chemo, and that there should be savings in the system elsewhere. Are those accounted for in those pharmacy trends?

MR. SCHULTZ: I believe we answered that question on that and I would have relied upon Dr. Plavin for that answer because I don't know that I can find the response quickly. So I'm not sure that I can answer your question. We might have to get back to you on that.

MR. MULLIN: That's fine. You talk a lot about exhibit 18 which you admitted earlier today, and you were focused on the green area in exhibit 18, and can't Blue Cross Blue Shield themselves reduce that green area through negotiating better rates with hospitals?

MR. SCHULTZ: We can and we do as Mr. Garland testified.

MR. MULLIN: Somewhat conflicting testimony, there. Your quote was you're ready and willing to lead.

MR. SCHULTZ: Yes.

MR. MULLIN: Okay, and it almost seems to conflict with an intertwining theme between each one of your testimonies this morning as far as the issue of the reserves, and there seems to be a very clear theme throughout the questioning there this morning and, Ms. Greene, you said that this is not sustainable, something has to change, included rates have been inadequate since 2014, and you also went on to further state that you demonstrated to the Board Blue Cross Blue Shield of Vermont's efficiency, and I would ask you, Miss Greene, the argument that has been presented has basically focused on any change to any other factor of your rates other than CTR is a direct impact on CTR, and could it not be argued that rather than the Board granting inadequate rates that Blue Cross Blue Shield themselves have not adequately managed to the previous decisions of the Board as far as meeting any reduction in any of the other trends that were specific proposals that were areas to consider by Blue Cross Blue Shield in each of those changes, and couldn't someone equally argue that the failure to keep a higher reserve is linked directly to the company's inability to manage to the Green Mountain Care Board's decisions?

MS. GREENE: I suppose someone could

make that argument. My view and I believe Blue Cross Blue Shield's leadership view is that our rate filing or proposed rates when we submit them are designed based on what we know to be in place for programs and our efficiency and hospital contracts, the Green Mountain Care Board decisions, our OneCare contracts. Paul's team puts together what they think is their best estimate based on the expertise they have as to what the premium rates need to be in that -- in this case 2019 to cover those costs.

We have testified in past rate filings and the Board has, for instance, challenged us to improve on hospital utilization results as a way of improving the cost of care, et cetera. We have responded to that saying that it takes programs a period of time to come into play. Each year when we submit a rate we start with the current environment that has the benefit of all programs, employers, providers, and the HCO, and anyone else that's contributing to finding new ways to deliver care to the right people at the right time.

I would also put forth that in 2019's rate filing as it sits here in front of us we -- and Paul testified to the effect that we've got rate mitigation actions built into these rates of 4

percent. Part of that is the hospital containment initiative which is something new. Part of it is the more aggressive pharmacy benefit manager contracting and in partnership with the HCO on the cost containment. So I think we believe that we're working with all the stakeholders to do the best we can as a state to provide affordable quality care and access to that care.

The rates that we provide is a best estimate. There's been a lot of volatility and changes to our reform environment, and right from the beginning of the 2014 rollout of the exchanges and then subsequent piecemeal repeal of the ACA, all of those things are developments that we're navigating as we're making those best estimates. So the inadequacy that we've seen in our rates over the last few years clearly is partly due to reductions in rates by the Board, but it's also partly due to developments and things that we did not take into account when we were doing the rates.

So I believe that when we submit a rate for approval it is taking into account everything that we know that could happen and it needs to be adequate in that context, and then when history becomes history we have had more downside impacts

since the beginning of the qualified health plan market than we have had upside impacts. One of those being the Board's decisions.

MR. MULLIN: In your testimony you testified that acceptable RBC range is 500 to 700 percent for RBC; is that correct?

MS. GREENE: That's our current target range, yes.

MR. MULLIN: At what RBC level would the state effectively take over Blue Cross Blue Shield?

MS. GREENE: The various levels -- I believe it's 200 percent where they would take over, but there's clearly earlier levels where action would be taken. The Blue Cross Blue Shield Association, this is the Blue Card network that we rely on to have Vermonters travel nationwide, the association will begin monitoring and looking at our management practices at 375.

MR. MULLIN: Does Blue Cross Blue Shield receive benefits under Vermont statute that are far beyond your colleagues in other states?

MS. GREENE: I don't know that. I don't know what our colleagues in other states --

MR. MULLIN: Okay. I'll leave it at that.

MS. GREENE: I don't know what you mean by benefits.

MR. MULLIN: Well I think there are additional protections -- may be a better word -- that are in Vermont statute that some of your colleagues in other states would receive. There may be some reasons why it might be beneficial for a RBC to be hired in another state without those protections, but I'll leave it at that.

Can you tell me, Ms. Greene, what the policy has been for the last several years on wage and benefit growth at Blue Cross Blue Shield?

MS. GREENE: Blue Cross Blue Shield sets its wage and benefit growth budgets based on the goal of attracting qualified folks to come to work for our company. In the last few years we've approved a company wide average merit increase of 3 percent. When I first joined the company that was 2 percent, but we do believe that we have to build something into our budgets in order to attract and retain quality people.

MR. MULLIN: So it's no secret that in the past year you have lost subscriber lives to a competing company. Have there been any reductions through attrition or anything like that to address

the fact that you are now administering fewer lives?

MS. GREENE: So thank you for that question. We did respond to a question in the prehearing that described that we look across all of our books of business and look at increases and decreases in membership over time, and each quarter that goes by we'll look at how membership is running relative to our budgets and we will make -- we'll recalibrate the variable costs when membership goes down. For instance, some of our vendor contracts are driven by membership levels so we'll make sure those contracts are adjusted. Some -- we had staffing models that are built on the amount of membership as Andrew testified earlier.

All of our segments are served by the same infrastructure. So we'll look across the volumes that we're expecting so that we're not laying people off only to hire them back at a cost and train those folks. We're taking a forward view and we'll calibrate our variable costs according to the membership outlook.

MR. MULLIN: Has there been any reduction in FTEs or reduction in force since the loss of covered lives?

MS. GREENE: We started the year with

some attrition. You mentioned attrition is one of the ways that happens in the service area and some of the enrollment services functions, and to the extent that vacancies have been held open as we see how the total company membership unfolds and we'll be -- we hire classes of customer service folks in groups of six or eight. So we'll wait and see what the outlook for membership is. We also have other things going on in our business. We have a large project that we're implementing a new technology and so we need to make sure that our phones are there in case there's a problem with that rollout. So we need to take into account both the membership volumes and the other things that we're accomplishing and then calibrating the hiring process accordingly.

MR. MULLIN: Does the 3 percent growth rate that you have estimated is that based on the bottom line total of all employees wages and benefits or are you doing a proportional share if there is indeed a reduction?

MS. GREENE: Proportional share? I'm not following your question. Could you repeat it?

MR. MULLIN: Well let me just give you an example. If you had 10 employees and you paid a hundred dollars and you went down to 9 employees but

you were still paying the hundred dollars, are you reducing it proportionally for a reduction in force or are you just using the bottom line number for the total?

MS. GREENE: So the 3 percent and I might ask -- I'll help navigate this. The 3 percent increase is a trend on a per member per month basis. So that is going to be automatically calibrated for the changes in membership. What I was referring to the membership merit increases that when you look at our total 400 people that we have working for us, the people that stay with us to process the business we do have will need to be rewarded for the progress they are making in their career paths or their expertise and to be competitive. So if the total amount of costs that our business can support needs to go down as a result of a changed membership, that would be a reduction in FTEs. I hope that's answering your question. The 3 percent is based on the salaries -- the assumption around salaries for the staff that is on staff, and then it would be -- if we lose 10 staff it's not as if the rest of the staff get more than 3 percent. It's the 3 percent on the remaining staff.

MR. MULLIN: That would have been the

short answer.

MS. GREENE: Sorry. I got there. Sorry.

MR. MULLIN: Mr. Garland, in your testimony you testified that Blue Cross Blue Shield has reached a maximum efficiency because of competition, and can you tell me the last time that Blue Cross Blue Shield denied coverage in a hospital service area because of failure to negotiate rates with that hospital?

MR. GARLAND: I cannot.

MR. MULLIN: Can you tell me were there variations between likely situated hospitals? So I'm not comparing academic medical centers. Are there variations in the rates that you will reimburse that provider based on your contract negotiations with particular hospitals?

MR. GARLAND: Yes. Are we talking hospital services or physician services?

MR. MULLIN: Both.

MR. GARLAND: Hospital services absolutely. Physician services generally no. It's usually the same reimbursement for physician services leaving out the academic medical centers across the network in Vermont.

MR. MULLIN: Okay, but even in physician services isn't there variation because a private practice would be reimbursed less than a hospital because of the ability to charge the facility piece?

MR. GARLAND: Typically no. We do not pay facility fees. Facility fees is a Medicare reimbursement mechanism. We reimburse for facility services, but that reimbursement goes to the hospital. Physicians do not receive any facility fee reimbursement regardless of where they practice in our network, and virtually all physicians in our network, other than those at the academic medical centers, are on the same reimbursement schedule.

MR. MULLIN: Okay. What is the basis during negotiations that you determine it's okay to have a variational payment?

MR. GARLAND: Well what's challenging about our hospital payment analysis is that we don't have apples-to-apples comparison anywhere in our network and you must have experienced this when you're talking to the hospitals about their budgets. So if I say to hospital A it looks like your charges for OB services are 30 percent higher than they are at hospital C, D, and E, the response we'll invariably get yes but we have an ophthalmologist

that we really need to pay for and he doesn't have enough patients, and the only way we can keep him on staff is to charge more for OB and cross cover those services.

So we put as much information in front of the hospitals as we can, and as you would imagine we draw their attention to the fact that looks high to us. We're trying to win the argument. We push hard on those things. Ultimately our ability to complete that analysis is less satisfying than we would like because we don't have access to their books, we don't have access to their cost accounting, we don't know what they are spending on that OB service or that ophthalmologist. We only know what they are asking to be reimbursed and there are wide variations, as you probably also have experienced in your analysis, between what we may see reimbursed at one hospital versus the one that's just one county over and they go in both directions. It is true that this one charges 30 percent more for OB services but they really are charging 12 percent less for cardiology, and can I put those two together and determine ultimately which is giving me the better deal? Only to a point, but we push regardless. I'm sorry. Some of my peers are in the room here. We

support the evidence that supports the negotiation and we push on those things that pop up and deserve attention.

MR. MULLIN: Is there any internal benchmark or standard deviation from the average that the company would just say no we're not going past this point?

MR. GARLAND: The best benchmarks that are available to us are Medicare reimbursement and we do look at cost relative to what Medicare would reimburse for them. It is very difficult for us to say we're not going past a certain point because typically you have already opined on the appropriateness of that budget or that rate increase through your process and the hospitals feel like that legitimizes the request they are making to us, and we would probably need to go to a pretty significant escalation to say yeah absolutely we will not accept this.

MR. MULLIN: Okay. I understand that this gets into an area that you probably are loathe to talk about because of considering it to be a trade secret and confidentiality. So I won't proceed with this questioning any further other than to say in some respects insurers handling it as what they

consider a business quote secret really inhibits the ability to push on those rates. Would you agree with that?

MR. GARLAND: If we had complete transparency of cost and we had solid cost accounting that we could compare sort of apples-to-apples, we would have a very different dynamic in discussing pricing and other pressures would come to bear on those hospitals besides what I can bring in a confidential contract negotiation. Absolutely that is true.

That being said we still negotiate. Sometimes we win. I want you to hear me say that because I think we haven't focused on that again here. We do sometimes win. The wins are not as big as we would like and they are not nearly as big as they used to be, but they are there. We push. We use every bit of ingenuity and creativity and pressure we can come up with and we do win sometimes.

MR. MULLIN: So based on the conversation that you just had do you still believe that Blue Cross Blue Shield has reached maximum efficiency because of competition?

MR. GARLAND: I apologize that I don't remember precisely in what context I uttered that

phrase. Was it about contracting?

MR. MULLIN: Yes and your testimony was that you had reached maximum efficiency and I'm just curious if that's still your testimony?

MR. GARLAND: Other than pushing on the lever where we deliberately allow a contract to terminate, I believe that our team is both as skilled as it can be and as diligent and hard working as it could be in its pursuit of these negotiations. We work very, very hard and very, very long and we push very, very hard. I don't feel -- I can say with confidence as the person who manages these functions I don't look at my team and say we need smarter people or we need to be working harder to get better results. I think we worked as hard and as smart as we can and we get as much results as can be achieved.

MR. MULLIN: So you keep talking about without taking off a coverage area. Is there an internal Blue Cross policy that would prohibit you from --

MR. GARLAND: No.

MR. MULLIN: Okay. Those are all the questions I have.

MS. HENKIN: Member Holmes.

MS. HOLMES: Thank you. So actually

this recent line of questioning from Chair Mullin is similar to mine so I'm trying not to be too redundant, but I think there is this disconnect between the description of active negotiation with hospitals in particular or your providers with to some degree the there's only so much we can do because the Green Mountain Care Board has set hospital budgets, and a lot has been written about a lack of incentive of insurers just in general, not just Blue Cross Blue Shield, of negotiating because they can just pass off the increased cost to consumers. It's the experience the previous year plus some for the next year. So there is some concern here about how hard Blue Cross Blue Shield is bargaining, and in particular I want to ask a couple questions with respect to that.

So if you turn to page 27, this is the cost trend from among Vermont facilities and providers impacted by the Green Mountain Care Board's hospital budget review and other facilities and providers. So 50 percent -- 53 percent of the allowed medical claims are actually to some degree managed, have some oversight by the Green Mountain Care Board and 47 percent do not according to the filing, and if we actually look at the cross trend,

you know, for the Green Mountain Care Board regulated entities, 2.3 percent last year, 2.9 percent for the other facilities and providers, and this year it looks like for those entities regulated by the Green Mountain Care Board is going down to 2.1 percent from 2.3 and it's actually going up for the other facilities that are not regulated. So I'm going to 2.9 to 3.5 percent. One thing -- one question I have is why. So the entities that we're regulating is -- actually were to some degree -- maybe we can take some credit -- holding down some of the cross trend. What are you doing for the entities that we're not regulating to try and keep it in line with what we're doing here?

MR. SCHULTZ: So the numbers -- I just want to repeat my testimony from earlier. So if we look at what we currently know about contracts elsewhere and what goes under your umbrella, that 3.2 becomes 2.8 percent. I apologize. I don't have the correlating numbers for the 2.9 and 3.5, but we have pushed harder on those contracts and what we know now is that those are 2.8 percent. If we look at the hospital budget submissions, those rather than being 2.2 percent are at 3.2 percent, and the one other element I want to add to that before I turn it over

to Andrew is that the other facilities and providers a large chunk of that -- and I don't have these numbers in front of me so I'm not going to guess, but a large chunk of that is for out of area providers. That's for folks who assess -- if they are traveling they access these and those are negotiated by other Blues plans.

MS. HOLMES: On that note what percentage of that would you say is Dartmouth-Hitchcock?

MR. SCHULTZ: Dartmouth-Hitchcock we do negotiate with directly and again I don't have the numbers in front of me. I would be happy to follow up with those.

MS. HOLMES: That would be great. I would love to know what percentage of that 47 percent of other facilities and providers is actually the other large academic medical center that we don't regulate but that a lot of Vermonters seek. Go ahead.

MR. GARLAND: I can describe at least what goes on in that 46 percent. A significant amount would be managed by Massachusetts, New York, New Hampshire Blues. We don't directly contract those. We just have to accept those rates. We know

that nationally the Blues tend to do better than CIGNA or Aetna or United. So though the rate of increase is high, higher than what's happening here in Vermont, we're usually doing better than what other commercial plans are doing and that's because we have a very low goal community focus across the Blues network and that tends to turn into better rates.

We do negotiate with Dartmouth-Hitchcock every year. Those are serious -- I mean those negotiations take about six months beginning to end. It's almost a constant year-round process and I would say that we have been highly successful in accomplishing a lot for our members there. The other component would be things that we manage on fixed fee schedules. Without going into a lot of details in this room that will create noise for me when I walk out in the hall, I can tell you those fee schedules are not going up 3 and a half percent anywhere or anything like that. So the big drivers here would be what's happening out of state. The increases for the fee schedules that we manage tend to be much, much lower than three and a half percent annually.

MS. HOLMES: And what creative, innovative incentives might you be creating for

consumers to stay within the network?

MR. GARLAND: Consumers to stay within the network?

MS. HOLMES: Well to not -- you know you're talking about some portion of this being Massachusetts and out of state -- I should say out of the regulatory --

MR. GARLAND: Well some of our members have benefits that provide richer coverage if they stay in network. We offer tools on our web site that allow members to see the relative cost of coverage and that includes nationally. So they can compare the cost of a service at their local hospital or at the academic medical center in Chittenden County with a hospital in New York or Boston if they are considering that hospital option. They can compare the cost. Josh could talk more about his case managers and how they help people navigate when they know they are going to be in a very high care situation. I am sure that it is not our policy to try to revert people into high cost facilities in other states but to help them understand where high quality services are available here, but it's important to remember we have a lot of people who live along the border, across the border, or who live

in other states entirely and for some reason or other are receiving coverage through Blue Cross Blue Shield of Vermont, and they are just not going to access our local hospitals.

MS. HOLMES: Let me actually build on that a little bit then. You talked about the price and quality transparency on the web site now, and there's some testimony in here about that web site as well as a tool that potentially people could use to understand whose an accredited physician and what the price to them would be for a particular procedure and whatnot, but you also talk about the very, very low usage of that web site; and so one of the questions I have is what are you considering to try and drive more traffic to that web site, and, in particular, you also talk about in here Blue Cross Blue Shield has evaluated tools that might offer other incentives for consumers to be more price conscious or more price aware making their choices.

One that I have actually seen evidence that it works is actually shared savings program that patients get money back when they actually choose a diagnostic lab or some other sort of procedure that actually is the lowest cost alternative. I'm wondering -- you talk in here about saying that you

actually have considered these. I'm wondering what you have considered and how those innovations might actually reduce the rate.

MR. GARLAND: So we're in fact in the process of implementing a new tool. We have already identified the vendor, but the solution won't go into place until 2019 after we get past the other technology project that Ruth was mentioning. The tool we think will bring hopefully a much higher level of engagement because it offers tools to engage people on more factors than simply I'm going to go out because I know I have a service and see what it might cost. The tool gives us the ability to engage people across the wellness campaign or prevention campaigns that might be happening in their offices, it allows us to connect to community events that we're running, have people's attention and try to get them and go out and connect with the information on the tool so when we have their attention in a slightly different venue we can redirect them; hey did you know. It also has outbound capability to send people emails letting them know we have this therapy or you have recently scheduled this service, did you know there are lower cost alternatives available, click here to explore those.

The tool also has the ability to manage fairly complex and customized incentive campaigns. So if we wanted to target a particular area of high spend, let members know there's another place to get this lab service, let us tell you about it, and if you choose this lab versus that lab we can make an incentive available on Amazon or a dollar incentive. That ability is available for us as well after we get past implementing the tool and really pushing to raise awareness. We'll do a broad based campaign with member groups, physicians. Then we'll move to what are areas that we could now think about launching incentive programs that would really work for our membership where we know we have utilization opportunities. We're quite excited about it.

MS. HOLMES: Is there any expectation in 2019 that will lower utilization as well? Has that been manifested in your rate request?

MR. GARLAND: Given the project plan I think the goal for 2019 is to get the tool up and running and to raise awareness just so we can get people to begin interacting with it. I think broad based incentive campaigns and savings from them are much more likely to be something we're looking at in 2020, although even there I wonder if we'll have

enough knowledge to be able to price that prospectively. We'll see as we work with the partner what they have accomplished with other plans and what they can prove to us they can accomplish with us.

MS. HOLMES: Just before I switch over to utilization something different. In terms of unit costs in the past couple of weeks the pharmaceutical companies, maybe four or five of them, have made some announcements about some flat pricing or delayed price increases. Some of the bigger pharmaceutical companies. So I know that would have been too late to incorporate into your filing and maybe perhaps into your amended, but I'm wondering if those recent announcements would have any impact on your pharmacy trend?

MR. SCHULTZ: It will eventually have an impact on pharmacy trend and we applaud that sort of thing. We certainly hope it happens. I do want to point out, you can see it in the L&E account, the pharmacy trend for first few months of 2018 has been 20 percent. We did not change our pharmacy trend in the amendment even though the trend is clearly significantly higher than what we filed. So we're glad to see that activity. We hope it does mitigate costs in the future. If you ask me my professional

opinion today, I think our pharmacy trend is likely to be understated for 2019.

MS. HOLMES: One point in one of the -- whether it was in the question I cannot remember, but you stated Blue Cross -- stated in general Blue Cross is motivated to reduce access to unnecessary care, and there was a frequent citation of -- multiple citations of this National Academy of Medicine assumption that about 25 percent of all expenditures -- this is probably you -- have no impact on health outcomes. 25 percent of all health care expenditures have no impact on health outcomes. So if we look at just roughly the allowed claims, we're talking about 546 million dollars of allowed claims, 25 percent of that would be about 114 million dollars of expenditures that probably have no impact on people's health, right. A lot of money. Maybe that's a big broad estimate, but just doing a little back of the envelope.

So, you know, the cost containment initiatives which having sat through these rate hearings in previous years I applaud the section on cost containment. There has not been such a section with such initiatives before so I thank you for that, but if we look at it, this new cost containment

effort of reducing readmissions and reducing ER visits amounts to about a four million dollar savings, these two initiatives. So I'm wondering what are more significant efforts that could be done beyond, you know, these two efforts to really reign in this unnecessary and wasteful expenditures that that will have a big impact on rates if we could cut 25 percent of our expenditures that are having no impact on people's health. How do we do that?

DR. PLAVIN: We can bring patients back, but you also are mandated to cover things that we don't necessarily believe are actually medically necessary. So we have done a lot of work on -- to reign that in; institute an investigational policy, address kind of -- about to address lab management because that's becoming a runaway cost, but you know to think that we would be able to achieve the 25 percent it would have been done in the United States already. So to achieve a portion of that is good progress and we want to continue to do that.

So radiology we have touched. Lab we are about to touch, but that's not going to be in -- it will be -- that will probably more impact 2020 is my guess in terms of implementation, and the other policies that we have are built into our claims

experience and into our projections going forward. Can we do more? I'm hoping the ACO and OneCare model will help mitigate costs a lot more than we have including pharmacy in that arrangement or at least non-specialty pharmacy to start is a big step forward. Hopefully it will include specialty pharmacy as well.

MS. HOLMES: You reminded me that one of the big drivers of the utilization is the diagnostic lab kind of work.

DR. PLAVIN: Yes.

MS. HOLMES: Again that's an area that's one of the drivers of utilization. It's also one of the areas that you know there can be some waste.

DR. PLAVIN: To some degree there's a technology solution required and we have to make that investment in the technology to manage that. There's also the utilization management piece too. So we are addressing that actively right now. It's not going to be in time.

MS. HOLMES: Time is of the essence.

DR. PLAVIN: I know.

MS. HOLMES: You mentioned the all care model so let me ask you a couple questions about that, and I don't want to ask too many questions

because I'm pretty sure my colleague down the row is going to have some questions too, but how do you plan to work with the ACO in general to reach scale targets that we have for the state related to this particular filing, but also related broadly. We have committed a comprehensive effort at improving health care outcomes at lower cost in this all payer model. I'm wondering if you can speak a little bit how you're going to help us reach those.

MR. GARLAND: For this population we're all in. The limiting factor here is the size of the ACO network. As they grow more primary care physicians join their network, more and more of the individuals and members will be in, and if all primary care physicians were in, essentially the entire local population would be a part of the program. If you look at the rest of our population, we have a small segment of largely uninsured and it is relatively small at this point.

We have talked about the ACO, what is the right time to move that pool into a very similar arrangement to the one we have in the individual and small group, and I think it really is a matter of timing as they grow their infrastructure and their ability to manage more lives through the model. So I

don't see any impediments to move that one in, and then the final block of membership which is quite large is the self-funded block. There are more complexities here. Obviously we're not bearing that risk. So creating an arrangement where that risk is shared between the payer, which is in this case the employer, and the ACO is more difficult. Self insured groups are quite a bit smaller so we quickly run into issues of credibility of data. They want to maintain their status as self insured so we have to be careful we don't make them insured and get them in a place where they would be violating any laws, and we have to manage the benefit challenges that go to moving away from service payment to a fixed form of payment where two groups that are right next to each other on Main Street have widely different benefits and cost shares that need to be administered, but we launched our first self insured pilot. It's a fairly large group, 10,000 lives, and we've been working very hard with the ACO folks to push the model so that it is scalable and can be available as an attractive alternative for other businesses in Vermont or organizations that are ready to move that way.

MS. HOLMES: Are you optimistic by next

year you will have more of your self insured book of business?

MR. GARLAND: Yes. I think there will be some more. Whether or not -- I think broad based adoption by that segment will trail results, and when we're able to look at those folks and say we have some very positive results from individual small group, we have very positive results from our first pilot, then I think adoption will move much more quickly. Folks are really waiting to see okay we know what it is, but we're still waiting to find out is it going to work.

MS. HOLMES: One of the issues that come up often when we talk about reform and provider of -- the landscape of providers and provider morale is the administrative burden of the quality metrics, the burden of paperwork, and prior authorization I understand have a return on investment, but they also have a cost on providers. So I'm wondering if you can talk a little bit about just what you're doing, how you're trying to reduce administrative burden while still trying to use some cost containment strategies that would be helpful to the consumer at the end of the day, but also making sure those cost containment strategies are not reducing provider

morale and creating retention/recruitment in Vermont issues.

DR. PLAVIN: Sure. So as Board Chair Mullin knows, I've been on the primary care advisory group and subcommittee and we've been talking about this very thing. One of the things we're doing this year for most but not all EMRs we're rolling pharmacy management into the EMR at the point of care through technology essentially so that the providers have the information at the point where they are making the decision for care. So they don't have to -- it's all kind of rolled into that process and they can make informed decisions. They can look at formulary, et cetera, et cetera. So that will be -- that's -- that was very well received by providers in that group and I think will be across the state. However, it is limited to some of the larger EMRs right now and is rolling out slowly to others as well. So that's on the pharmacy side.

On the radiology side that is automated. There are opportunities. A lot of it's going to be technology. So a lot of it is human time and effort. We need to figure out how to make a smart technology investment to bring utilization management transition to the decision support at point of care. Medicare,

as you may know, is requiring now radiology utilization management so it's being more accepted where we can harmonize our approach with them. That might be a smart thing to do, and I think as we go through our policies we develop them in concert with our providers. I was just referencing that earlier in my testimony. So the more we can do that the more it will become the standard, if you will, and then in the future assuming that we have continued development with the ACO we'll be able to work much more in concert with providers around appropriate use criteria, building that into the standards of care and pathways. So it's not prior approval, but kind of what we just do because none of this is about -- it's about medically necessary care and care that improves outcomes. It doesn't help contain costs. Certainly most of it does. Some stuff, as we've testified on, is a societal choice to make an investment.

Actually to the pharmacy question maybe I can talk about economy for a second which is that a $253,000 medication for cystic fibrosis may prevent one or two admissions a year. So you're spending $253,000 to improve the quality of life of a kid most of the time. You're maybe avoiding two admissions

which is far less money than $253,000. We're making a choice to do so because it's the right thing to do over the long term. So we make these trade-offs around willingness to pay as a society for some things. Many of these things as we suggested can be good cost containment methodology to reduce waste.

MS. HOLMES: I think I just have two more questions I believe. Several of the components of the rate reflect care management costs, right? So there's money going out to OneCare Vermont. There's money -- there's money allocated towards per member per month to OneCare Vermont. There is per member per month allocation to ESI, the Express Scripts for clinical management. There's Blueprint money allocated, and then 14 percent of your administrative costs are related to medical management and quality and wellness. So there's a lot of money largely kind of being allocated towards care management, clinical management, and some of it's now being -- some of the care management Blue Cross Blue Shield used to do internally is now I would imagine somewhat being outsourced, right?

So OneCare Vermont is doing some clinical management, care management. Blueprint community is doing some. How do we ensure there's

not a duplication of services along the care management spectrum such that we are -- you know there's money embedded in the rate and there's internal Blue Cross Blue Shield staff doing that kind of work, there's OneCare Vermont doing that kind of work, there's Blueprint people doing that kind of work. How do we know there's not an area where there's too much overhead throughout the system?

DR. PLAVIN: So we are working closely with OneCare. In fact, they have a technology called Care Navigator which is a community care plan and so all the care managers that might be involved with the case can actually share information back and forth and they have different purviews. So here a mental health designated agency you're going to focus on the care management around that piece. We might actually spend more time on navigation of benefits per se or out of network care that happened in Boston for an example, OneCare, and so what we certainly don't want to do is duplicate costs, and over time you're right we probably will change what we do. Maybe what we do as some of that function becomes that of OneCare and the Blueprint. OneCare doesn't really provide direct care management. They rely on the Blueprint, but that's an evolution as you know.

We're at the table. We meet with them regularly. We're on the committees and we certainly don't duplicate and we certainly refer to them. We will likely, as you had suggested, have to reenvision how we do things as our relationship with the ACO OneCare evolves. I think it's pretty nascent right now and so we're still doing a lot of utilization management. That utilization management ideally could be done in a different way, but it requires the ACO to take that over. The cost of that overhead might transfer from us to them ultimately, but it will still be a cost. I don't know how efficient -- how much more efficient we can make it.

MS. HOLMES: With respect with the assumption about the two percent rate increase linked to the elimination of the individual mandate, I think this is brought up a couple of times, but the individual -- that assumption assumed that all members without premium assistance will reduce and/or preventative care will drop coverage, about a thousand people, and I think, like the Health Care Advocate, this strikes me as high. I think there are surely many people out there who may never see a doctor for a year. I might be one of those that would never drop my insurance because I'm risk

adverse, and I think -- as I was thinking about it I would think a better way to identify those people who see no value or very little value of insurance but for the mandate would buy catastrophic and bronze plans because they don't anticipate being users of the plan, but they feel like there's a federal mandate I've got to buy this insurance plan, but 25 percent of the population that you have identified as dropping coverage when the individual mandate penalty is eliminated are in gold and platinum plans. So they have chosen to be in the most expensive most generous plans, but your assumption is that they don't really want need them and they would drop it.

So if you look at that, that's about -- you know if you only look at say the bronze plan enrollers, forget -- you didn't give a number in your testimony here of how much -- what percentage of those at one thousand are in catastrophic plans, but you broke down bronze, silver, gold, and platinum there's only about 400 people in bronze plans. So wouldn't a better assumption be maybe those roughly 400 people drop because they don't probably value insurance as much and those people who have chosen to be in silver or definitely gold and platinum value insurance for its risk and are probably not going to

drop it.

MR. SCHULTZ: I thought you were done.

MS. HOLMES: I probably wasn't.

MR. SCHULTZ: I think that would be another interesting way to look at it. I want to reiterate when we looked at this we did not have as much information or high quality information as the actuaries that you jointly with DFR hired to take a look at this. I didn't have information about income. I didn't have information about what MVP charges or what their membership looks like. So I did try to model this in such a way that I will admit it is a relatively simplistic way to look at it.

So again do I think that these are precisely the people who will leave? No. Do I believe there will be people who leave who have more than just the preventive visit or no care at all? Yes absolutely, and in fact if you compare the membership assumptions from the study you commissioned, they are assuming a far greater number of individuals leaving the market. They are still coming back to that 2 percent, and perhaps if we had -- if I had an infinite amount of staff and an infinite amount of time to look at this and I had access to the same information, I would have been

able to do a much more detailed indepth study instead of choosing a relatively simplistic model. I noted that model led to a result that is right in the middle of the range that the actuary you hired came up with using their better data, probably more resources frankly, and I was satisfied with that result was actuarially reasonable.

L&E in their opinion on the matter came to the same conclusion this estimate we had was a reasonable actuarial estimate. So do I think it's a perfect reflection of reality? No I don't, but I do think it's a reasonable answer, and I'll also say we assumed a greater proportion of people had left that would have had a higher impact on premiums because of the decreased scale would have increased our costs and things like that. So I think by doing this this way we actually handled it in a slightly lower premium impact than we may have otherwise done.

MS. HOLMES: Okay and I guess my last and final question talks about efforts that you had to reduce fraud, waste, and abuse. So from 2014 to 2017 the percentage of claims recovered grow from .09 to 1 percent, but there were no expectations of any further reductions in fraudulent claims. So sort of held constant at about 1 percent is the expectation.

It just sparked me as curious. I did a little research to find out what is typical in the percentage of fraudulent claims -- what do people estimate the fraudulent claims percentage to be.

So the National Health Care Anti-Fraud Association estimates about 3 percent of all health care spending is lost to fraud and the FBI estimates it at 3 to 10 percent. So I'm just wondering if you increase the percentage of fraudulent claims recovered to say that 3 percent, what impact would that have on rates?

MR. SCHULTZ: That would have a pretty direct impact on rates. I do want -- I'm not an expert on fraud, but I do want a comment a little bit on the statistics. I know from my previous experience as a Medicare actuary that a very large proportion of the fraud that's committed in this country is on the Medicare side. I can go into more detail on that if you're interested, but given the time maybe I shouldn't.

So we think that -- we continue to implement additional programs. You can see that in one of our responses over time. So as providers -- providers aren't doing this out of ill will for the most part. These are things we're finding that are

claims that are not submitted the way they should have been and providers learn from that and they start submitting claims in a more appropriate way. So as we move through time that one percent that we identified last year, if we're going to find one percent again that's a different one percent. That's not just the same providers doing the same things because they kind of learn from that experience.

So we do continue to enhance our efforts here and come up with new and different programs and kind of try to stay in pace with some of the billing and practices that we see. So we do think we're going to be able to maintain that one percent. I would like to think, and I think there's good evidence, that in Vermont that the fraudulent practices are not as high as they may be elsewhere like they may be for Medicare. So I think that one percent is actually a pretty good result.

MS. HOLMES: But is there room to increase that?

MR. SCHULTZ: There may be and we implement programs all the time in an effort to try to do so.

MS. HENKIN: At this time we're going to take a 15-minute break for lunch and we're going to

be starting again at 5 minutes to the hour. We are about an hour and 20 minutes behind where I anticipated and we're not through the Board's questioning. So please take a very quick break and we will see you back at 5 minutes to 2.

(Recess)

MS. HENKIN: Okay. We are now going to continue with questioning from the Board and I'll go to the board member at the end.

MS. USIFER: I just want to go back a little to something that Jess was talking about. On page 223 when you talk about the members who are going to lose the 2 percent that we're taking for those members who are not going to join the plan, I wanted to ask have you considered any changes in bad debt as well when you made your assumptions?

MR. SCHULTZ: We did not. No.

MS. USIFER: So you kept that debt whole?

MR. SCHULTZ: Yes.

MS. USIFER: And I know the fact Vermont is going to reinstate a penalty in 2020 came after the fact of you coming up with your 2 percent. Don't you think that would have some impact on some of the members? I'm not saying a large percent, but to

assume everyone doesn't have a thorough understanding of we're off on the federal as far as receiving a penalty but it will come back on that future time for Vermont?

MR. SCHULTZ: I don't think it will have any impact. As L&E stated in their report, we have guaranteed issues in place. So there's nothing preventing these members from leaving in 2019 and coming back in 2020. So no. I would like to give you a different answer, but I don't think the Vermont mandate effective in 2020 will have an impact on 2019.

MS. USIFER: Okay. Can you look at page 12, and part of the reason for the rate increase 1.3 percent was looking at the 2017 to '18 medical utilization that was reduced to 1 percent from 2 percent by GMCB last year, and now you have reexamined these and you're restating that again for this filing, and I just want to understand do you have data -- any new data that's supporting that actually what's coming in is closer to the 2 percent versus the 1 percent or you're saying that was your original assumption. We adjusted that last year and now we're readjusting that.

MR. SCHULTZ: Is your question in terms

of new 2018 experience?

MS. USIFER: Yes. The specific part where you added 1.3 percent for the 2017 to '18 trend component because of the adjustments that Green Mountain Care Board did last year.

MR. SCHULTZ: I'll answer that in two ways. So we did have an additional year of experience that we were able to examine to take a look at what that utilization trend run rate is and again reconfirm the 2 percent.

I'll also answer it in terms of the question is there additional new data as soon as -- since the time of the filing, and I'll give you the same answer to that I usually give to Ruth to my right. It's still pretty early to be able to fully assess what the 2018 experience would be like. So we did include the additional year of experience we had from '17. We did not include any experience from '18. Very early return shows there is some additional pressure on 2018 rates over and above what we had anticipated, but I did not factor that into the filing and I did not factor that into the trend calculation.

MS. USIFER: And is that over and above what you had anticipated or what was filed?

MR. SCHULTZ: It's over and above what we had anticipated. We did file our anticipation of the 2 percent utilization trend and what we're seeing so far is that experience -- emerging experience is slightly behind that. I can't put a number on it because again it's very early in the year to look at medical claims. We can look more concretely at pharmacy claims which is part of the 1.3 percent as well, it's about half of it, and as L&E documented in their report and we documented in one of our questions in the Q & A pharmacy trend is running much closer to 20 percent for the early part of the year. It's easy for us to look at pharmacy claims. They are electronically submitted so those are almost realtime in today's world. So we're able to assess some 2018 pharmacy claims. Again we did not change our trend. We did not increase it for that increasing pharmacy trend we're observing thus far in 2018.

MS. USIFER: And then on the association health plans where you guys have not originally submitted that in your submission and now you think there's more certainty that will happen and that was bringing in the potential of 2.2 percent for rates which is probably 8.4 million or so dollars that

would be contributing, and just wanted to know if you thought about offsetting that from the AMT tax which I understand is also a federal plan and it's not necessarily definite but is assumed to be happening in the later part of the year, and if we did that and did not roll through that 2 percent and assumed we could offset that with the AMT and there would be time to look at the actuals next year, and then understand did you really get the AMT of 16 million rather than put this into the filing now at this late time, and I understand also put some moderate point 1 percent change for the chiropractic and things like that, but I'm just looking at it as they are both federal programs -- federal things that are running. We're not necessarily sure of either yet. We don't have a hundred percent surety that the association plans will run in. We certainly will know down the road whether you got 16 million from the AMT and whether it occurred, but one way to capture that would be to offset.

MR. SCHULTZ: I think there are two parts to that response and I'll return it to Ruth to the second part. In terms of the actuarial work when these association health plans come into being my team and I are going to have to price those as well,

and I'm going to have to meet the same standards of making sure they reflect the population that I expect and the benefits that those plans are going to offer. So I think that's an important consideration because if you completely ignore any impact it might have on QHP when we go to price AHP, I can't make an assumption that 8 million dollars is just going to disappear from the system altogether. It's the same people. Whether they have them here or over here I'm still going to charge them or we need to still charge them rates that are adequate.

So, therefore, whether they are a member of the qualified health plans or a member of an association health plan that's the same bucket of money. So we've got to balance both things. If we just decide to pay that -- if we essentially decide to decrease rates to pay that out of the AMT, to me that speaks to a solvency decision in terms of the CTR that senior management instructed me to file. So for that piece of the response I'll turn to Ruth.

MS. GREENE: My response to that is much like the HCA's question sort of what would happen if. I think I'll go back to the Commissioner's solvency opinion which clearly states that one of the fundamental aspects of protecting solvency is to

submit rates that are fully funded, and with the knowledge that we have here sitting here today about the association plans for 2019 we believe there will be an impact. So that's why we believe we need to file the amendment.

If for whatever reason there's a cut in the rate or there's some new event that happens, that will all come into our surplus, and when we review that and look at what's required to sustain our RBC level when those events occur we're constantly looking at it. So I think to the extent that something were to happen, mainly there's another rule on AHPs that will come out between now and the end of the year that's from the federal government, we will be, as I said, navigating these waters, and the 16 million will come into surplus and whatever our situation is at that time it will be a positive thing because it will help us navigate, but there's already so much pressure and financial risk on us in terms of the lower end of our range that it would not be consistent with our need to submit fully funded rate proposals to not file the amendment at this point.

MS. USIFER: The only challenge to that might be if you have the knowledge today, we assume we will get the AMT money back today with the

knowledge that we have, right? There's nothing saying that we won't get it back. So it's just sometimes we're putting things in when we have the knowledge on the association plans. We also do right now have the knowledge on the AMT. We're just not putting it in because it could change.

MS. GREENE: It could change and we know that the federal government has changed its payment policy. So we believe it's appropriate to reflect that when it's received not when we're estimating that we'll get it.

MR. SCHULTZ: Can I elaborate on that for a second? So even if we do receive the entirety of that 16 million dollars, that is not going to push us outside of our solvency range. So we've testified in the past that if we fall outside that range we will amend our CTR and file something that is different from our long term assumption. If we fall below our range, we'll have to increase the CTR to try to get back there. If we've above our range, we'll decrease CTR to again back -- back within the range.

I want to make it clear that 16 million dollars is not going to push us outside of our solvency range all else being equal in terms of how

claims are coming in, et cetera, et cetera.

MS. USIFER: I guess the last question is I definitely followed the cost containment programs you have rolled through here. Are there anything you can talk about on the horizon that maybe can be accelerated into 2019? I mean we're still just midyear in 2018. Are there things you guys were looking at that you may reap benefits from in 2019?

MS. GREENE: I think the example possibly, Andrew, that you gave earlier is one that we're working on and it's on the horizon. You mentioned that our goal is to implement it in 2019, see what the results are, and then we'll have to decide if that's something that we can incorporate into the rate filing. I don't know if there's any others in the hopper. That's a relatively large one in terms of interacting with members realtime I think was the example that Andrew had given earlier so that we can get them to good quality care, but -- for possibly improvement, but there is a lot of focus on that one because it's so important to our members.

DR. PLAVIN: Lab management is going to take longer. So there's very few independent labs in this state like other states. So it will take a bit longer to kind of realize benefits.

MS. GREENE: Again another example I can just offer up as a way to show you there is a pipeline. There's a project that we're in the beginnings of assessing the ROI and that relates to whether or not there's new data and technologies to apply to automatically checking claims as they are submitted and throughput. We have mechanisms now for that, but our understanding is there's some technology out there in the marketplace and we're going to look at that. So that's just an example of something that we're constantly on the lookout for, those sorts of things.

MS. USIFER: Thank you.

MS. HENKIN: Member Pelham.

MR. PELHAM: I was waiting for Robin to start to talk. So I have some questions having to do with this premium filing, the relationship of these premiums to Vermont Health Connect and their calculator, a little bit on the cost shift, and a little bit on the other language that was in the special session budget bill that affects Vermont Health Connect just to see about your understanding of it.

So I'm new on the board and this process of asking questions is a little different for me

because usually I used to sit there and have to answer questions. So I'm sympathetic to your position. The -- to get a sense of scale on your filing cover sheet it says this is worth about 26 million dollars. So in terms of the rate increases people can talk per member per month, things of that sort, but the amount is 26 million dollars which is helpful in terms of a sense of scale and these premiums when approved before subsidies. They are before running them through Vermont Health Connect where most people will engage their policies.

So I'm wondering have you -- do you have information or have you done analysis that shows what these premiums alone independent of advanced premium tax credits and cost sharing reductions what the percentage of these -- what the relationship is? Are these premiums to percent of the federal poverty level?

MR. SCHULTZ: We have not done that analysis. No.

MR. PELHAM: So would it surprise you -- I just did a couple. Actually what I did do was went to the 2018 because those are approved rates and there is a calculator for those rates and I could absolutely tie it out between the calculator and the

premiums, and so I'm looking at a couple at 250 percent of poverty that the premium before the Health Connect would be 28 percent of their income and for an adult with child the premium would be 32 percent. These are bronze plans, 32.3 percent and across all four plans. So if you do a matrix of individual, couple, adult to child, and family, and then the six income levels across the top of the federal poverty level chart, that those cumulatively the average premium is 27 percent of income, and so I know that we have a second next stop on the train which thankfully we do have that, but would you consider rates in this arena as being affordable or unaffordable as a percent of income?

MR. SCHULTZ: I think the Vermont Legislature saw that they would be unaffordable above 300 percent, thus, the existence of those programs you talked about provided by the state subsidies already. Also federal subsidies for those individuals.

MR. PELHAM: Well that's exactly what I want to get to in a minute. So I went down through these and just to tell you where my numbers were that across all the silvers the average is 33.3 percent if you did that matrix. Across all golds it was 36.6

percent, and across all platinums it was over 41 percent. So then when you go to the Vermont Health Connect calculator and you start running your premiums through that system it makes a big difference and affordability is really affected by the almost hundred million dollars of subsidies that exist that we talk about today. So the bronze plans -- and there is no standard of affordability. I believe your answer to the Health Care Advocate that there is no -- we don't have a standard and we're all using our best judgment and trying the best we can.

I think there is one standard in the Affordable Care Act of about 9.5 percent for an individual without help from an employer. So that's just kind of a rough measure. Looking at the bronze plans most of them seem to be affordable and meet that criteria, but as you start kind of scaling up to silver plans they become kind of by that standard unaffordable at around 400 percent of poverty, and you go to the gold plans at around 250 percent of poverty and the platinum plan is around 150 percent of poverty. So as your incomes come down it's a relationship this makes sense. So it's clear to me that these subsidies are key to affordability. So let me just kind of leave that alone and go to the

next area which is you mentioned the cost shift.

The cost shift is you have it 393 million in 2014 up to 491 million in 2017 and the Medicaid cost shift at 209 million is the actual number we have.

MS. GREENE: For the total.

MR. PELHAM: That's right, and you talk about collaborating with the state to provide seamless enrollment and management of the products offered through Vermont Health Connect. So have you had discussions with the state relative to the filing for 2019 as to how the subsidies that the state might make available would make these plans more affordable?

MS. GREENE: So the process as we've come to understand it over the years is that once the rates are approved the Department of Vermont Health Access will take those rates and run it through the technology that matches that up to the calculator and they will update the calculator. We have not run the 2019 rates through that view if that is your question. Once those rates are up and running we do coordinate very closely -- I think the seamlessly reference is getting at we work very closely with the Department of Vermont Health Access on the outreach

and communications making it really clear what the changes are and how folks can navigate the new plans, if there's any new plans or any -- in this case this year we have the silver solution which we're working very closely to make sure the communication is proactive.

MR. PELHAM: My understanding is the Vermont premium assistance is an entitlement. So from a state appropriation point of view it's not a fixed amount that has to be managed to. It's an entitlement in addition to the advanced premium credit at the federal level.

MS. GREENE: That's how it worked in the past. It's actually a separate plan design so if someone is eligible for the Vermont premium assistance, their plan accounts for that, right, in what they see for premiums.

MR. PELHAM: Now do you -- do you know, because I don't, whether or not the cost sharing reductions sponsored by the state, not the federal level which are gone now, are the state cost sharing reductions an entitlement or is that an amount of money that the calculator has to manage to?

MS. GREENE: The way cost share reductions work is that it's based on the claims that

are paid. So my understanding is that the state estimates what they think they will pay for the Vermont piece of the cost share reduction and then they pay that based on enrollment, but at the end of the year we settle up what was actually paid for claims and what sort of cost share reduction was required to have that person experience of the appropriate cost share. So I'm not clear if in your nomenclature that's an entitlement or not, but that's how it works.

MR. PELHAM: If it gets trued up, it's not just an open ended entitlement. So here are the numbers. For 2018 the Vermont premium assistance was 6.6 million and the CSRs were 2.6 million. That's from the JFO documents. You can go online and do the budget tracking documents that's what you will find.

For 2019 the Legislature has appropriated 7.1 million for Vermont premium assistance but only 1.4 million for cost sharing reductions. So that's a decrease of '18 from 5.6 million to 4.7 and that's just the general fund share. Do you have any sense as to why the Legislature and the Governor would have decreased the cost sharing reduction appropriation?

MR. SCHULTZ: I can take that one if you

want.

MS. GREENE: Sure.

MR. SCHULTZ: Actually fairly limited understanding is that the Legislature for whatever reason didn't decide to fully subsidize CSRs. That was not to say that the benefit is going to change. They do expect the benefit to remain. They do expect that the total outlay is going to be 2.8 million dollars and they are going to have to find that money somewhere, but my understanding of the negotiations that went on they only included the 1.4.

MR. PELHAM: So let me -- I don't have much more here. I just want to go to the special session which you talked about where there were two pieces of legislation that affected you, the cost sharing related to chiropractic and breast cancer. Did you have any discussions with the state as to them passing a law at the end of the session and then -- but not appropriating any money for it?

MR. SCHULTZ: That's an interesting question. So my understanding is that if there are new mandated benefits, the state is required to pay for those. The way the state has approached these types of changes in the past is that it is not a new benefit, but rather it is a benefit change in cost

sharing and as a result that needs to go into premium rates as opposed to having a state appropriation.

MR. PELHAM: Okay. So I'm trying to make the connection between the actual appropriation going down and the legislative approach you're going up for services and benefits. Did you testify to either of those two bills having to do with those two changes to benefit?

MR. SCHULTZ: Sarah is saying we did.

MR. PELHAM: Then you did. So just to kind of close the loop here there -- in the appropriations bill there was change to the language to a reserve called the case load management reserve. Are you familiar with that at all?

MS. GREENE: I personally am not.

MR. SCHULTZ: No.

MR. PELHAM: So in '19 -- and here again you can go to the Joint Fiscal Office and find these -- that is in the general fund and for fiscal '18 they had 22 million dollars in that fund. For fiscal '19 it is up to 100 million dollars. It's a huge increase and I know something about that from when I was Finance Commissioner. We created it in the Dean Administration. We used it to stash cash that we knew the Legislature wouldn't touch to be frank with

you because they wouldn't want to take it away from human services programs, but this is a huge increase, and I'm told, I don't know for that fact, that that increase was driven by the kind of true-up and settle up of Vermont Health Connect, and that is money that can be used to -- I'll read it to you -- a sub-account for Medicaid related pressures related to case load, utilization, changes in federal participation, existing human service programs, and settlement costs associated with the management of the global commitment.

That's new language and what the Legislature did is kind of assign it to two areas. One is the incurred but not reported associated with local commitment, and the other was for this language and assigned that 14 million dollars; and, finally, and this is the question, you don't need -- the law is structured such that you don't need the Legislature to appropriate the money. It can be appropriated by the emergency board and the emergency board is combined of the Governor and the chairs of the finance committees, money committees in the House and Senate, and so when we get to an issue like the individual mandate which is an upward pressure on ratepayers, and L&E has estimated for us that the

amount associated with just the individuals who in my opinion are under the most pressure because they don't have an employer helping them, et cetera, that the cost of an individual mandate to them is -- the 2 percent increase would be a little over three million dollars and to MVP about one million dollars.

So would you consider going to the emergency board and asking them for -- because this individual mandate is a one year event, it's an anomaly, and rather than lose those people in the system and hope you get them back a year down the road just to try to find some incentive to keep them in the mix would you be willing to consider -- I'm not saying to -- but consider going to the emergency board given that there's a hundred million dollars in human services case load reserve now to help mitigate the burden on ratepayers of your premium filing?

MS. GREENE: So I'll invite my colleagues to comment as well. I wouldn't rule any idea out at this point. We're dealing with the curve balls frankly that are coming from the federal level. There is a federal -- the Board has actually organized the federal issues working group which is a very collaborative stakeholder group to look at ideas, and my suggestion would be to have that group

look at whether or not that might be an option in the case of current or future.

MR. PELHAM: So if that was a good idea --

MS. GREENE: And I don't know what would be involved. I don't even know who has to move it or what the --

MR. PELHAM: You go to the emergency board and ask.

MS. HUGHES: I'm sorry to interrupt, but we're not a government agency so I'm not sure how we could get in under that tent.

MR. PELHAM: I do understand that, but your premiums are directly related to Vermont Health Connect and what people buy. So they get filtered through that system, and I'm making the point that there's new statutory language that is specifically directed at Vermont Health Connect with a reserve that has -- now has a hundred million dollars in it and it shouldn't be off your screen. That's all.

MS. HENKIN: Thanks, Tom. Robin.

MS. LUNGE: Have you conducted a market analysis about the competitiveness of your premium rates?

MS. GREENE: Competitiveness in Vermont

of our premium rates?

MS. LUNGE: Yes.

MS. GREENE: For qualified health plans?

MS. LUNGE: Yes.

MS. GREENE: When the rates are filed we look across all of the plan rates by metal level and have a look at how different or similar the rates are. It's a market analysis.

MS. LUNGE: That would be something you do internally?

MS. GREENE: Yes.

MR. GARLAND: Actually this year we took an additional step. We did hire a small research firm, a boutique firm, to do a little external research for us on our current position in 2018, our anticipated position in 2019, and to get a little more insight into purchasing drivers, what were causing people to think about or how people were thinking about the premiums and what kind of choices they would make as they go ahead. We have only seen the preliminary results of that. The detailed analysis is due to us exactly next week.

MS. LUNGE: So any information from those preliminary results were not available for integration into your filing?

MR. GARLAND: No. We received the preliminary stuff on the 18th or 19th. It was just last week and it tells us more about how people are thinking about the purchasing decision than I think -- a level of detail that probably wouldn't be helpful to actuarial science.

MS. LUNGE: Thank you. Related to the case management initiatives in your filing you indicated that you're working through some new work flows related to identification of individuals before they become high cost and complex cases quote unquote. How are you integrating these work flows with the work of OneCare Vermont?

DR. PLAVIN: So that we actually meet with them regularly. So we have a team that meets with OneCare and talks about -- this is using the CRG grouper to identify emerging risk, and people jump to new risk levels within those groupers. So we have a shared pool of patients that were identified for case management and so then those patients kind of float to the top of the queue, if you will, for outreach either on our side or in collaboration with the ACO.

MS. LUNGE: You also indicated that -- I'm sorry I don't have the case number of your filing, but that some of the technology costs that

would be additional related to new case or care management would be about $150,000.

DR. PLAVIN: Yes.

MS. LUNGE: Do you have different care or case management processes for ACO members versus your general population?

DR. PLAVIN: So we are developing those right now. So again we have a case management group that is doing exactly that work at this moment.

MS. LUNGE: What, if any, are you considering in terms of reduction of prior authorizations in a future ACO program?

DR. PLAVIN: So that is kind of a question of how they would implement utilization monitoring so that they can -- so we can kind of move that. It's becoming shared risk, a partnership which is good, but for 2019 I think it's more of a 2020 initiative, but I think that definitely is in the future.

MS. LUNGE: Have you looked at what Medicaid has done?

DR. PLAVIN: Sure, but the results are not final yet is my understanding. So yeah we have looked at what they have done and we're anticipating learning from that.

MS. LUNGE: For your 2019 ACO program for the qualified health plans are you moving to a fixed payment model?

MR. GARLAND: For 2019?

MS. LUNGE: Yes.

MR. GARLAND: No.

MS. LUNGE: Why not?

MR. GARLAND: Well there's a lot of good things we did in the contract. We got RX in, but we said it was important and I think what it's important for a commercial market to have some opportunity for the clients to share in the initial upside. I think it builds a lot of credibility and it will absolutely help us as we turn to the group market. There are technical challenges that are not insignificant that also made 2018 or 2019 -- 2017 for 2018 I guess significantly less attractive. We will revisit this with OneCare at the first quarter of 2019 to ask as we move into that year when attribution is settled are we at a point when we can at least move some of the back end payments so it mimics the fixed payment system, but then there's the final hurdle we'll have to work through, and this is a commercial only challenge which is of course to map to benefits. Even within the QHPs we have a very wide disparity in

cost share, and if we move to a place where we're moving a global budget, then we have to figure out a way to fairly charge member y with a bronze plan their $3,000 deductible versus the member with the platinum plan and their $500 deductible.

We're going to have -- it's going to take time to work through the mechanics of that particularly because we do have folks that are using health savings accounts. So for some folks there can be real tax implications to the way we manage that and have to go cautiously.

MS. LUNGE: How will your attribution numbers shift if your predictions around the association health plans come through?

MR. GARLAND: I think it is not likely that they shift at all. There's a lot of caveats there. The association health plans themselves are still waiting for final rules and so the associations have given us a strong sense of what they are interested in and what they think they want to do. I suspect that the ACO will be a pretty natural fit for them and that we've already taken that first step with individual and small group is likely to lead most of them to continue to participate in the ACO. I think we're very likely to see any association to

say ACO is not for us we want you to rethink this decision.

That being said, we don't know the whole universe of folks who are interested in association health plans, only those who have spoken to us, and we could have a third party show up tomorrow and propose something different than anticipated, but I don't see it being a major disruption to what we're working on with OneCare.

MS. LUNGE: Isn't the ACO program part of what you file in your forms?

MR. GARLAND: I don't know if it is a form filing.

MS. GREENE: No.

MS. LUNGE: I can ask DFR. They are here too. So you don't see any issues with offering the ACO program to an association health plan regardless of what plans the associations potentially have?

MR. GARLAND: For now it looks like the majority of interest in the association health plans is on the fully insured side and in that case it's our risk. So our default position would be when it's our risk we're doing the ACO for individuals and small group. So an association would have to push

back on us very hard and say we have a reason why we're not there with you, but I don't see any evidence of that.

MS. LUNGE: Okay. Thank you. Most of my questions have been answered. In your filing you described at a high level some of the outreach that you would be doing related to both the silver loading quote unquote and the individual mandates, but could you more specifically talk about your member outreach that you will do related to those two issues?

MR. GARLAND: Yes. I think, as you mentioned, we have described this in some detail in a couple of places and I can find the references for you.

MS. LUNGE: I actually did not think it was in some detail. I thought it was in a very small amount of detail to tell you the truth.

MR. GARLAND: Unfortunately I'm not directly involved in this work group, but what I know is that always proactive and reactive customer communication is extremely important to us. So on the proactive side we're a part of the multi-stakeholder working -- I think we've referenced this before. The Health Care Advocate are on that group, DVHA participates in that, and together we'll

be working on what are the messages, what are the themes, what are the media that we can all tap into to get the message out, and we'll develop with that work a broad based communications strategy that will include written communication postings on our web sites. We leverage our social media tools to get the word out. I'm sure we'll have a broad canvass of tools and we know it's particularly important this year because of the silver solution.

Inside the organization we have already begun training the dedicated team that works with the individuals and small groups as they are trying to make purchasing or product decisions. So there is a small group of highly trained individuals who just work on this problem. They will be fully trained on silver solution and be able to field questions, and where they hit their limits regarding the calculator and things move people to the right resources so they can get those questions answered, and I'm sure our larger customer service team who doesn't specialize in those services they will also be cross trained so if they identify people struggling with those issues they can move those customers to the dedicated team that does them.

MS. LUNGE: Are there any plans around

auto enrollment or auto mapping to new plans related to either individuals who are switching plans or small businesses, for example, who should be switching from the silver exchange plan to the off exchange plan?

MS. GREENE: So I don't know the specific answer, but I do know that one of the areas of improvement at Vermont Health Connect is with respect to preparing for the upcoming renewal, and they put together a passive file of all the enrollees that are coming over and it's that file that would control what plan the membership is selecting or being renewed into for '19. So I can take that question back to the folks who are working on that and see what the answer is.

MS. LUNGE: And that makes sense for those who enrolled through Vermont Health Connect, but what about the individuals directly enrolled through you and small businesses directly enrolled through you?

MS. GREENE: It's very much what Andrew just described. We would be targeting individuals that we feel need to or are affected by the changes in such a way that they need to be real clear what they would like to do and that we've got their

renewal wishes understood correctly, and to the extent that it's the service or the outreach in collaboration with DVHA and to the extent that there's any communication that's required we will be doing that very directly and in person. There is no plan to auto place people. That was sort of a thing of the past when things were crazier than they are now.

MS. LUNGE: Thank you. So I believe that Blue Cross's position on the state and individual mandate would support it. Is that your understanding?

MR. SCHULTZ: Yes.

MS. LUNGE: And could you tell me what testimony was provided to the Legislature regarding the impact of not doing a penalty for 2019 by Blue Cross?

MS. GREENE: I cannot.

MR. SCHULTZ: I can't speak to that.

MS. GREENE: We can dig that out for you.

MS. LUNGE: Thank you. Related to the association health plans what was the date the federal final rule was released?

MR. SCHULTZ: I believe it was June

22nd. If that's not the date, real close to that.

MR. GARLAND: That's right.

MS. LUNGE: June 2018.

MR. SCHULTZ: Yes.

MS. LUNGE: And the state rule is not yet released?

MR. SCHULTZ: Correct.

MS. LUNGE: And then as discussed earlier there are a lot of enrollment and population shift assumptions in the current rate filing including those related to the individual mandate, those relating to the association health plan, those relating to the shift in business last year. I might have missed one in there. Is it fair to say that enrollment assumptions are one of the more challenging aspects of actuarial science?

MR. SCHULTZ: Yes that's fair.

MS. LUNGE: In your assumptions related to the association health plan did you make any assumptions about sole proprietors?

MR. SCHULTZ: No we did not. We did not for a few reasons. There have been studies that have been published on the impact on sole proprietors in other markets. Vermont's a little unique for many reasons. One of them is we don't do age rating as we

discussed earlier. So in other markets it would be very easy for a sole proprietor to take a look at a rate for a 42-year-old on a qualified health plan and compare it to a rate in a 42-year-old in a association plan and make a decision they can live with. That is not going to be the case in this market because of the lack of age rating. So sole proprietors will have to make some choices not really knowing or understanding what the rate difference is likely to mean to them.

The evidence in other markets are the rates will increase because of sole proprietors leaving the individual risk pool moving to AHPs. We didn't think that was appropriate to include in our filing both for the reasons it's going to be harder for them to compare plans because many sole proprietors are going to be receiving subsidies and therefore will be incentivized to stay with Vermont Health Connect. Those are really the main reasons we didn't include them. I think it would have been a reasonable assumption to include something for the sole props in here too. That would have increased rates further, but we decided not to go down that path.

MS. LUNGE: Thank you. To your

knowledge did the federal association health plan change the federal preemption rules related to state law? And if you don't know, that's fine.

MR. SCHULTZ: I don't know.

MS. GREENE: I don't know.

MS. LUNGE: Related to the Vermont vaccine fee have you received any final guidance from the Department of Health about the cost of that fee or tax? Whatever you call it.

MS. GREENE: Final guidance might be a strong statement.

MS. LUNGE: Final number.

MS. GREENE: So we were provided updates to how they were going to roll surpluses in that program forward and I'll let Paul speak to it, but I believe we have the latest information that is available.

MR. SCHULTZ: It's in rates. We basically assumed they would waive the fee for a number of months. It was more or less equal to the amount of time they would need to get the funding back down to its reasonable level. Based on information I've seen since then I'm not entirely sure that the premium holiday will last as long as we assumed, but it's a really small amount in the

filing. So if the latest and greatest information is a little bit different, there won't be much of an impact one way or another.

MS. LUNGE: Other than the $150,000 investment in technology related to care management are there any other health care reform investments that you have included in your filing?

MR. SCHULTZ: I want to make it clear the $150,000 that you're referring to that's not included explicitly in this filing. That's money that we -- that was not incurred in 2017 so it was not part of our roll forward and so that 150 is not in here.

Beyond that, again, our process is to start with what we spend in 2017 and as much as that includes some initiatives to move forward with these cost containment strategies that already existed that will find its way into the 2019 projection as well, but we did not increase the projection in any way for any of this future activity beyond that trending forward that we always do.

MR. GARLAND: I can just add our base budget includes a number of resources that are dedicated up to one with full time and several who have up to 10 to 50 percent of their time allocated

to work on the interface with the ACO, and that's both on the legal side, on the payment -- provider payment side, on the medical services side, to work on the other programs that have gone on in Vermont. Some nurses sit on the community health teams. We have quite a broad base of engagement built into the base admin budget and we could easily draw an outline around it and tell you what those are.

MS. LUNGE: Thank you. I'll take a minute to look at my notes and I think I should be pretty much done. Am I remembering correctly that you have filed a lawsuit against the federal government to recoup the cost sharing reductions that would be funded?

MS. GREENE: I can speak to that. The both situations with the federal government defunding of the CSR and then the risk corridor program which is one of the original three R's of the ACA we worked with two different law firms to retain them to provide a lawsuit to see if we could recoup those monies. It's -- they will share in any recovery that we get. It's somewhat of a long shot, but we figured on behalf of our members in Vermont we would leave no stone unturned.

MS. LUNGE: And what's the status?

MS. GREENE: The risk corridor one is running into trouble. That's one where we're pretty much in the same situation as health plans nationwide, and to the extent that there's a lot of similar lawsuits there was a ruling that made it sound like that wasn't to go our way on the risk corridor one.

On the cost share reduction we're still in the process of getting a ruling on the first step in the process and we remain optimistic that Vermont's in a unique situation because a lot of the other states and regulatory frameworks have contingency plans for 2018 in terms of rate changes, and Vermont is unique in the sense that we and one other jurisdiction do not have that option. So we may -- we are optimistic that the CSR one will possibly yield some results, but it's way too early to tell.

MS. LUNGE: Great. I just have one last question. You have mentioned the speculative nature of federal payments and I just wanted to clarify a couple of things. The cost sharing reduction and risk adjustment were both programs that were established in the Affordable Care Act, isn't that right?

MS. GREENE: That's true.

MS. LUNGE: The alternative minimum tax change is a different piece of legislation that was passed in December of last year I believe?

MS. GREENE: That's right. December 2017.

MS. LUNGE: Thank you.

MS. HENKIN: We would like to move on now to our next witness. I want to just say that I'm not sure how long the Department of Financial Regulation will go, but we do have witnesses here from Dallas who will not be returning and I would like to get them done. So I would like to finish up questioning and if they are not finished up by about -- it will be 3:30, we are going to go right to DFR -- right from DFR to the actuaries and come back to DFR on another date. It looks like we're going to have to take some evidence and some questions coming in and we may have to open up for more testimony. So I will let DFR proceed, but we may be interrupting you in about a half hour or so depending on how this is looking. Are you just going to testify or is your attorney --

COMMISSIONER PIECIAK: I was planning to testify and take any questions from the Board and

from the other parties here as well. So good afternoon. I'm Mike Pieciak. I'm the Commissioner of the Department of Financial Regulation. First and foremost I want to thank the team from DFR that's here that helped review this filing. Like always they did great work and I just want to thank them and recognize them for that work; and then, secondly, I want to also just recognize all of us in the room for a second because I just came back from a National Association of Insurance Commissioners meeting and this was the Commissioners only meeting, and I look at some of the other rate filings that are occurring across the country. I think the average this year is double digits. Maybe even high double digits. I know the Maryland Commissioner the rates went up by about 30 percent. That's at least what's filed. In California I think they approved a 8.7 percent rate increase, and it was reported on that was back to more modest rate increases.

So as you can see from across the country people are really dealing with this issue of rate increases in a much more dramatic way than fortunately we are in Vermont. Many of those states are also dealing with coverage as well. So carriers pulling out of their market and not their entire

state being covered. So again we don't have that issue here in Vermont. So I think everybody to some degree has to take credit for that; the Green Mountain Care Board, the Health Care Advocate, and also the carriers as well.

So I was just going to talk a little bit about DFR and our role in this process, an overview of DFR so that the board members that might be new have some familiarity with that. I'll talk a little bit about solvency, talk a little bit about risk based capital, RBC, that you heard today about. Generally overview our oversight of Blue Cross Blue Shield. Talk generally about some impacts to solvency that we watch out for, and then turn to our opinion letter that we issued this year and talk specifically about the issues that we highlighted, and then of course take any questions that you might have.

So that those that might not be familiar the Department supervises the securities industry, the banking industry, the captive insurance industry, and then also the traditional insurance industry here in Vermont. I consider ourselves first and foremost a consumer organization. We protect consumers. We protect them from fraud. We protect them from

products that are not good products for them. We handled in the last five years about 1800 inquiries from consumers returning to them about 11.4 million dollars in restitution. On top of that we have had about 1.3 million dollars in penalties against regulated entities in the state.

So I think first and foremost we think of ourselves as a consumer organization. Certainly when we're talking about solvency, solvency is the primary number one consumer protection in the insurance arena. That's something we take very seriously. We also have a mandate to make sure that our markets are robust, there's availability of products, and those products work well for Vermonters.

So by numbers we have about 1400 licensees that do business in Vermont. Those are carriers that are doing business here in Vermont. A dozen or so of those are domestic insurance companies. When they are domestic insurance companies we obviously take a much greater interest in their solvency. We're the primary solvency regulator so when we're talking about solvency you know I mention it being a primary number one goal of the Department because we need an insurer to be

around to make good on the promises that they have made to consumers, whether that's a life insurance company, a P & C company or a health insurer as well. So solvency is really what we do as the greatest consumer protection. It's something we hold in the highest regard.

To help us reduce solvency and understand solvency and look at those 1400 different carriers that may be operating in Vermont and other states the NAIC has developed what's called risk based capital. It's a ratio for us that uniformly and objectively looks at the surplus adequacy for carriers across the country, compare them to one another, and then determine sort of where they are in the trajectory in terms of how close they may be to insolvency.

The RBC was developed in the 1990's as a result of some insolvencies that occurred in the 1980's. Prior to that there was basically a fixed capital requirement. So if you can put 5 million dollars away, you can operate in our state. That turned out not to be sufficient because obviously there was great risk beyond just being able to put down that 5 million dollars. So RBC is something that's developed. It's specific for industry types.

There's a health care RBC, a P & C RBC, and life insurance RBC. So they are specifically by the type of insurance that's being provided.

I will mention that has been talked about that the RBC ratio for Blue Cross Blue Shield has been approved for a range between 500 and 700 RBC points. I'll also mention that on average all of the health insurers in the country together their average RBC based on any NAIC data from 2016 is 925. So even the average RBC of all of the health cares in the country RBC our range is below that, but we still think our range is reasonable and provides a level of solvency to Vermonters and to the Blue Cross Blue Shield organization as well.

So again the general oversight. Much of the Blue Cross RBC is one factor. One of the downsides of RBC is it looks historically. It doesn't look into the future. It's looking at past results, and obviously when we're looking at solvency we want to know what's happened, where the trends are, but also what's on the horizon and how that's going to impact the company.

So when we're reviewing Blue Cross Blue Shield, we have quarterly financial statement reviews, we look at all the financial statements on

their face and also do certain analyses on those, provide tools from the NAIC that it allows us to look at certain ratios. We also have an annual review that we conduct that looks more in depth at the company's financials, claims analysis, investment analysis, RBC analysis, and that is obviously a much greater in-depth review.

We also do examinations at least every five years. We completed one in 2015 so there's another examination in the not too distant future that we will conduct. Those are very long intensive reviews, 9 to 12 months. They are on site. They are looking at almost everything, but we certainly focus our attention on things that we think have greater risk exposure for consumers, and then we also have what I just call sort of intermittent meetings when things come up, when we need to get certain data from Blue Cross Blue Shield, when we need to talk to their executives or their experts. We do that on a somewhat frequent basis.

So if I can talk generally about some of the impacts on solvency that we've mentioned in our solvency opinion, these aren't necessarily specific to Blue Cross Blue Shield this year, but these are threats to solvency that can happen in any given

year.

One is certainly adverse medical trend. So medical trend cost of service ends up being higher than the amount Blue Cross Blue Shield anticipates it being. That obviously will go down to the bottom line decrease surplus and decrease RBC. Adverse utilization. So this would be a situation where people are using more health care than was anticipated whether it's the economy is better, whether there's a flu outbreak or some other sort of issue on the medical side that could certainly cause adverse utilization.

There's premium inadequacy. So premium inadequacy could mean, for example, the Board -- the Blue Cross Blue Shield doesn't get the rate they need from the Board certainly, but it also means administrative expenses could be more than were anticipated. There could be issues related to federal health care. We thought that was so significant that we broke it out into a separate risk factor this year, but there could be a number of issues that impact premium inadequacy.

Membership growth is another one. I think of that sort of increased risk and I can talk about it when we get to our specific opinion, but

when the growth in membership occurs and there's not a corresponding growth in surplus that increases the risk and reduces the RBC and has a greater impact on solvency, and then finally we thought it was so significant that we pointed it out this year federal health care policy. There's been so many changes in the last two years around health care policy. At least those that were intentional decisions have all in some ways seemed to have undermined the ACA or that was their intent. We'll also talk about a federal change to taxes that was somewhat unintentional as far as we can tell in terms of its impact on health insurers, but certainly will benefit potentially health insurers, but certainly the trend out of Washington, D.C. has been health care policy that's been unpredictable and that has looked to undermine in some respects the ACA.

So with that I think I will turn it over to our specific opinion this year. I think you have that filed and it is probably listed as an exhibit number. I don't have it in front of me, but there are a few things I wanted to point out a little bit different this year than in past years. Certainly primary is the drop that we've seen in the risk based capital ratio. The RBC has trended backward since

2014. That is a trend -- the trend is one of the things that we look at. We look at what the number is at, but we also look at where things are trending. The trend has been unfavorable to a pretty significant degree in the last three or four years.

Also the current status of the RBC. Not only has the trend been negative, but it sits now toward the bottom of the RBC range. So that's something that is of concern to us. Again, as I mentioned, RBC is one metric that we look at. I included another one in the solvency opinion this year that I thought helps illustrate the point.

If you look at the 2017 numbers from Blue Cross Blue Shield and compare them to the 2013 numbers, in 2013 they had 420 million dollars of earned premium and they had a surplus of 132 million dollars. Fast forward that to 2017. The premiums earned have increased to 578 million dollars. That's for all covered lives. That's not just for the exchange, but the entire population. That's an increase of about 37.4 percent, but if you look at the surplus during that same time period, it's gone from 132 to 134 million dollars. So 1.2 percent increase. So basically what that's telling us the risk exposure has increased pretty significantly, at

least 37 percent, but the population -- the amount of money that they have to offset swings like adverse utilization, medical trend, all those other solvency issues has remained somewhat stagnant only going up 1.2 percent.

We compared that to some of our other companies we regulate. The increase in premiums written was somewhat similar. The other companies we took a sampling. They had gone up about 36 percent, but their corresponding surplus had gone up about 38 percent during that same time period. So again comparing them -- comparing Blue Cross Blue Shield to itself that's certainly something that was giving us cause for concern. When looking at some of their contemporaries also highlights that concern for us.

Then, lastly, again I think the solvency opinion touches on this well, but we see a wide variety of federal health care changes that have been impacting, potentially will impact, and also unknown impact into the future. So CSR defunding is certainly something that had been talked about for a while, but when it happened it happened very quickly. Certainly impacted Blue Cross Blue Shield during 2017 for the three months it didn't receive payment. Obviously impacting Blue Cross Blue Shield during

this current year. Fortunately there was the silver loading solution that we implemented. However, I will just caution and mention this in the opinion that Secretary Azar, who is the head of Health and Human Services, indicated that they could not do rulemaking to prevent the silver loading solution for the current plan year 2019, but it wasn't off the table in future years. So even the solution that we've come up with is somewhat tenuous and something that we again looking out into the future highlight as a risk factor.

Association health plans. This is again a federal policy. The Department is working to implement a robust regulatory regime around association health plans. We think if we don't do that then it leaves us susceptible to out of state plans coming in that maybe are not offering as high quality or robust benefits. So that's something we're working quickly to implement emergency rules, but certainly it will have an impact on the association market.

We also touched upon the individual mandate, limited or short term duration plans. Legislative fixes have mitigated those impacts to some degree, but again those are things that their

primary effort in my opinion was to try to undermine the ACA. We've mitigated those impacts, but yet to see what the true impact will be in 2019 and going forward. Also at the time of the opinion the risk adjustment program was put on hold and I think this just demonstrates again the uncertainty of federal health policy.

So I think our overall message with our solvency opinion this year was that things are trending down. They are at a very low point in their RBC compared to previous years, and with the current federal environment it is not a good time to be trending down at the bottom of your range. Uncertainty in Washington, D.C. makes it very difficult to predict what will happen in a given month let alone a given year or a couple years out. So that's why I think you see some increased urgency in our opinion letter this year.

So I do want to mention one thing before opening up to questions because there was a benefit in the federal changes relating to the alternative minimum tax and the elimination of the corporate alternative minimum tax. So as you know Blue Cross Blue Shield is scheduled to get payments over the next let's call it five years. The first one being

at the end of 2019 at the earliest. Maybe in 2020. We issued a permitted practice this winter that told Blue Cross Blue Shield that they could fully non-admit their deferred tax assets. So basically they are going to get 16 million dollars in 2019/2020. We said those dollars, since they are so far out to the future, should not be reflected in their financial statement because otherwise it would be misleading and overstated. Those are monies that cannot be used right now today. If they needed 16 million dollars today, they couldn't go to their bank account and grab it. They probably couldn't do that for all or most of next year. 2020, the end of 2019, is the earliest they can access those funds, and obviously the same is true for all the following years after 2020. So that's why we issued that permitted practice and I just wanted to make that clear to the Board. So again that is to say again it is scheduled. Whether or not those payments come to fruition is something else we put in our solvency opinion and just caution the Board. We hope they do, but with the changes that we've seen in federal health care policy the last few years it is certainly not a certainty and we want to reflect that in our opinion.

MS. HENKIN: Thank you. I'll let questions from the carrier. Do you have any questions?

MS. HUGHES: I have no questions of this witness.

MR. MULLIN: HCA.

MR. ANGOFF: Thank you, Commissioner.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Good afternoon.

A. Good afternoon.

Q. Let me just make sure that I understand -- I think I do -- the various RBC levels. Under 70 percent is the mandatory control level?

A. That's correct.

Q. Under a hundred -- between 70 and 100 is authorized control?

A. Authorized, yup.

Q. What's between 100 and 150?

A. So at 150 to 100 there's mandatory regulatory reporting and controls. Basically we have to set some sort of regulatory regime that's going to be in place and mandate that the company do certain things such as raise capital. In this case because Blue Cross Blue Shield is a non-profit it's hard for them to do that, if not

impossible. We might have to say you have to have a mandatory rate increase of x percent on certain segments of business or we could I guess potentially require a merger or some other sort of serious situation.

Q. And then between 150 and 200 what's that?

A. So around 200 -- between 300 and 200, depending both on the -- basically how quickly they are going down and then also at some point when the RBC ratio hits a certain point, that 200 percent, we also require company -- the company to issue certain -- issue to us reporting about how they are going to fix the problem that's going on. So this isn't us telling, but the company coming up with its own solutions. So all of those things I just mentioned could be solutions. Raise capital. Again they can't do that readily because they are non-profit. Could be a merger. Could be cutting back on certain lines of business.

Q. So basically if it's under 200 they have to file a plan with you while explaining how they are going to get --

A. Or potentially 300, but yeah.

Q. And then under 300 is that a trend test level?

A. Yeah. So if they are trending down to a significant degree, then they have to do that same type of reporting to us as if they are at the 200 percent RBC.

Q. And then over 300 that's the no action level?

A. Yes. There's no action statutorily. I would say between 300 and 500 the Department informally would want to know what they are doing to get back to their range, and also I want to point out that Blue Cross Blue Shield has their own RBC targets and triggers. So at I think it's 375 percent Blue Cross Blue Shield's parent association is going to come in and require additional reporting, additional information about how they are going to get back into a more positive RBC range.

I'll just mention I think the real issue is coming between 400 and let's call it 200 percent because if you have to start meeting very regularly with the parent of Blue Cross Blue Shield, with myself, with our department, it distracts you from your core business organization. It takes -- it's time intensive, resource intensive. So that's not a position where any insurer wants to be in.

Q. Sure. MVP's RBC is substantially less than Blue Cross's, right?

A. So you may be familiar with this, but MVP is not a domiciled company here in Vermont. So we look at their rate, but we don't look at their solvency in the same significant degree that we do for Blue Cross.

Q. Sure. They are not a domicile, but if they

were would you have a concern about their current RBC?

A. Well RBC is obviously a confidential number. So I'm not sure how we would get MVP's RBC, but if any company were trending down, if any company were at the bottom of its range, certainly we would have the same concerns.

Q. MVP's RBC is in the answers to one of the L&E questions in this proceeding. You understand the 16 million that Blue Cross will get this year under the Trump tax bill that's not included -- you understand that's not reflected in the rate filing?

A. Well just a couple things to point out. One, it's not this year. It's going to be earliest 2019, maybe 2020, and then, secondly, the money is not guaranteed in our opinion. It is money that's scheduled to come to Blue Cross Blue Shield, but in this current administration in Washington D.C. certainly this was an unintentional windfall, if you will, to Blue Cross Blue Shield. Because of that it gives us even greater concern whether the schedule will actually be paid out as we anticipate.

Q. You understand though, as Member Lunge said, this is -- the windfall that will come to Blue Cross is not part of the ACA. It's not something that HHS has authority over. It's the IRS. It's a separate bill. The IRS does not have a history of not refunding money that is

-- that Congress has mandated that they refund?

A. But I think you will agree with me all of those agencies report up to the President of the United States and I think that's where all these health care policies are emanating from, and again because it was an unintentional decision I think that raises the level of concern that the schedule will be paid out as it is, and I also want to touch upon this idea it's not reflected in the rate filing because I do understand from my own review and our team's review that the contribution to reserve normally at 2 percent has come down to 1.5 percent reflective of not having to pay federal income tax into the future.

Secondarily, and I applaud Blue Cross Blue Shield for this, they are not trying to get back at the reduction in the CSR payments in this year's rate filing, but anticipating using that ATM tax credit in the future to mitigate what would otherwise be a risk -- would otherwise be a rate increase. So that is good, and then also they have also very prominently said they are going to use all of the remaining money for risk -- for rate mitigation in the future.

Q. That is what they have said. So I think we understand each other. I didn't understand at the beginning of this Blue Cross's position they were dropping

what they call contribution to reserves, what the federal government calls profit. They are dropping that from 2 percent to 1.5 percent not because they are using any of that 16 million or any of the 14 million in the next years for that purpose, but only dealing with the second part of the windfall which is they don't have to pay federal tax in the future, right?

A. For that one piece, yes, but of course, you know, there's six and a half million dollars they lost due to CSR defunding and that's not incorporated into the rate because they anticipate using that alternative minimum tax payment to mitigate that increase. Then also again they very publicly stated they are going to use the remainder for rate mitigation.

Q. They have stated that. Do you agree with Blue Cross that a point of RBC is equal to about four million dollars?

A. I believe that's correct for Blue Cross Blue Shield and their revenues.

Q. Did I get that wrong? I'm sorry. A million dollars -- a CTR -- if you reduce CTR from 2 percent to 1.5 that's worth about 4 million bucks?

A. Yes. I think I understood what you said.

Q. The other way is four million dollars. If you increase it, it's four million dollars, right? So this 16

million that they will get back from the government that would be equal then, wouldn't it, to about 64 points of RBC?

A. I think Blue Cross Blue Shield's answers to one of the questions -- I don't know if it came from the Health Care Advocate or from the Board -- showed the impact on RBC for those various amounts and 16 million I think it was about 64 points.

Q. And then of course just carrying that out for 30 million then would be 120 million -- I'm sorry. For 30 million it would be 120?

A. I understand it to be about a hundred, yeah.

Q. You mean it's not linear. The more -- the greater the contribution the less a point is worth?

A. I think I just need to suggest that all else being equal if they get the full amount, I understand the impact to be around 100 points on the RBC.

Q. On page 3 of your solvency opinion you note that membership growth is a risk factor. If the company is growing, it's going to have a higher RBC. Well it also acknowledged, don't you, the opposite is also true. If the company is shrinking, then it can have a lower RBC?

A. That's correct. Now when we look at Blue Cross Blue Shield holistically and if you look at that premium to earn number, there's also a per member month

number there as well and both those numbers have gone up. So when you look at Blue Cross Blue Shield globally their covered lives has continued to increase even if those in a qualified market has decreased.

Q. This 500 to 700 percent RBC range is that something that the Department mandates? Sorry. Have you put out an order mandating that Blue Cross retain RBC ratio between 500 and 700?

A. So it's definitely a Department mandate. That's something we've worked with Blue Cross Blue Shield and set that parameter. Again we think that's a reasonable parameter given the situation in Vermont, stability of our market, and again I just referenced the fact that on average the RBC number for all other health carriers is 925. So even our range is considerably below that, but again that's a range that we worked with Blue Cross Blue Shield on with our financial team and it is something that is a mandate from us for them to work in.

Q. By the way are you sure that 925 is the number for all carriers and not all Blue Cross?

A. No. All health care. All health care.

Q. Don't the for profit carriers in general have much lower RBCs than the non-profits?

A. Some do. Some could have higher.

Q. You're pretty confident that 925 is country

wide all carriers?

A. That's a NAIC statistic.

Q. So is there an order that you or Betty Costle or some predecessor of yours put out saying Blue Cross must have 500 to 700 RBC?

A. We don't do it by order, but again we have had -- we have mandated that via our general regulatory oversight with Blue Cross Blue Shield.

Q. And the mandate is in what form? I mean is there anything in writing an outsider can see?

A. There's not, but again the RBC and the function of the Blue Cross is really a regulatory role so not necessarily I think required in this instance, but something that we work with Blue Cross Blue Shield to get them in between that range and also to mandate that range.

Q. Was the 500 to 700 percent RBC -- was that something that was initially targeted by Blue Cross or did you all say Blue Cross that's where we want it?

A. So Blue Cross Blue Shield it wasn't sort of a number that was picked out of the sky. It was something that was done with great thought on Blue Cross Blue Shield presenting to us a range. We looked at that and then we confirmed and included that as a mandatory range. I understand Blue Cross Blue Shield is engaging in a process of looking at whether that's the appropriate range again.

I guess both actuarially, financially, and other sort of analysis that go into that, but that was something that's developed by the carrier, brought to us, we review for reasonableness, and then approve and mandate.

Q. I don't want to spend much time at all on this because I haven't read the amendment, but are you familiar with the Blue Cross amendment on AHPs?

A. Yes.

Q. Okay, and am I correct in understanding -- I think I am based on an answer that Blue Cross gave to the Chair -- that this new AHP market Blue Cross wants to -- is actively trying to participate in?

A. My understanding is that there are individuals in Vermont that are trying to actively participate in it and they have reached out to Blue Cross Blue Shield.

Q. Okay, and were you here for Blue Cross testimony where Blue Cross said in answer to a question by the Chair we hope to be selected as either the carrier on risk or the ASO prior in this market, and they also said if and when we are selected we're going to participate in this market. Were you here for that?

A. Yes.

Q. Does it trouble you at all that what Blue Cross is now trying to do is to charge the individual members, QHP purchases, for products that it's going to

create or help create or participate in that takes some of the good risk out of the QHP pool and so Blue Cross is charging the people in the individual market so that it can make additional money in this new AHP market and at the same time mess up the individual market. As the Insurance Commissioner does that trouble you at all?

A. Well what troubles me is again the federal policy that's been laid out. What would trouble me more as an out-of-state carrier coming in and taking those lives away from our exchange and not having robust regulatory requirements that our emergency rules are anticipating having. I would suspect that any carrier in Vermont would react to -- from a business perspective would react to change and regulation particularly at the federal level. So at some degree in Blue Cross not responding to this thing that none of us in the room have any control over that would somewhat trouble me, and then again it seems to -- you seem to elude to the fact that Blue Cross Blue Shield is not cross subsidizing among the various offerings, and again that's something that we look for in any rate filing is that cross-subsidization. We would not want to see that. We would want to see each risk pool standing on its own.

So I think Blue Cross Blue Shield is responding from a business perspective in a way that you

would anticipate a carrier responding to, and again if they weren't responding, if they are flat footed, that might be cause for concern.

Q. But they have control, don't they? They don't have a hundred percent control, but they have substantial control on how -- the extent to which this new market, which would mess up the individual market, how big a part of the entire Vermont insurance market -- how big a part that becomes of the entire Vermont insurance market, and obviously neither you nor I have any control over the federal government, but as Insurance Commissioner you do have control over your domestics, and again that they are now asking, as I understand it, to raise the rate for individuals more because they are going to go off and help create -- help facilitate this new market that's going to mess up the individual market. That's not something that caused you concern?

A. Well I think the characterization is somewhat unfair. Again, as I understand it, the marketplace has dictated the interest in these plans. That have gone to carriers including Blue Cross Blue Shield. Once realized it's a business opportunity. Presumably they are now interested in being selected for that business opportunity, but again it's going to be the individual businesses or providers that are driving interest in the

association health plans not Blue Cross Blue Shield, and if Blue Cross Blue Shield didn't do it, again, someone would do it. More likely than not someone from out of state and I would much more prefer someone in-state having that risk.

Q. But you agree Blue Cross could decline to do it?

A. They could. I might have some concern about that business decision.

Q. Are you saying that the Department would step in and force Blue Cross to -- what are you saying when you may have some concerns about that?

A. Because I think there's an opportunity there for a domestic insurer to fill a gap that's been created by the federal government. So I see no reason why they wouldn't want to pursue that opportunity.

Q. And the reason they would raise rates to individuals in the exchange market?

A. Again that brings me concern, but it is a federal issue. All rate filing -- amended rate filing does is rerate the risk pool that remains after the association health plans are in operation. We might disagree with the association health plans generally and in concept, but that's the reality. So I think that's where my concern is more directed.

At this point I think too the Department and the carriers in the market are responding as practically responsibly and quickly as we can.

Q. Of course none of us know how substantial the AHP market is going to be?

A. That's true.

Q. And we don't know how long it's going to last?

A. That's also true.

MR. ANGOFF: No questions.

MS. HENKIN: Board.

MR. MULLIN: Welcome Commissioner.

COMMISSIONER PIECIAK: Thank you.

MR. MULLIN: What do you believe is the number of carriers that will be necessary to create a true competitive marketplace?

COMMISSIONER PIECIAK: I think the Vermont marketplace now has two major carriers in the qualified health exchange and I think there is competition within that marketplace. So I think we see competition with two. I think any number greater than that would add greater competition obviously, but I think we certainly see competition with two carriers.

MR. MULLIN: When you were talking about the percentage increase did the national association

also share a spreadsheet that showed out of pocket per member per month costs for individuals enrolled in plans by state?

COMMISSIONER PIECIAK: I haven't seen that information.

MR. MULLIN: I think it would be an interesting thing for you to look at.

COMMISSIONER PIECIAK: Yes.

MR. MULLIN: We started a lot higher because we were already at guaranteed issue with a community rating and a lot of states are catching up.

COMMISSIONER PIECIAK: In terms of the rate increases.

MR. MULLIN: In terms of the final rates. We don't have much to pat ourselves on the back about unfortunately. We wish we could. You have thrown some numbers and I got to say the court reporter inspired me because I can't even take notes fast enough to keep up, but you were talking about premium revenues versus total dollars of reserves. Those total revenues was that across Blue Cross Blue Shield's book of businesses or was that only QHP filings?

COMMISSIONER PIECIAK: That was anything they were bearing the risk.

MR. MULLIN: Okay. So you did subtract out anything they were just doing the administration only?

COMMISSIONER PIECIAK: Yes. Exactly right.

MR. MULLIN: Great. That's helpful. Vermont uses RBC. Other states are not necessarily using that same standard. I think we heard last year in MVP's testimony that New York uses a different standard.

COMMISSIONER PIECIAK: New York does a lot of things different.

MR. MULLIN: What makes RBC special?

COMMISSIONER PIECIAK: So I don't know there's anything particularly special about it, but what it does provide for regulators is, again, an uniform standard. Most states do use RBC and it's objective in that you know a carrier in Vermont can be viewed compared to a carrier in California by these metrics that we are all using. So I think it's that uniformity and that objective analysis that provides regulators somewhat of a comfort. It also provides regulators clear triggers. So again if they get to a 30 percent RBC, there's a clear trigger in terms of action that they have to take under our

statute, and again if they get to 375, for Blue Cross Blue Shield there's a clear trigger as to action they have to take. So it also provides that clarity and not that subjective analysis as to where they stand.

MR. MULLIN: So not saying that this is the case in this particular situation, but if a carrier failed to comply with a regulatory decision, should that be used as an excuse to ask for additional reserves?

COMMISSIONER PIECIAK: I'm thinking. I'm trying to understand the question.

MR. MULLIN: So in earlier testimony today from Blue Cross Blue Shield they testified that cuts in other rating factors, other actuarial factors, resulted in lowering their reserves, and my question to you is should a company be able to use their own inability to manage to a regulatory decision to argue for higher reserves?

COMMISSIONER PIECIAK: I think I understand your question now. So I mean I guess I tried to make sure that this was clear at the beginning, but you know we obviously are concerned with Blue Cross Blue Shield and their solvency, but ultimately we're concerned with consumers and the consumers being able to get their claims paid. So

regardless of what caused the company to get to a place where they need additional surplus, looking out for consumers I would say that they should have sufficient surplus on hand to ensure their solvency.

MR. MULLIN: So basically any carrier could ignore any reduction in the trend and come back the following year and ask for a higher reserve?

COMMISSIONER PIECIAK: If they needed a reserve increase, then again I think it's a separate conversation about not following the regulatory order, but certainly again we look at the solvency of the company and protecting the consumer. So that's our ultimate concern.

MR. MULLIN: So what would incent a carrier to make structural changes?

COMMISSIONER PIECIAK: Well I think, you know, there have been a number of changes that have occurred from Blue Cross Blue Shield in testimony that you heard earlier when it comes to their administrative cost, when it comes to the way they are trying to provide access to care, and also increase the quality of care. So there seems to be some progress from the carrier. It's not a main component of what our regulatory outlook is in terms of looking at the company, but certainly I think this

process creates a certain degree of incentive certainly.

MR. MULLIN: I guess I'll just close with an analogy not a question and I will say New York Yankee's have the second best record in baseball yet they are five games behind in their division.

COMMISSIONER PIECIAK: And I'm happy for that.

MS. HENKIN: Let's move along.

MS. HOLMES: Two questions. So in your solvency analysis do you review the fiscal management of premium dollars and, in particular, do you review how carriers spend revenues on personnel costs, board salaries, executive compensation, investment choices, administrative overhead, and cost containment strategies?

COMMISSIONER PIECIAK: Yes. I would put those more into the bucket of our ongoing overview -- oversight certainly on an annual basis and an exam, conversation with management happen at the annual level and also through the examination process, and so how they are using premium dollars is certainly something that we have a concern about. If administrative costs were increasing for reasons that couldn't be explained or they are increasing above

what was happening on the national level, that would be a concern for us.

MS. HOLMES: That's more in your ongoing analysis not in your specific solvency analysis?

COMMISSIONER PIECIAK: I think that's correct. Our solvency analysis, again, we're looking for rate adequacy. Obviously the administrative component is part of that. So we think the rate as filed would cover the administrative cost as well as the claims so that they anticipate being paid.

MS. HOLMES: And the second question is increasing enrollments. Obviously you testified here that requires a greater surplus to protect against solvency. So did your solvency analysis take into account the potential for decreased enrollment because of the individual mandate change, because of the migration from the AHPS, and also the potential for future losses in market share due to the differential in prices of the two carriers that are --

COMMISSIONER PIECIAK: Yes. So that's a question. Yes. I'll start with the AHPs. So certainly those are individuals that aren't being removed from the global marketplace. They might be moved from a certain segment and presumably some of

those will end up at Blue Cross Blue Shield.

MS. HOLMES: But not all. You don't know.

COMMISSIONER PIECIAK: Not all. That's true, but the ones we anticipate having interest in Vermont would be fully insured association health plans. So again not all, but some would migrate. With the individual mandate repeal those individuals would just be out of the marketplace altogether. So certainly you could see a decreased membership and corresponding increase in RBC because there would be less reserves required for that, but again we view all of those things when issuing our solvency opinion.

MS. HOLMES: The third one was the potential loss of market share because of the rate differential between Blue Cross Blue Shield and MVP.

COMMISSIONER PIECIAK: Yeah. We've seen Blue Cross's RBC in the last year go up or not decrease as much as it would otherwise because they have lost some of their membership under the qualified health market, but again looking globally their per member per month lives has continued to increase. So large group and other types of insurance have continued to grow. So they haven't

necessarily lost market share globally and the covered lives globally looking at the company.

MS. HOLMES: We have to make a decision about CTR for this filing. We have to look at what is the impact of this filing.

COMMISSIONER PIECIAK: I think that's exactly right, and again we look at solvency globally and I think this is looking at how this filing impacts solvency globally. So certainly the qualified health market is decreased, but again their overall risk profile is either the same or increasing from last year.

MS. HOLMES: Thank you.

MS. USIFER: Just a question on the schedule that under the capital and surplus and change from 13 to 17, are you able to talk about what the RBC was at the start of that and what it is at the end?

COMMISSIONER PIECIAK: So I can't speak to the exact RBC, but I can tell you during that entire period it was within the range. At the start of that it was much higher in the range. I would call it in the mid to high and now it's low toward the bottom of the range.

MS. USIFER: And if it goes above the

range, what type of actions do you take if it were 800?

COMMISSIONER PIECIAK: That's a good question. So we would view anything over 700 as excessive and we would have an opinion that stated as much. So we anticipate and expect Blue Cross Blue Shield to try to plan to that range on the low end and also then on the high end.

MS. HENKIN: Robin.

MS. LUNGE: Hi. How are you?

COMMISSIONER PIECIAK: Good.

MS. LUNGE: Have you reviewed the Federal Department of Labor rule related to association health plans?

COMMISSIONER PIECIAK: I have and my team has more specifically.

MS. LUNGE: And are you aware of any changes to preemptive rules in that?

COMMISSIONER PIECIAK: So that's a good question. The way we view the federal rules in terms of preemption is -- and the Secretary of the Department of Labor had stated this prior to the rules coming out that their intent was not to preempt the states. We had heard that orally a number of times. Clearly the rules have stated that there's no

intended preemption, but then of course the rules have also said that there is a threat of preemption.

States are not enacting the association health plans in line with the spirit of the final rules and I don't think I have the language exactly correct on that, but what we take that to mean we disallow them or did something to that extent that Vermont or other states could base preemption on. So I think we're free to regulate, but I think we are handcuffed to some degree about how far we can go in that regulation.

MS. LUNGE: You wouldn't be surprised that I also have reviewed the rule. The comment related to preemption in my recollection, and you're welcome to submit something if I'm incorrect to that, was specific to self-insured association health plans. So if you could please let me know if I'm wrong about that in the future.

COMMISSIONER PIECIAK: Sure.

MS. LUNGE: But my understanding from my review was the preemptive comment was specific as to self insured.

COMMISSIONER PIECIAK: Sure. I'll ask our team to look at that.

MS. LUNGE: Thank you.

MR. PELHAM: Just a quick question. So you talked about the 2017 surplus at 130 million dollars and I've seen that in the Blue Cross Blue Shield, and I know that's the numerator of the RBC calculation and I know that it's a confidential number, but what comprises the denominator? What are the ingredients that go into the denominator?

COMMISSIONER PIECIAK: I'll just talk generally about the category. Certainly we look at what I call the asset quality, but you could also look at it as asset risk, what are the assets that the company has on its balance sheet, how open are those to risk. Certainly a life insurance company that has long term bonds or something they are anticipating a lot of interest rate, you know, income, and so a low interest environment or changing interest rate environment could be an impact for them.

We also look at the underwriting risk; so what's the pool, what's the population that's being underwritten, what's the age, what's the mortality, morbidity, all of those categories, and then there's sort of other general category. To break that down a little bit more we would look at I guess I would call it enterprise risk or operational

risk, reputational risk, credit risk, all those sort of things that don't fall neatly into asset risk or underwriting risk.

MR. PELHAM: So these are -- are these kind of established parameters or steps, indicators by the National Association of Commissioners?

COMMISSIONER PIECIAK: Yes. That's exactly right. There's the RBC statute that was formulated through the NAIC process and then passed here in Vermont and many other states across the country.

MR. PELHAM: Thanks.

MS. HENKIN: Thank you.

COMMISSIONER PIECIAK: Thank you.

MS. HENKIN: I would like to move ahead to have David Dillon come up. We're hoping to get through this today. We may be arrested for staying in the State House too long.

DAVID DILLON,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. ARDUENGO:

Q. Good afternoon. Could you tell us who you are?

A. I'm Dave Dillon. I'm senior vice president and principal with Lewis & Ellis.

Q. What is Lewis & Ellis?

A. So Lewis & Ellis is an actuarial consulting firm. We're founded in 1968, however, we do other insurance consulting as well. I'm also involved with insurance compliance work and insurance financial solvency, financial examination work in addition to the traditional actuarial work.

Q. What is your educational background?

A. So I have an undergraduate degree from Oklahoma State University in mathematics, and then I have a graduate degree from the University of Iowa in statistics and actuarial science.

Q. How long have you been an actuary?

A. So I have been in the field for 22 years. Started about 1996. I've been a credentialed actuary for 16 years. I've been at Lewis & Ellis almost 20. It will be 20 in February.

Q. Do you have any professional certifications?

A. So I have two primary certifications. I don't know exactly how this came about, but the actuarial world has two organizations that we're kind of beholden to. One is the Society of Actuaries and that is more education and research body, and that's kind of the passing our exams

and being certified to become an actuary. Once we pass our exams and become a member of the Society of Actuaries we also have a professional requirement which includes continuing education and that's through the American Academy of Actuaries which I'm also a member.

Q. How long have you been retained by the Board to provide actuarial services?

A. So we were engaged beginning in 2014.

Q. How many Vermont health insurance rate filings have you worked on in that time?

A. Including the two we're discussing this week it is 66 in that time.

Q. And in what market segments?

A. So it's primarily individual, small group, and large markets.

Q. Do you work on health insurance rate filings in other states?

A. Yes. Since 2010 and the passage of the ACA my team that this Vermont team is a subset of we have worked with 22 states regarding rate review and health care reform issues. We are currently assisting eight other states. So nine this year on record review issues with the ACA specifically.

Q. And in that work do you get a comparative look at the health insurance market nationwide?

A. Absolutely. So my clients -- we have a wide range of states that do have different issues. So it's kind of good to see how some of these market impacts like have been discussed today; the mandate, non-funding of the CSR, things like that we definitely see a wide range. I would say we have -- of the nine states my team works with we have three in the northeast; DC, Maryland, you guys. Then we also see kind of opposite of that we work with Louisiana, Arkansas, South Carolina, and we have some in the middle as well; Kentucky and Nebraska.

Q. In your work how do you keep up with changing reform issues?

A. I do -- I'm a very active volunteer with the Society of Actuaries. I am the Chair of the Society of Actuaries strategic initiative called Commercial Health Care What's Next. We started that a year ago, almost exactly a year ago, and it is a series of upheld white papers that addresses issues such as the individual mandate, association health plans, things like that. So I'm heavily involved in that process as an editor there.

I am also involved -- I'm with the Society of Actuaries. I am the chair and lead interviewer for the health podcast series. So I produce podcasts on behalf of the Society of Actuaries regarding all health related issues. So that really keeps me informed of what's going

on, and then just corporately with Lewis & Ellis I do a few things. I issue a newsletter to send out to clients who are interested regarding what's going on. I do that quarterly, and then if anyone in this room is a friend of mine on LinkedIn, you will know that I try to disseminate as much information as possible to interested parties as it comes. I probably post three times a week, if not more, on related issues.

Q. And generally speaking how is the health insurance rate filing reviewed?

A. So I'll kind of start with the big picture. There is a company that files and as actuary that reviews it there's probably 200 pages of guidance that the actuary has to submit -- has to follow and primary things we do is we make sure that guidance is followed. There's three sources -- primarily three sources of guidance. There's the federal regulation with the ACA, there is the state based rules and statutes, and then from an actuarial standpoint we have actuarial standards of practice. So we follow -- we make sure that the company follows all of those regulations.

Generally speaking your state based regulations and actuarial standards of practice are more general in nature. They are a little bit maybe more about the standards of review. While a lot of the federal

guidance now is much more -- I don't know if you want to use the word prescriptive, but it is a little more targeted on what we have to review.

For a state to have an effective rate review program there are 15 categories of things that we have to review. I won't go over the whole laundry list, but it is things like the -- that have been discussed today; medical trend, changes in benefits, change in reserve needs, change in capital and surplus. So we hit all of those items in the review.

You know one thing I was going to say as part of doing the rate review, not just with you guys but with all of our states, I kind of view our role as kind of an actuarial translator. Right. We take all the regulations. We sanitize it. We tell you what that means. I kind of look at it as -- you know as kind of a Goldilocks analogy; is the filing too hot, too cold, or right in the middle just perfect, something in between.

Now I will say that one thing we are not are actuarial fortune tellers. While we can review a process a company does, we review the process, we make sure all the factors that they should consider are considered. Once we look at those factors we make sure that they have had a decent process, you know over the 200 rigorous pages of guidance, but we might say the porridge is just right,

but we can't -- you know we don't know if it's 150 degrees temperature or 190 degrees temperature. There could be a variance. There's different -- everyone sitting up here has a different definition of hot. So we try our best to say it's within a range, but if -- generally speaking so if something is too hot, we'll say all you guys are going to say it's too hot or if it's too cold we're going to say it's an extreme it's too cold. We try to keep it in the middle, but we're never going to be able to exactly nail what will happen two years down the road even though we will use rigorous models to develop a range.

Q. And what's the process for reviewing a health insurance rate filing in Vermont?

A. So specifically when the submission date comes around and kind of the button gets pushed, the company submits the filing, it usually takes about a day, but Green Mountain Care Board staff let us know it has been submitted, and we have access on SERFF which is the system for rates, forms, and filings. So that is the NAIC's mechanism in every state, but one uses that and so we -- Blue Cross will submit all of their filing documentation, all their requirements for the federal rules, state rules all that through SERFF. So that is how we receive that information, and then over the review period we utilize that system to communicate with the company through what

are called objection questions in the filing, and the term objection doesn't necessarily mean they are negative. That is kind of a SERFF definition, but it's just the way we ask questions through that system.

Q. So would you say that when you are reviewing a filing you're performing an independent analysis and calculation?

A. So I would say partially. It really depends on the assumption and the materiality of that assumption. Several of the assumptions that have been discussed today; risk adjustment, utilization trend that are very material to the filing we -- a lot of times we will do an independent calculation if maybe the company doesn't use an approach that we have used in the past. So maybe we'll -- we're just more comfortable with using our approach we might do that, but if a company utilizes kind of a formula or process that's similar to what we have done we're not going to necessarily recreate the wheel. So it kind of does depend on the assumptions.

Q. So you mentioned earlier the process of sending out objection letters. Is that how you receive additional information of a company during your review?

A. That is correct.

Q. And in your review do you do a peer review?

A. Yeah. So when you kind of asked about the how

we do a specific review what we do is when we get it in SERFF we really are set up -- we have three people assigned to each filing. Josh Hammerquist is what I would call our lead reviewer. Okay. I am the primary peer reviewer and then Jackie Lee is a secondary peer reviewer and we kind of have different roles. Jackie and I also both -- we both are kind of assigned to the MVP filing as well.

So Josh when he gets the filing and submits it through SERFF I would say the first thing Josh does is a completeness -- make sure all the requirements are included, things like that, and then Josh is going to be the one that really kind of lays it out, really do the deep, deep digger in all of the little assumptions. So there's probably 30 to 40 different assumptions that are changing in each rate filing and so he reviews all of those changes submitted by Blue Cross. He kind of presents a summary to me, and then what I do when we first get the filing I kind of do a big picture look. I kind of want to know what's going on before I know what the company is telling me.

As to what's been discussed today is the 2019 filing is primarily based on 2017 experience. It's kind of the starting point and there's some adjustments along the way. So typically what I do is I will jump in. Even

before I look at what the rate increase request is I ask Josh to give me just the 2017 results. Okay. I look at that and then I assess based on big picture market issues how I think that might change that experience. We talked about the non-enforcement or the non-payment. CSR's, the health insurance fee going away that's going to change the rate request, things like that. So I kind of end up doing an informal upper and lower bound on the rate increase even before I see what they say. I think that helps me get engaged once I see that number how kind of crazy it is or there's some reasonableness to it just from a starting standpoint, and for this year I came up with a ball park of 5 to 10 percent and it fell right into the middle of that. So there weren't any initial red flags that it was extremely high or extremely low. We're obviously going to beat on every assumption in there, but at least there were no significant red flags, and I will say there are a lot of times we do see significant red flags in other states in other carriers that fall outside of that range.

Q. So you mentioned today's filing. Are you familiar with today's filing?

A. Yes.

Q. How long did you have to review it?

A. We had 60 days.

Q. So if you turn to your report, you put into

your report there's a standard of review and you mentioned before the actuarial standards of practice. I was wondering if you could just tell me a little bit about that standard of review and which of the factors are relevant to you?

A. So as I mentioned earlier kind of big picture review. We review the filing to make sure they comply with the federal rules, state rules, and actuarial standards of practice, and then within the state rules you guys are charged with multiple factors to review, and three of those are actuarial in nature and those are defined in actuarial standards of practice and that is excessive, inadequate, and unfairly discriminatory. So when we do our review and write our report we are making a recommendation to you on those three items about the filing.

Excessive. We'll get into that a little bit. So excessive basically means we need to review all of the claims, the expectation of the claims the company is doing, the expectation of admin. We review those provisions to make sure they are reasonable and that the premium that is being charged is reasonable in relation to the sum of those pieces. So we look at the claims, we look at the admin, we look at the profit margin, kind of add those up and make sure the premium charge makes sense

to that.

Q. And can you define adequate as an actuarial term?

A. So inadequate is kind of defined as the flip side to the excessive. So it's really, again, we look at the claims, we look at admin, we look at the profit provision. We kind of sum those up and compare that to what the premiums being charged, and if we do not believe that the premium charged is enough to cover what we would expect the company's population to use in terms of benefits or anything like that, we would call that inadequate.

Q. And can you define unfairly discriminatory?

A. Sure. Unfairly discriminatory is really kind of defined as charging one person too much if they are substantially similar to somebody else, but typically in Vermont that is not typically as big a consideration because you guys are different in a lot of ways and a lot of states in terms of community rating and merged market and so that kind of almost takes a lot of those considerations out.

Q. So when you say in your report that a given assumption is reasonable and appropriate what does that mean?

A. So when we say something is reasonable and

appropriate that is basically -- as I was when we talk about excessive we'll talk about the claims and all that you implies, right? When we say incurred claims there's a lot of assumptions there. When we look at admin there's assumptions in that. So when we say something is reasonable and appropriate that is saying when we've looked at those components we believe those components are not excessive, they are not inadequate, they are not unfairly discriminatory, and as I alluded to earlier we're not necessarily a fortune teller. This isn't going to be the exact number that's going to be realized in years, but based on information the company has at that time we say that is a reasonable projection.

Q. And when you give an actuarially reasonable range in your report does that mean that all of the numbers in that range are equally likely?

A. No it does not. You know as an actuary it can be a little tricky to give ranges and people have a different view of ranges. Typically when we give a range, not all the time but most of the time, it is based on -- a lot of you would know -- in the normal distribution there's a bell curve. So when you give a range on that, that is typically 95 percent likely. So when you see a bell curve people give ranges that's the most common.

So what that means is when you have a bottom

of the range even with a bell curve that observation is not that likely. It could happen, but it's not super likely. So even within a range it can be a little tricky to make recommendations with ranges. We would say right around kind of best estimate. That is a lot more likely.

Q. And in your report did you make recommendations to modify the filing as originally submitted?

A. Yes. We made five recommendations.

Q. Let me just stop right there. Is it your understanding based on the testimony today that the company agrees with those recommendations?

A. Yes.

Q. For the sake of time we're not going to go through each of them since they are undisputed.

A. Okay.

Q. But as to your recommendations can you explain what the ultimate projected rate increase is in the individual and small group market?

A. Sure. So when I answer that I'm going to kind of answer it two ways. The first way is I'll say kind of strict definition. The original proposed rate increase was 7 and a half percent. Okay. So simplistically if they were charging a hundred bucks before, they are going to charge 107.50. After the four recommendations that had

been reduced to 7.2 percent. So it was about a four percent reduction when you kind of do it relative nature to that.

The second way I'm going to answer that question is I'll call kind of from the effective rate increase view. As has been mentioned several times today, but a lot of the premium that is going to be charged will be covered by the federal government and be subsidized by the federal government. So even though Blue Cross might be charging -- proposing to charge 7 and a half percent before, in reality that was 5.3 percent as an effective rate increase because so many of the people on the silver plans and some on the bronze and gold plans get subsidies from the federal government. So the actual increase to premiums like out of their wallet was about 5.3 percent proposed and based on the recommendations that is 4.6 percent. So that .7 percent is about a 13, 14 percent reduction in the rate increase that was proposed by the company.

Q. So I wanted to discuss some elements of your report that you didn't issue a specific recommendation on. In your report you said that the company's proposed administrative costs were reasonable and appropriate. Could you go through that assumption?

A. Yeah sure. So we did a couple things with the

admin. Similar to the claims 2017 is kind of really the starting point and that's where we start in our analysis. With the annual statement there's a supplemental health care exhibit which provides -- which was kind of mandated through the ACA and all companies have to provide this information and so we start there. Okay. So that is kind of the first -- we find that out in March. So we know this information before the filing and so it's kind of the first piece of information on claims. We look at that and go okay how does the admin in the filing compare to what they are reporting to the state. If you do that exercise, you will see there are differences and so that begs the question what are the differences. Multiple questions were asked through the review. I think the first thing that has to be pointed out is the annual statement is based on statutory accounting principles which we have heard today in multiple cases is different than the generally accepted accounting principles or GAAP. So if you account for that, that is one big difference between the statement and the filing. So that's kind of the next kind of starting point.

And then there are the company proposed changes based on a lot of the membership changes with the different plans and things. We reviewed that. The company basically assumed 50 percent of their costs were

fixed overhead. In our experience of doing financial examinations and reviewing rate filings that is a reasonable assumption to us, and so based on that, that was kind of the next starting point kind of adjusting the '17 and then the company made some projections from -- for wages from '17 to '19 to increase the admin. What we did there is we did research in Vermont from over the last 10 years with the information reported by the Department of Labor and confirmed that a three percent wage increase was reasonable across the State of Vermont over those ten years and we concluded that Blue Cross's assumption was reasonable.

Q. Okay. So I also want to ask you about the company's proposed utilization trend. In your report you said that that trend was reasonable and appropriate and I wanted to ask if you still agree with that opinion after it was -- after listening to Paul's testimony today?

A. Yes I do.

Q. Did you determine what would be a range of reasonable utilization trends in your report?

A. Yeah. So the utilization trend has been a topic of discussion in the last few filings over the years, and this one was a little bit different this year in that the company historically has done kind of two approaches to analyzing utilization trend. Last year we

discussed a third way, going to the independent calculation approach. We used a different approach. Probably -- I'm not going to get into their heads, but probably to cut me off at the pass a little bit the company did some of those approaches this year because they knew I was going to ask the questions utilizing that approach. So the company did utilize three. So we were able to use a lot of the information provided by the company in addition to maybe doing our own independent work.

So based on that information and relying on a lot of the work we do with other states and similar utilization trending we base our utilization trend range on a plus or minus 20 percent to that factor, and then again that's kind of the 95 percent. The bulk of that range would be in the middle there around 2 percent best estimate.

Q. So if the company had filed a 1.6 percent utilization trend, would that also have been reasonable?

A. So that's kind of tricky as I was alluding to. If I were doing the filing, I would not file 1.6. I do not believe it is that likely. So what I would say is with the range I would say that if it's lower than 1.6 or above 2.4, I would definitely kick it out as unreasonable right away, but if it's in the range, I would probably say

that, you know, the numbers closer to the middle are better reasonable numbers. So I would probably say -- I would just answer it by saying that would not be an assumption I would utilize if I filed the rates.

Q. Let's talk about overall medical trend. What was your range for the company's overall medical trend?

A. Let's see. I believe it was 3.6 to 4.6 with the best estimate of 4.1.

Q. How is that determined?

A. So basically we kind of did it from the component standpoint. We talked about the utilization trend and we also looked at the unit costs. The unit cost here in Vermont there's not as much variability as with the utilization trend. Obviously because you guys have so much control over a significant portion we don't see as much variability in Vermont on a unit cost side as we do in other states. So we use I'll say a similar approach but not an exact approach, and I think our range for the total was roughly a weighted average of plus or minus 12 percent from the best estimate.

Q. Did you use the same approach to evaluate the company's proposed pharmacy trend?

A. So what we did with the pharmacy trend was -- this is one I alluded to earlier. We won't necessarily do an independent calculation if a company does something

that is similar to what we would do, and the company in this case did do an analysis very similar. So this is one where we've relied quite a bit on their calculation. They appeared reasonable and so it was done a little bit differently.

Q. Okay. So one of the -- one of the other key changes in this filing is an increase in premiums resulting from the removal of the individual mandate penalty. Did you review the company's assumption in this regard?

A. Yes.

Q. And did you find it to be reasonable and appropriate?

A. Yes we did.

Q. After the filing was submitted Vermont passed a law implementing a state based individual mandate. Does that change your opinion regarding the reasonableness of the company's assumption?

A. No it does not. As the company alluded to, L&E was engaged by both the Board and DFR to do an analysis on the individual mandate. So we have -- through that work we have pretty intimate knowledge of a lot of the information about Vermonters and as alluded to we had a different method to calculate the impact, but as can be found about our estimate we primarily focused on the

financial aspects of the mandate. If any of you guys have read the Congressional Budget Office Report on the mandate non-enforcement, they talk about there's some financial and non-financial. We think it's much maybe cleaner to focus on the financial aspects; primarily the income level, the premium level, the health status of the person in question.

So when -- we have also -- through the reviews over the last few years we have learned that Vermonters are very savvy. They are very well informed regarding health care reform issues relative to other states. So when a mandate comes in for 2020 it is our opinion that that will not impact the 2019 rates because of the financial aspects that people will heavily weight what the non-enforcement in '19 will mean to them. So we believe that the 2 percent or the Blue Cross's estimate is still reasonable even in light of a mandate for 2020 and later.

Q. Now let's turn to contribution to reserves. Do you review for solvency risk margin and CTR?

A. Yes. So even though the DFR does it as part of the federal regulations regarding rate reviews, I alluded to earlier a couple of the bullet points that have to be reviewed, our change in reserve needs and change in capital and surplus.

Q. Did you get a chance to look at confidential

information concerning the company's RBC?

A. So we're provided a lot of the information -- a lot of information about that. So we definitely review and assess the appropriateness of the CTR assumption in light of the company's financial situation.

Q. And did you find the company's 1.5 percent proposed CTR to be reasonable and appropriate in this case?

A. Yes.

Q. Are you aware of what Blue Cross's target range is for RBC?

A. Yes. 500 to 700 percent.

Q. And what is your opinion as to what CTR would be needed to keep the company within the midrange of that target RBC?

A. So relying on the company's detailed calculations I believe it's right around one and a half percent for the long term basis to keep them in the middle.

Q. So if the company had submitted a 1 percent CTR, would they still be in their target range?

A. I do not believe so. No.

Q. So there was earlier testimony today about the Tax Cuts and Jobs Act and how it impacts the carrier. Could you please describe what the carrier assumed and

what your assessment of that assumption is?

A. Sure. So there's really two implications of the tax bill. One is the non-profit nature. They no longer have to pay the 20 percent tax rate. So it's -- very simplistically what we did is the company's always assumed a long term 2 percent CTR as being appropriate. Call it a factor of .8. So that is a judgment of us of a reasonableness for a CTR. So if they submitted a 1.6 percent CTR, that seemed reasonable. Slightly lower than that. So that's the primary -- or that's one of the main implications is that they did modify their CTR as a result of that.

The other thing with the tax bill was the alternative minimum tax issue, which is a little bit more of a longer term issue, and in all of the reviews we have reviewed so far this year, and we have reviewed -- since 2014 we have reviewed over 900 ACA filings, we have never seen a company take a specific capital and surplus level that is not actuarial standards practice in terms of how to rate. It is typically through the CTR process. That's what the CTR provision is for is to have a provision for the solvency side. So we think it is appropriate that the company address the AMT issue through the CTR.

Q. Okay. Now let's turn briefly to the silver loading that was briefly testified to earlier. Did you

review reflective silver plans in this filing?

A. That was one of the big changes for this year was that the cost sharing reductions were no longer going to be funded at the federal level so there had to be a mechanism to cover that. The -- so even though they were not funded the federal law still required that the company had to pay for that portion of the benefits. So there had to be a mechanism to fund it in some other way.

The State of Vermont addressed that specifically and allowed off exchange plans for those that do not have -- for persons that do not qualify for subsidies. So that approach, which was a very common approach across a lot of states, not every state did it that way, but it was a very common approach, it basically put all of the cost sharing reduction that wasn't funded on the premium plans on the exchange because the federal government would be paying it through a different mechanism through the APTC or the premium subsidies. So the reflective or off exchange were created to give the people that had higher incomes, higher than the 400 percent, a mechanism to have a silver plan that wasn't loaded or more expensive as a result of the federal government not funding the CSRs.

Q. And your testimony earlier was that a significant portion of the premium increase for that

reason would be borne by the federal government. Could you say what that percentage is?

A. Yes. So if we go to page 17 in my report or I think PDF 307, that table after the modifications really kind of describes that. You can see that there's the silver loaded bullet there that satisfies what the proposed is, and we're saying that you can see it's really not applicable for -- the Vermonters aren't feeling that because that's being paid by the federal government. If you -- if you look at the overall numbers, you can see the difference, again I alluded to earlier, that in the proposed 7.5, 5.3 was going to be effectively the effective rate increase on consumers in Vermont. So that that 2.2 or whatever would be picked up by the federal government.

Q. And there's just one last question I want to ask you about with regard to the filing as originally submitted. So Paul testified earlier about Blue Cross's cost containment strategy and how he disagreed with how you incorporated that into your range. Can you briefly explain how you incorporated Blue Cross's cost containment strategy into your range and whether his testimony changed your opinion in that regard?

A. Yeah. So what we did, as I alluded to earlier, is we based our range based on an inherent

volatility around best estimates for utilization trend. We believe we have a reasonable range because our best estimate we believe is consistent with their approach of including the cost containment in the trend numbers, and so we just based our inherent volatility around the best estimate consistent with what we had seen in other utilization assumptions.

Q. So with the recommendations that you outlined is the filing as originally submitted excessive?

A. After implementation of the recommendations we do not believe the filing is excessive.

Q. And is it adequate?

A. It is adequate after the modifications.

Q. And is it unfairly discriminatory after the modifications?

A. It is not unfairly discriminatory after modifications.

Q. So you're aware that there's been an amendment to the filing?

A. Yes.

Q. Have you had an opportunity to review that amendment?

A. That was -- that amendment was submitted just a few days ago. We have made an initial and cursory look, but the information provided in that amendment was not

enough for us to draw any conclusions at this time. So we do not have a written response at this point. We have posed additional questions to the company based on that amendment and so we have asked them for additional information for us to utilize and then to make a full assessment regarding that amendment.

Q. So you do not -- you do not have a full opinion for us today as to Blue Cross's amendment?

A. All I will say at this point, so this is still preliminary and as I said it is not written, based on the information we have reviewed the two increases as a result of the benefit increases appear reasonable, however, we have asked for additional information. Regarding the association health plan we would really like more information. That is more of a significant amendment. However, I will say based on all of the new guidance that has come out from the federal government and apparent actions by DFR since the submission of the filing we do think it's reasonable that the company has requested this, but we don't have enough information at this point to say that -- if their amended rate change is appropriate or not.

MR. ARDUENGO: Thank you. I have nothing further.

MS. HENKIN: Can we get through some

questions over here in the next few moments?

MS. HUGHES: We can and I hope --

MS. HENKIN: As you can tell we will probably be finishing some of this by phone and we will have to reopen due to the amendment, but let's go to the bitter end.

MS. HUGHES: That last colloquy eliminated all my questions on the amendment because it's not ripe yet.

CROSS EXAMINATION

BY MS. HUGHES:

Q. Can you turn to page 294? You have a box there that's labeled Green Mountain Care Board or GMCB hospital budget review, and does the information contained in that box reflect the recent hospital budget submissions?

A. I don't believe it addresses the most recent.

Q. So that may not be totally accurate?

A. Correct.

Q. And could you turn to page 302 and you heard the Commissioner earlier review certain categories of regulatory uncertainty. Is the box on page 302 one of the uncertainties the Commissioner described?

A. Yes that is.

Q. And can you elaborate on the risk explained in

this box relative to Blue Cross?

A. Yes. So risk adjustment -- so recently there's been several lawsuits and obviously with the risk adjustment the payments were put on hold. I guess we'll find out at some point if that's temporary or permanent. However, the risk adjustment is really kind of one piece of incurred claims and so basically what has happened with non-payment of the risk adjustment, and this goes across all carriers and all states, is the companies that are sicker than the market are going to not receive the money that they were promised to cover the sicker people, and currently the people that -- the companies that are healthier as of today will not be paying money to those sicker companies and they will get to keep as of today -- keep that money rather than give it to the people that really provided the care.

So it is -- this is a market disrupter if it stays this way. In the Vermont market it's very common knowledge that Blue Cross is a sicker population than MVP. So Blue Cross has significant risks that if this payment is not made that basically the actuarial soundness of their rates is no longer there.

Q. Thank you. On page 303 you mention a comparison of Blue Cross Blue Shield Vermont to other Blue plans with respect to their administrative costs and how

does Blue Cross compare with those other plans?

A. So while I don't remember the specific like PMPMs, but as we outlined in our report it was -- Blue Cross of Vermont was in the bottom five percent. It was by far -- had by far one of the smallest amount of admin expenses.

Q. Thank you, and as you know Blue Cross is requesting a 1.5 percent CTR and does that favorably compare to what you're seeing elsewhere?

A. So I would say since 2014 in the ACA market I would say we have seen anything from 0 to 6 percent in terms of a CTR. That can vary dramatically by market. We've seen -- in Vermont we've seen a proposed zero before. A couple years ago. I would say typically, again kind of going to most likely, I would say the most common we see are between one and a half and three percent. So yes the one and a half is very common for what we see.

MS. HUGHES: May I have one moment?

Thank you.

MS. HENKIN: Attorney Angoff.

CROSS EXAMINATION

BY MR. ANGOFF:

Q. Mr. Dillon, you said you made a recommendation as to the Blue Cross rate filing meeting increased standardS, correct?

A. Yes.

Q. Those standards are the proposed rates are not excessive, right? It's not inadequate?

A. Correct.

Q. And it's not unfairly discriminatory, correct?

A. Correct.

Q. Okay, and you have got a big stable of states, it's not just Vermont, that you work with, right?

A. Uh-huh.

Q. And I couldn't quite understand what you were -- there were 22 states among your -- the states you work with or then nine states. How many is it?

A. So currently it is nine states. We have assisted other states with reviews. Some of those have hired staff. They don't need outside staff any more, things like that, but currently for this year for the 2019 rate filings Lewis & Ellis is assisting nine states.

Q. Okay, and do any of those states have a rating law like the rating law that Vermont has that's before us in this case?

A. For the states we work with I believe the answer is no.

Q. Sorry. Go ahead.

A. No.

Q. So you opined that the rate here is not

excessive, inadequate, or unfairly discriminatory, but you're not offering an opinion as to whether the rate is affordable or not?

A. I am not.

Q. You're not offering an opinion whether it promotes quality care?

A. I am not.

Q. You're not offering an opinion as to whether it promotes access to health care?

A. Correct.

Q. Nor are you offering an opinion as to whether the rate is unjust?

A. Correct.

Q. Or unfair?

A. Correct.

Q. Or inequitable?

A. Someone might say inequitable and unfairly discriminatory are similar.

Q. Fair enough.

A. But from a pure definitional standpoint that's defined actuarial we are not.

Q. So on page 2 of your opinion -- I'm sorry. Exhibit 13, page 292 of the PDF, when you are say they are under the box -- you see there's a little paragraph standard -- labeled standard of review?

A. Yes.

Q. Okay. So when you say this letter is to assist the Board in determining whether the requested rate is and it goes through all the standards in the statute?

A. Yes.

Q. You are -- really don't mean affordable and so forth. You mean your job is to assist the Board in determining whether the rate is excessive, inadequate, or unfairly discriminatory?

A. That is correct.

MR. ANGOFF: No further questions.

MR. MULLIN: Anything else? Board members. Maureen. Jess.

MS. HOLMES: I just have one question. I have great respect for actuaries, both of you tremendous respect, but I would ask you would you agree that since you start with the experience -- the plan's experience in the prior year and then you add trend to it that any inefficiencies, fraud, or waste that were exhibited in the prior years would just be baked into the future year?

MR. DILLON: So I think it can be, but most companies will review those issues and we believe that -- and in this specific case we believe for 2019 that adjustment that the company's included

for that is appropriate.

MS. HOLMES: Okay. When you talk about adjustment are you talking about which --

MR. DILLON: Like a reduction. Just any of -- like the impact of their programs. We believe that their one for 2019 is appropriate.

MS. HOLMES: If we use that number of 25 percent of medical expenditures are potentially wasteful with no impact on the health of the patient population, that's not being adjusted for?

MR. DILLON: No. I would agree with that. If there is -- maybe I would classify it as excess utilization of MRIs or things like that, that a consumer might say I need an x-ray and it's issued. No that would not be necessarily in that adjustment number.

MS. HOLMES: Thank you.

MR. MULLIN: No questions.

MR. PELHAM: I was looking at a question I wanted to ask.

MR. MULLIN: We are getting --

MR. PELHAM: Two quick ones. In terms of small group versus individual in this merged market do you have any sense or insight into how much health employees in small group entities get paying

premium versus individuals who don't get any?

MR. DILLON: I do not have a Vermont specific answer to that. I would say generally speaking based on my experience in other states I would say relatively small portion for smaller employers. Generally speaking small employers it's a big decision to even kind of get an offer for coverage. It's not always -- so we do not see that as often.

MR. PELHAM: So by small range five percent? Ten percent?

MR. DILLON: Don't hold me to it, but okay I'll agree with it.

MR. PELHAM: I won't hold you to it. Second question is in terms of administrative costs what is it that you tie out to because this is my second rate hearing and so we looked at large groups and I think in that filing the administrative cost kind of totaled up to 10 million, and then I kind of looked at the National Association Annual Report 2017 and there's a -- they have general administrative costs there for Blue Cross Blue Shield of 16 million and then another 8.3 million of that is earned -- that is assigned to administrative costs, but it earned non-insured book of business. So I'm just

wondering what is it that you tie out to?

MR. DILLON: So typically what we tie out to is the individual and small group numbers that are included in the supplemental health care exhibit. That exhibit was designed by the NAIC to provide boards and entities like you information on the admin, and so the company has followed that. That's our starting point, and that's what I was alluding to and then some adjustments are made, appropriate adjustments to get from like a statutory basis to pricing basis, but that is the starting point.

MR. PELHAM: So you're comfortable that if I have all the filings before us with Blue Cross Blue Shield, that those administrative costs plus or minus would add up to the totals?

MR. DILLON: I would assume so, yes.

MR. PELHAM: That's all. Thank you.

MS. HUGHES: May I ask one brief clarification question?

MS. HENKIN: Brief.

BY MS. HUGHES:

Q. So the small group market employer support that you were referring to does that take into consideration the fact that the Vermont small group market definition is up to a hundred employees?

A. No and again, as I said, I do not have Vermont specific information and my answer was directed more towards what we've seen elsewhere which is not necessarily the same definition.

MS. HUGHES: Great. Thank you.

MS. HENKIN: Thank you. Are there members of the public here that have signed up to speak? There had been two names on the list. I don't know if they are still here, but if so, could I please see who they are. Mark Stanislas is the one person. Is there anyone else? Mark, would you like to make your comment?

MR. STANISLAS: I just had a couple questions and I will direct them to the Board and the Board --

MS. HENKIN: We take public comment. We don't take questions at this.

MR. STANISLAS: Okay. So under public comment there's been some comments made that new information has become available about the rate filings, okay, particularly, you know, with the hospitals and particularly with University of Vermont Medical Center. Okay. So under public comment I would just like to say, you know, it's important to put that in context of what the total net patient

service revenue budget is for that hospital, and if it was put into that context, the change from 2017 actual to 2019 budget was only 5.1 percent. So that's two years of rate -- that's two years of utilization, two years of unit cost, and any changes in mix. So I would ask Blue Cross Blue Shield if -- did they factor that 5.1 percent change from 2017 to 2019 into their rate filings.

MS. HENKIN: Thank you. The other person Kate Cross I do not believe is here. We do have public comment open tomorrow evening also starting at 4:30 at City Hall in the Memorial Room.

We are going to only recess this hearing because we are going to have to take information about the amendment. We will let everyone know as to when that will be. We do have that valve at the end of about 30 days and whether or not we will need to actually have an open hearing or whether this will be done with interrogatories we will determine that and send out something on that shortly, but today we'll take a recess and I will turn it back over to the Chair for right now.

MR. MULLIN: Just want to let everyone know we're encouraged to exit the building as soon as possible to keep it within our time limits.

MS. HENKIN: So you have about four minutes to leave the building.

(Whereupon, the proceeding was adjourned at 4:25 p.m.)

C E R T I F I C A T E

I, JoAnn Q. Carson, do hereby certify that I recorded by stenographic means the Green Mountain Care Board hearing re: 2019 Hospital Budget Hearing, at the Vermont State House, 115 State Street, Montpelier, Vermont, on July 23, 2018, 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 302 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 Burlington, Vermont, this 25nd day of July, 2018.

_____

JoAnn Q. Carson
Registered Merit Reporter
Certified Real Time Reporter