STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER 08-15-rr

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

July 29, 2015
9 a.m.
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89 Main Street
Montpelier, Vermont

Hearing held before the Green Mountain Care Board, at the City Center, 89 Main Street, 2nd Floor, Montpelier, Vermont, on July 29, 2015, beginning at 9 a.m.

P R E S E N T

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I N D E X

CHAIRMAN GOBEILLE: Good morning everyone. Welcome to day two of Vermont Health Connect rate review festival. I will turn this hearing over to Hearing Officer Judy Henkin. Judy.

MS. HENKIN: Good morning everybody. As I always do I'll start by telling you to turn off your cell phones if they are on so we don't have obstructions during the hearing.

This is a hearing today in Docket Number 08-15-rr and it's Blue Cross & Blue Shield of Vermont's 2016 Qualified Health Plans Rate Filing. We have Blue Cross over here. The Health Care Advocate's Office is here today too and has a witness. We will also hear from the Department of Financial Regulation.

I would like to just go into a few preliminary things. I'm Hearing Officer by designation of our Chair Al Gobeille. My name is Judy Henkin. We did stipulate to some documents. Yesterday we went through having them admitted, but we can admit them now if you would like to just get that out of the way.

MS. HUGHES: That would be much simpler. Thank you.

MS. HENKIN: Yes. It is much simpler.

So we have these in binders here. The stipulated exhibit list was numbers 1 through 21. There is a note some are labeled confidential and contain material that is not part of the public record, and those the Board has but those are not posted to our site. Is there any change to that list?

MS. HUGHES: I think we really won't be needing 18 through 21. They are there, but I think the issue that prompted us to ask to have them as exhibits has gone away. So I don't believe we will be using those exhibits.

MS. RICHARDSON: I would agree with that. They were included initially in the binder, but we don't expect to be using them today.

MS. HENKIN: Okay. So let's enter into evidence -- by agreement of the parties we'll enter numbers 1 through 17. Correct?

MS. HUGHES: Yes.

MS. HENKIN: And those are entered into evidence at this time.

(Exhibits marked 1-17 were admitted into the record.)

MS. HENKIN: A little formatting. We'll let -- Blue Cross is going to present their witnesses first and I believe you have two witnesses or one?

MS. HUGHES: Two witnesses, Ruth Greene and Paul Schultz.

MS. HENKIN: Both will be testifying. And the HCA has one witness?

MS. RICHARDSON: Yes.

MS. HENKIN: I'll let you start with an opening statement and we can get moving on this. There is a sign-up sheet for public comment if anyone is here to make public comment today. We did designate a time that we thought it would start, which is usually the close of hearing which is sort of open ended, but because we do expect people to come to make comment today who expressed interest in coming we've said it would be around 1 o'clock. If we are done, we'll break for lunch and come back for that public comment, but again there is a sign-up sheet if anyone is here for that reason. An opening introduction for the Board.

MS. HUGHES: Thank you. I'll be brief. My name is Jackie Hughes. I'm a lawyer with Blue Cross & Blue Shield of Vermont, and we're here today with our team to present our 2016 Qualified Health Plan Rate Filing. As you all know Blue Cross is a very active participant in health care reform efforts and our participation on the exchange and in

qualified health plans continues that tradition.

Lewis & Ellis I want to thank them for their rigorous but friendly review. I mean we had a very open and cooperative working relationship with them. I also want to thank Donna Novak of NovaRest for her very timely and thoughtful review of the filing.

Like the preceding years we're trying to get the right number, and I think that to that end we have worked with Lewis & Ellis to narrow the issues, and I'm pleased to report that after discussions with them we are in agreement with their four recommendations, and so we are asking for a rate increase of 7.2 percent on average.

We are -- after making those modifications we believe that the rate filing meets the statutory standards, and I know it's a big long list, as Mike Donofrio went through it yesterday, and I won't go through that now other than to say we believe that we've got the right number for the Board's consideration, and although Ms. Novak agreed with the four L&E recommendations, she has a couple other suggestions that we don't agree with, and we'll get into that in our testimony.

Our goal today is to make our filing

clear to you and to answer any questions you have. Thank you.

MS. HENKIN: Lila, do you have an opening?

MS. RICHARDSON: Yes, I do, and I think I know most of the people in the room, but for the record my name is Lila Richardson. I'm an attorney with the Office of the Health Care Advocate. The HCA is appearing as a party in this case to represent the Vermont ratepayers who will be enrolling in plans offered by Blue Cross Blue Shield of Vermont on the exchange marketplace beginning in January 2016. That's what this rate filing is dealing with.

We consider this a very important filing. I know the Board and Blue Cross also do. According to the filing documents in this case Blue Cross Blue Shield is projecting that approximately 70,000 Vermonters would be enrolled through the qualified health plans through Vermont Health Connect in 2016. This obviously is a large number of Vermonters and it's also a very large percentage of the total number of Vermonters who are enrolled under the Vermont Health Connect plans.

Our major goal in this hearing and this rate filing is to ensure that Blue Cross Blue Shield

of Vermont's rates for the products it's offering are both reasonable and as affordable as possible. As Jackie Hughes has laid out in her opening, some of the issues have been resolved in this filing already based on the review that was done by the Board's actuary Lewis & Ellis. The original rate request was 8.6 percent including a small supplemental post submission increase, and after Lewis & Ellis's review Blue Cross Blue Shield is agreeing to the recommendation from Lewis & Ellis that the rate increase be reduced from that amount to 7.2 percent.

The HCA is very concerned about the affordability of premiums if the rate increase is approved even if it is reduced by the amount that's recommended by Lewis & Ellis and agreed to by the carrier, and I want to just emphasize why this is important to Vermonters. Lower income Vermonters often do receive subsidies to help pay for the costs of premiums, but other Vermonters are required to pay the full price for individual coverage, and they therefore experience the full impact of any rate increase. In addition, there are small employers that are purchasing on the exchange and they also experience rate increases, and they will often pass those costs on to their employees.

The Board has already received many public comments expressing concern about affordability of plans on Vermont Health Connect. I don't know the exact number, but I know it's several hundred and that will be part of the public record. Again, we've come to an agreement as the parties in this case about the recommendations from Lewis & Ellis.

So the HCA, which also agrees with these modifications, would be focusing on two additional areas of disagreement with the filing. First, we dispute the assumptions that Blue Cross Blue Shield has made about the number of groups in the current small group market who will purchase plans on Vermont Health Connect and about the effect that that will have on the rates, and that we're recommending a relatively small adjustment to the rates based on that disagreement.

Second, we contend that Blue Cross Blue Shield has overstated the level of contribution to reserves it needs and that the requested CTR of 2 percent should be reduced, and we will be offering evidence from our actuary who reviewed the filing, Donna Novak, about these two issues.

So, in summary, we're asking the Board

to reduce the proposed rate in order to achieve rates that are as reasonable and as affordable as possible in the Health Care Exchange.

MS. HENKIN: Thank you. Jackie, you can call your witness.

MS. HUGHES: Thank you. I will call Ruth Greene.

RUTH GREENE,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HUGHES:

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

A. My name is Ruth K. Greene.

Q. And where do you work?

A. I work at Blue Cross Blue Shield of Vermont.

Q. And is your CV included in exhibit 17?

A. Yes, it is.

Q. And could you briefly describe your professional background and experience for the Board?

A. Sure. My most recent experience is coming up on three years with Blue Cross Blue Shield of Vermont. Returned to Vermont after living in Maine for 25 years working in the employee benefits industry. I held several financial management positions for a company called Unum.

They do group disability and group life insurance, and my 25 plus years with them included an assignment overseas in the UK managing the financial aspects of their subsidiary over there, and I did many rate reviews and rate product introductions in that market.

Going way back I am a graduate of the University of Vermont and born and brought up in Vermont, and feel in my current role at Blue Cross Blue Shield of Vermont I oversee all aspects of financial management of the company. I'm CFO and Treasurer, and that would include the development of the rate filings for all of our businesses.

Q. Can you describe Blue Cross's purpose and philosophy in developing the rate filing that is before the Board?

A. As Jackie mentioned, Blue Cross Blue Shield of Vermont really is very much focused on our best estimate of the claims that will be incurred in 2016 that our premiums will have to cover. We look at the claims and the expenses required to administer the products and the claims payments and the contracting, et cetera, and we do our best to make sure that the rate that's driven by those numbers is not too high and not too low. We really are going for consistency and stability on the exchange, and the vast majority of the premium rate is made up of

claims. So we spend a lot of time putting into rate development the assumptions around that, and Paul will get into the details of that later.

We also very much include a contribution to reserve that is intended to just sustain the member reserves to protect the members in the case of any adverse events. We do promise to pay claims no matter what, and those reserves are serving the purpose of protecting all of the Vermonters that we're covering on the exchange through qualified health plans which Lila mentioned was predicted to be a little bit over 70,000 members in 2016.

Q. And can you briefly describe the components that are in the rate filing?

A. Sure. Paul will go into some detail later, but the vast majority of the premium, as I mentioned, is claims experience. 91 percent in our estimate for 2016 rates is for claims. We do have a small 6.3 percent administrative charge to administer all of the plans in the qualified health plans, and the CTR is the other piece, but the vast majority of the premium and the premium rate is driven by the claims assumption, and it's the medical cost and pharmacy cost that will drive that over time fundamentally.

MS. HENKIN: Can I ask you to speak up a little so people can hear you in the back? Speak

into the mike a little more. Thank you.

BY MS. HUGHES:

Q. So with the request of 7.2 percent can you describe how much of that is driven by health care costs?

A. We find in our assumptions for 2016 that the medical trend, including the pharmacy trend, is really by far and away the biggest driver of our rate increase. With the agreed upon rate increase of 7.2 percent that is mentioned in the opening statements, the medical trend driving that is actually higher than 7.2. 7.5. So the 2015 rates moving into 2016, in order to keep pace with just medical cost price increases and pharmacy price increases, requires 7.5 percent. So all of the other assumptions changing year over year, really there's several ins and outs, again, that Paul will go through in some detail, but the biggest driver is the medical cost trend.

Q. And is that trend within Blue Cross's control?

A. I think, as we've talked in previous hearings, we do our best through negotiations and contracting and payment reform to impact the medical trend, but we really have no direct control over that. We -- of course the hospital budgets the Green Mountain Care Board will be looking at later this year very much drive the fundamental components of that, in addition to the pharmacy trend.

With respect to the pharmacy trend we're seeing specialty drugs drive our costs, our members' costs up, and we were able to include in this year's rate filing for 2016 an improvement in our pharmacy cost because we renegotiated through an RFP our three-year contract with the pharmacy benefit manager. So we were able to build that improvement in those trend increases into our rates, and we do pass a hundred percent of all of our pharmacy discounts and rebates back to all of our customers. That's somewhat unusual in the industry, but we would pass all that through a hundred percent.

So those are the kinds of things that we do to try and influence the medical trend. We also work with providers in the various work groups in the industry to figure out ways to improve the quality and cost of care.

Q. And can you address why it's important that Blue Cross remain a strong financial company?

A. As I mentioned in the earlier part of my testimony, the agreement that Blue Cross Blue Shield of Vermont makes when we cover someone for insurance is that we'll pay their claims no matter what. So we do make very good estimates to what the claims cost will be for a large population such as the population in the qualified health plans, but there will be situations and things that we can't foresee and can't predict, and the business that

we're in is a risk business, and therefore we require those reserves, the member reserves, and those reserves need to be of the level that are deemed appropriate by our financial regulator to protect in all of those cases.

Q. And how would you characterize Blue Cross's financial position?

A. Our financial position right now is we've had -- over the last four or five years we've had some years where we've charged enough premiums to cover the claims and other years we haven't charged enough premiums to cover the claims. So over the accumulated five-year period we've been short a little bit, but I would say that's a good indication that we've done our best to estimate the claims.

Our surplus and member reserves is hovering sometimes modestly above and sometimes below the midpoint of the target range that we manage to as a way to make sure that we're not building up too much surplus, but also having enough there to protect the members in the case of those unforeseen events.

Q. And are you familiar with the standards for rate approval?

A. I am.

Q. And how does Blue Cross manage its rate filing to achieve those standards?

A. I guess I would start by just sharing that the standards for rate approval that the Board has to adhere to, a couple of the excerpts is affordable, promotes quality care, promotes access to health care, and protects insurer's solvency; is not unjust, unfair, inequitable, misleading, or contrary to the laws of the state.

The pieces of that criteria are very aligned with Blue Cross Blue Shield of Vermont's stated vision. We have a stated vision at the company that speaks to our vision as far as transformed health care system where every Vermonter has health care coverage and receives timely effective and affordable care. So we really go about everything we do at the company, including rate filing development, with that in mind.

Q. So breaking down some of those pieces how does Blue Cross promote quality care for its members?

A. Some of the things that we do to promote quality are very direct -- directly in the quality arena. We have programs, some of them are federally mandated and others might be state mandated, where we're looking at quality delivery and sort of subjecting ourselves to certain audits, that the delivery of care is meeting certain standards.

We also have other ways of promoting quality in terms of the products that we put on the qualified

health plan exchange. We have a wide range of products and they have very comprehensive health benefits in the service and everything that we provide behind that, including focus on preventative and wellness benefits. It's very much a part of the quality picture.

Q. And does Blue Cross have any specific programs that integrate health management?

A. We do. We are very focused on integrated health management, whether it's looking across the care of our members from the pharmacy and drug provision to the medical care to whether it's mental health care needs. We really are very much brought into and promote an integrated whole person view of care management, and we find that works out best from the quality point of view as well as affordability and safety for our members.

Q. And so are there any specific programs that are available to members?

A. Yes. A couple of examples would be one that people probably are aware of is we have a Better Beginnings program which works with expecting mothers and works them -- right with them right through the process of having their baby and then works with them after they have had their baby to make sure they are both -- they and their baby are healthy, and we measure the results of that against the national standards.

Q. And can you address access? How does Blue Cross promote access to health care for its members?

A. Access is, again, something that we go into our rate and product design for the qualified health plans very much assuming that we're going to offer the full complete Blue Cross Blue Shield of Vermont network. We don't have any limitations there. That network includes a national presence through our Blue Card feature where people, Vermonters, when they are traveling nationally they would have access through that network to 72 percent of doctors nationwide and 76 percent of hospitals nationwide, and that Blue Card network also has a very comprehensive international capability as well. So the access really through that network is second to none.

We also -- again I mentioned the full range of products. So depending on members' needs they can select from a wide range of products; and, lastly, I guess I'll mention somewhat unique I hope to the recent circumstances is we've been adamant to see our members through as the Vermont Health Connect Exchange rollout has been difficult, and so to the extent that we've been able to work with the state to make sure that there's no gaps in care and there's been continuation of coverage when someone's eligibility is sort of in question we've been very proactive in making sure that we see our members

through those difficult situations.

Q. And how does Blue Cross ensure affordability of products?

A. Affordability is the hard one to -- I'll call it the hardest nut to crack because the State of Vermont has very high standards when it comes to health care products. The essential health benefits which underpin the qualified health plans on the exchange are determined by the state, and so there really is a very high bar when it comes to providing health care. The good news is that it's very comprehensive and covers a lot of services. The difficult news is that that comes with a price tag, and so what we do is work very hard to provide care management for our members so that we don't have unnecessary medical costs being incurred. We work with the providers on payment programs to ensure that quality and costs are managed.

I mentioned earlier the pharmacy benefit contract. We were able to renegotiate that and bring those costs down. So we're chipping away at affordability. We also take very seriously at Blue Cross Blue Shield of Vermont the need for us to constantly improve our cost structure and reduce administrative costs where possible to make sure that that is contributing as best it can to the affordability of our premium rates.

So, you know, I read most of the public comments that I had I think it was as of Monday or Tuesday and I'll read all of them, but I can certainly acknowledge the frustrations around the high cost of health care and it is something that we take very seriously.

Q. And affordability, are there other factors that you need to also consider including affordability?

A. Sorry. Could you say that again?

Q. So is affordability the only factor that you have to balance when putting together a rate filing?

A. No. I think that's what I meant in my statement about the context for affordability is very much in the sense of the quality and access, and all of those things pulled together, you know, you can't push any one of them to an extreme because you lose something on the other dimension. So it's very much an important thing for us to balance all of those things and get the right estimate of what we think the rates will be.

Q. And so in this filing in particular did you strike that balance in your opinion?

A. In my opinion I believe that we -- this rate filing is our best estimate of what we think the claims will be, including the medical expenses as well as our own administrative expenses to support that and the appropriate contribution to member reserves to sustain

those levels to the level deemed appropriate by our financial regulator, and I do think as in previous years we've worked as best we could to make sure that there's no implicit margins or anything in the rates. It's our best estimate of what we think the claims and expenses will be.

MS. HUGHES: Thank you.

MS. HENKIN: Lila, do you have any questions?

CROSS EXAMINATION

BY MS. RICHARDSON:

Q. I have a few brief questions. When you testified about the financial strength of Blue Cross and solvency concerns you referred to a target range that you manage to, and could you explain what that target range is?

MS. HUGHES: I'm going to interject here. We've actually been cautioned by the Department that even the target range may not be appropriate for public discussion, and I know there's a representative of the Department in the room and I'm just throwing that out there that we've been cautioned, and Ruth works for Blue Cross and I do not want any repercussions as a result of answering the question in this hearing.

MS. HENKIN: And I do understand that

she cannot disclose the base capital around the RBC per statute. I believe the discussion -- I believe the discussion of a range is not an issue, and I don't know if the Department wants to address that. Ryan Chieffo is here.

MR. CHIEFFO: Is now the appropriate time to address that?

MS. HENKIN: Well we can kind of get this one out of the way. I did anticipate there would be some discussion about this issue, but I did not realize that it would extend to discussion of what projected range would be or an appropriate range.

MR. CHIEFFO: I would say I think from past hearings and just in past documents I do think most people here understand that there is a range and potentially even what that range is. I would appreciate -- the Department would appreciate if we kept it very high level. We don't want to drill down into numbers whether it be specific actual levels that the company was at in any given financial statement or where it is currently, but addressing the range generally we don't have an issue with.

MS. HENKIN: Thank you.

MS. RICHARDSON: That was my intent with

the question to avoid any specific mention of risk based capital amounts for Blue Cross for any particular year, but you testified that there was a target range. If you could just identify what that is?

MS. HENKIN: And you need to speak up a little too. Thank you.

CHAIRMAN GOBEILLE: Just move it closer.

MS. HUGHES: And just to be clear are you asking for numbers?

MS. RICHARDSON: Yes. Number of target range. Not any specific calculation.

MS. HENKIN: Or what the experience is. I think the target range I will allow that. I will allow that.

MS. HUGHES: Okay, and I'm not sure that that is exactly what Mr. Chieffo said.

MR. CHIEFFO: Is it necessary to talk about upper and lower bounds of a range without numbers within the range? Is there a context for that? I'll defer to the Hearing Officer. You know I think the most important thing is that we don't discuss the actual levels. I don't know how much value it provides to talk about a range if we're not going to discuss what's within a range.

MS. HENKIN: And I'll allow this to continue at this level. I think this is a high enough level and it's not actual experience, and I think that we can start with this and if there's an objection as we get a little further down this path, I will address it then.

MR. CHIEFFO: Thank you.

MS. RICHARDSON: I just have a question. Would it be appropriate to identify just how the range is set?

MS. HENKIN: I'll let the HCA ask her questions and move this along, and we'll keep the discussion very general as we said. Mr. Hogan.

MR. HOGAN: Even more fundamental could somebody identify the statute or the reason why we can't discuss this?

MS. HENKIN: We could do that, but I think we'll hold that off until there's an objection on this, and if you have questions about it, we can get a little more deep into what is prohibited by statute, but I think this hasn't reached that level and I'll allow this to go, and if it does, we'll address it at that point. You may continue, Lila.

BY MS. RICHARDSON:

Q. Do you remember the question?

A. I was going to say could I be so bold as to ask you to repeat the question.

Q. Yes. Without giving any specific number relative to Blue Cross Blue Shield's risk based capital can you identify what the target range you testified to is?

A. The target range, and I think it would be helpful to make a comment about how it's developed, the target range is identified as such because at Blue Cross Blue Shield of Vermont we have a very rigorous enterprise risk management program, and so when our senior leaders and managers are looking at things that the company is facing in terms of challenges or even day-to-day operations we test against the risk management criteria, whether or not something could threaten the company's financial strength in some way.

So we developed a target, surplus or member reserve level, because we wanted to be able to test if we thought something was going to threaten that in some way and measure it. So the target range begins -- the bottom end of the target range begins with what's required both from the NEIC's point of view as well as the Blue Cross Blue Shield Association in order to maintain the brand and the Blue Card network and the membership, if you will, in that very valuable organization. There's a minimum, and

then we do sensitivity testing on what other adverse events could bring in terms of epidemics or if medical trend suddenly shot up or whatever, and so we do those sensitivity tests, and then that combined with the regulator and the Blue Brand requirements builds the bottom end of our range, and then the top end of the range is determined based on what we believe would be a collection of events that could happen over time, and recognizing that member reserves takes a number of years to accumulate, if we were to have an event that brought our member reserves down, we would need to be able to take time to build that back up over time. So the upper end of the range is determined in such a way that we believe it's protecting member reserves in several scenarios.

I guess you did say I could say what the range is. So the range that we currently manage to is 500 percent to 700 percent of our control level risk surplus.

Q. And when you use the term control level risk surplus is that another term for risk based capital?

A. Yeah. The risk based capital denominator, if you will, of that 500 percent to 700 percent is a risk measure that's determined through the statutory regulations.

Q. And you mentioned in your description of how you arrived at the target range there are some standards

that the Blue Cross Association promotes. Is that an accurate --

A. Yes. There's a certain level. Both the NEIC, and I don't happen to have these with me, but the NEIC and the Association have certain levels where if a company were to go below a certain level, they will come in and institute much more rigorous monitoring and control of the company. So we believe our target range is in a place where it's good protection and efficient.

Q. So you would meet those standards as well as any --

A. Yes.

Q. -- anything that would cause any regulatory issues for you?

A. Right.

MS. RICHARDSON: Thank you. I have no further questions.

MS. HENKIN: I'll open it up to the Board. Mr. Hogan, do you have a question?

MR. HOGAN: I'm sure you will reign me in on this. Isn't it true that the elements of risk based capital are published in your balance sheets each year?

MS. GREENE: Yes. That is true.

MR. HOGAN: So I really would like to

understand what the limitation is here. I don't understand the limitation and I see Judy pulling out a law book, but I want to know more about this.

MS. HENKIN: Would you like to answer? Would you like to go ahead and tell him about it?

MS. GREENE: I can't quote the exact law and chapter, but maybe you could, but it is I'm told --

MS. HENKIN: It is a statute and it's been pointed out to us at other occasions by Blue Cross at other hearings, and it's Section 8308 and I have reviewed it for this hearing again, and specifically at this point I believe it's applicable that the company itself can -- and their employees pretty much cannot disclose the capital risk based reports that's not required to be set forth in a publicly available annual statement.

I believe there's limits on it, Con, so I don't want to go into it too deeply. I don't think there's an objection at this time. So you asked a question that she could answer, and there is a prohibition on some of this but not all of it.

MR. HOGAN: Well I think it's an important question, and I'm just looking to see what the limits are here under law, particularly in the

case where these numbers -- the elements of these numbers are published in the balance sheets.

MS. HENKIN: Attorney Donofrio will respond.

MR. DONOFRIO: Without getting into a discussion about the intent of the law, the underlying rationale for the law, the law does specifically state that an insurer cannot place before the public directly or indirectly in any manner the risk based capital levels of the insurer.

MR. HOGAN: Even though they have already done that in the publishing of their balance sheets?

MR. DONOFRIO: I'm not saying that there isn't some tension between what the law says and what the reality of the balance sheet is. I'm just telling you what the law says, and so the law puts the insurer in an uncomfortable position of having put the raw materials for calculating the RBC levels in the publicly available document, but then the law tells the insurer they can't directly or indirectly make it available to -- the actual level available to the public.

MR. HOGAN: Does that same control apply to us as a Board?

MR. DONOFRIO: No.

MR. HOGAN: So we can discuss it as a Board?

MS. HENKIN: I'm not sure what the purpose would be here because we're not testifying, Con. I think if we're going to ask questions of this witness, we'll have to cross that bridge if there's an objection to what's asked, but there are some limitations on to what the company can testify to. So I would at this time like to continue without trying to get that from this witness.

MR. HOGAN: I understand that. I just want to make my position clear --

MS. HENKIN: And the Chair also wants to comment.

MR. HOGAN: -- that this is a very important part of overall financial condition of the insurance companies, not just Blue Cross, but MVP and everybody else, and I think that it really does need to be discussed publicly, and so I'll leave it at that.

CHAIRMAN GOBEILLE: So, Con, what I would say and what I would say to the people in the room is that Vermonters don't like secrets and whenever you say something can't be discussed that's

when everybody in Vermont immediately wants to know what it is, and the point is the Board can discuss it. The numbers are in front of us. We can have a conversation about it. We have deliberative sessions where this is part of the case, and we certainly can use that.

The point that Mr. Donofrio's making is that we cannot ask Blue Cross and have them answer us because it says in the law that they can't do it. I also think there's limits on what DFR can say in the law. When the law was written they hadn't yet thought of me and so -- and you. So we kind of fall out of that, but I think in order to be fair to the hearing we have to realize we have the information and we can use it as we see fit.

MR. HOGAN: Okay. That's all I need to know.

CHAIRMAN GOBEILLE: Fantastic.

MR. HOGAN: Thank you.

CHAIRMAN GOBEILLE: Thank you.

MS. RAMBUR: So I have a question and a comment. First question. Since this issue of contribution to reserves is so central to this deliberation I think this is a fair question. So if not, someone will stop me.

I'm just curious if the ranges as they are determined nationally and locally reflect the number of insured lives as well. I mean it seems logical to me that if you had a very large insurance pool you would have a different kind of range than a smaller pool. So could you just address that?

MS. GREENE: I think broadly the volume we call it of membership in our book of business determines the denominator, the risk based capital, and that's part of the formulas, and in fact if a company grows a lot and brings on a lot of membership suddenly, that would be sort of a demand on the capital and pressure.

MS. RAMBUR: So more would widen or potentially widen?

MS. GREENE: Well I think the amount that you're targeting to hold would be bigger, but the range of the ratio would be the same over time.

MS. RAMBUR: And then you've testified that the bulk of the increase relates to medical trend, so really reflective of utilization, and also a 6.3 administrative charge, and as I'm recalling data from around the world they often talk about 15 percent administrative charge, and from my experience as a former administrator at UVM our educational

overhead is 12 percent and social service projects 23 percent.

So I would just -- this appears to be a very commendable administrative rate, and I'm wondering is there a national average or benchmark because at least from some of the things I've seen this looks very commendable, and also I don't know what the admin rate is in public programs. I have been trying to find that and it was not possible for me to unravel that. So could you just comment on what you see in peers?

MS. GREENE: Sure. Well first thank you for drawing that out. I do like to brag about it sometimes, but this isn't the forum necessarily to do that.

The national numbers that we see are usually double digits. Our Blue Cross Blue Shield of Vermont over the last few years has really focused both on being efficient in reducing administrative costs, but also our growth in our membership has helped us, and so we do recognize that there's a certain amount of value that you get from being able to have that larger membership, but we have, just as an example, we have a program in the company called Blue Ideas where everyone in the company is asked to

submit ideas about how to improve operating efficiency or how to improve a customer experience, and those programs are just a continuous effort in our company to maintain a competitive administrative ratio.

MS. RAMBUR: Thank you.

MR. HOGAN: I have one more, couple more, but we had testimony yesterday from another company where it looks like their rates are going to be only a fraction of yours. What will this do to your enrollment as you move through the year?

MS. GREENE: Well we don't know for sure. Nobody knows what will actually happen. We know that the rate increase for all the carriers, both carriers on the exchange, they will be very competitive in the bronze plans. We do expect the quality and the network breadth and the brand of the Blue Brand to be meaningful to a number of people renewing on the exchange and coming to the exchange, and a lot of people, both small groups and individuals, once they get to know an insurance program or product they tend to stick with it because they like it, they get to understand it, and so we expect a fair amount of stickiness in our program due to that.

So we're expecting that there would be some impact, but not a significant one to the extent that it would call into question the rate assumptions that we've made.

MR. HOGAN: What are your calculations in your rate filing?

MS. GREENE: Calculations with respect to membership?

MR. HOGAN: That's right.

MS. GREENE: I don't have that here. We can probably ask Paul to comment on that when he testifies, but we do assume that there's some growth coming in obviously from the 51 to 100 small groups coming into the plan, and we do expect a relatively high rate of retention or renewing members, and we look at the experience from 2014 to 2015. We look at who's coming and going and we kind of project forward based on that and we incorporate a little bit of the rate competitiveness, but we don't have that information when we do those calculations. So, you know, there's no explicit assumption in those membership calculations because we build the rate based on our best estimate without the knowledge of what other carriers --

MR. HOGAN: You could be surprised?

MS. GREENE: We could be. It could happen.

MR. HOGAN: Thank you.

MS. HENKIN: Dr. Ramsay, do you have any questions?

DR. RAMSAY: Yes. Thank you, Ms. Greene, for your presentation again, and I want to move to the pharmacy trend, and this is -- this is basically to get a -- one of my comments to my colleagues on the record because when we talk about pharmacy trend we know there's the brand, generic, and the specialty drugs, and you know for what we -- and there are a number of widely prescribed brand drugs that have converted over to generic.

So would you agree that the more my colleagues and I can do to increase our generic prescribing ratio the lower we can keep your overall pharmacy trend? You and Paul would agree to that? Okay. I just want to have that on the record.

MS. GREENE: I agree and Paul can say what he thinks when he's up here.

DR. RAMSAY: We are trying. We are trying, but that message has got to be out there.

The second thing is about your discussion of quality improvement issues and the fact

that we have had a lot of public comments about this rate filing, but I will just say that as a family doctor I get public comments throughout the year about the interaction between a payer and a physician, my colleagues. Do you have any -- and we talk a lot about the patient experience here and that's really the ultimate goal.

Do you have any initiatives that would recognize or that would address that clinician or provider experience of care with Blue Cross Blue Shield? That to me -- I mean that's -- I have to advocate for my colleagues, and I do hear comments about this. So just explain to me if that is a model that you have in place.

MS. GREENE: Sure. We have a number of different types of programs. As you mentioned a lot of them are focused on patient experience and member safety, et cetera, but whenever we're working on a program our provider folks will reach out to the providers and seek input, and I know that we're involved in a number of pilot programs to figure out what would be the best balance between monitoring versus measuring results and not monitoring upfront, and so there's a number of ways that we work with providers. We're always open to working with

providers to get things to be most efficient from everyone's perspective. If there was a standard protocol that all providers were going to follow and it was the best way to ensure that we have the right care and avoid unnecessary care, then we would be all for it. We don't feel obligated to do that work. The providers are more than capable of doing that work.

I think sometimes what we see is there's inconsistencies across a range of situations, and so even the programs, the federally qualified health plan, or, sorry, the qualified health plans and some of the programs through the ACA require certain standards to be met, and so we have to do those, but outside of that we would be, you know, open to working with providers on whatever is the right solution.

DR. RAMSAY: You know certainly in terms of full disclosure I don't hear the good things. That's always going to be the case. Okay.

You mentioned about your Blue Cross Blue Shield's efforts around payment reform that could affect the medical trend. That 7.4 percent. I want to get back to that medical trend, and I don't think that you could find an economist or health policy

person or someone who works in a fully integrated health care system like Geisinger or Intermountain Health that don't agree the more investment you put in primary care the lower you're going to keep your medical trend.

Tell me about the strategy that Blue Cross Blue Shield has for continuing meaningful targeted investment in primary care to keep that medical trend lower whether it's the utilization or severity. However you want to define it. Tell me what the strategy is besides the Blueprint because as you know there has not been meaningful reinvestment or increased investment in Blueprint practices until this year as mandated by the Legislature since 2008. So what's the strategy?

MS. GREENE: Well I can speak very high level to that, and obviously I do think that some of our folks have been in to the Green Mountain Care Board to talk more specifically about the contracting ideas that our prior contracting folks have to get the primary care physicians to be rewarded for certain outcomes and optimize, if you will, the balance of care between the primary and then waiting for a later acute situation to happen.

So our strategy is very much to include

the primary care physicians in the integrated care management protocols and strategies and it is a key, key piece of health care reform.

DR. RAMSAY: You know I mentioned also yesterday, and I know some members were here, about how this is -- this is the third time the Board has reviewed the rates and each year things change. Now we have -- compared to the first year we did this we have a more mature Blueprint program which -- in which my colleagues have been very accountable to achieving NCQA certification, most at level 3. NCQA the same organization that develops hedis, the quality indicators that you use to market your products. So that's more mature.

Blue Cross has been actively involved in using a shared savings payment model for its qualified health plans. That is maturing. We have had testimony from, again back to the Blueprint, about savings achieved specifically because of the patient centered medical model, including the community health team and care management programs validated by Medicare doing their own independent review, but also showing savings accrued by the commercial insurers.

So all that being said, will we see in

future rate filings specific line items around the savings? Let's say a shared savings program does achieve savings. We won't know about the commercial for another month or so. Will we see that reflected in rates for the future? Those savings have to go back to the consumer. They cannot be just allocated to new administrative burdens, new care -- new duplicative services around utilization control. We can't do that. So will we see that?

MS. GREENE: So the way that would work is to the extent that all those programs and others that you and I haven't mentioned, all those programs will change over time what the claims that are incurred by the folks that we insure, and to the extent that that amount of claims incur changes and we'll see that in the experience. So, for example, in the experience that we've used for the 2016 rate filing any improvement or opportunities that have been put in place in 2013 and 2014 those are embedded in that claims experience, and I just didn't mention this in the other part of my testimony, but the commercial rate increase is also -- medical trend is impacted by the cost shift as well. So as much as we all work really hard to save the overall medical cost, to the extent that the hospital budgets have to

be balanced, and the commercial rates is where that comes from, sometimes you don't see it come through to us because it's kind of in the mix of the overall hospital budgets. Hopefully that helps -- helps answer that question.

DR. RAMSAY: You know the reason I -- I don't keep focusing on this primary care issue because I'm -- just because I'm a family doctor, but you know I see your 2 percent utilization trend. Your utilization trends literally don't match national figures. We see that in testimony here, and your argument is that the utilization trend for Blue Cross Blue Shield's book of business in this product line is due to an intensity rather than volume, whereas, most national utilization trends depend on number of visits and I understand that. Okay.

So if the utilization trend is really dependent on intensity and the intensity of the services we're providing in this state are not targeted, are not addressed, moved towards primary care, we won't keep that medical trend down. That's a fact.

MS. GREENE: That will happen. I'll ask Paul to make a note to speak a little bit more about the utilization trend. The utilization trend for

this block of business, subject to Paul's clarification, is somewhat unique because the claims that we were using to estimate 2016 rates is based on 2014. 2014 was kind of a start-up year. We had three months of a lot of people extending and people coming into new plans that they didn't know. So we had to do some special analysis to just look at people who had kind of continued through that.

So I agree with your comments that utilization trend really is something that we have to have under control, but I do think that that particular utilization trend in this filing is somewhat unique given the base that we started from in 2014.

DR. RAMSAY: When we hear from your actuary we'll talk a little bit more about that.

The last thing is just a very specific question that if you have your book, if you go to section 3 --

MS. HENKIN: Exhibit 3.

DR. RAMSAY: Exhibit 3, and it's listed on page 183, and you know I meant to ask this around the -- down to number 4 I just happened to notice that around these allowed claims .18 percent of the allowed claims, which is $666,000, have been excluded

from the chart since they were associated with a member that was retroactively cancelled. I know there must be some explanation for that, but whenever I see that, when I have a patient that has incurred a whole bunch of claims and then I find out that they have been retroactively cancelled I kind of need to know what that means.

MS. GREENE: And again I might defer the technical question over to Paul, but again the 2014 coverage year presented a number of challenges as we sorted through what was true experience.

DR. RAMSAY: I understand it was a transition, but I just need to be reassured. All right. That's all I have.

MS. RAMBUR: I have one more quick question before we go on. Dr. Ramsay posited an opinion about generic drugs and prescribing and you concurred, and so I would like to ask -- make a parallel comment and see if you concur. If patients who are consumers also demanded the use of generic drugs when appropriate, would that also decrease the pharmacy trend?

MS. GREENE: Patients demanding it as opposed to physicians?

MS. RAMBUR: Being part of the

conversation. So I guess I'm saying -- Dr. Ramsay is saying we as prescribers, I'm formerly a practitioner, we have some control of this, but as a consumer I also have the opportunity to say is there a generic that would be equally appropriate.

MS. GREENE: Yes. I'm sort of putting them both in the same bucket, but yes.

MS. RAMBUR: And that would impact the pharmacy trend as well potentially?

MS. GREENE: Using more generic as we currently use because we have seen the generic percentage increase.

DR. RAMSAY: But it's leveled off.

MS. GREENE: It's leveled off and you reach a little bit of a diminishing return, but the more generics beyond what we've assumed, yes.

MS. RAMBUR: I think it's a shared responsibility.

MS. HENKIN: Chair Gobeille.

CHAIRMAN GOBEILLE: Thank you. So the first thing I would like to do is make a comment. I think that over the last couple of years we've done everything we could to make it pretty hard to sell insurance in a lot of ways, and you and MVP, and I didn't say this yesterday and I apologize, have

fought through that, and there's a lot in this book that reflects that if you really look at the numbers of the challenges, and I just would say that the frank conversations that I have had with your CEO Don George over the months and over the last couple years dealing with setbacks and problems and things that you have run into have always been frank and courteous, and I appreciate that and you should pass that on. If he happened to be here, for example, that would be great.

So good work to both insurance companies because the implementation of the Affordable Care Act has been tough and we know that. Unfortunately tough translates in business terms into the word cost, and so if we could go to exhibit 5 page 190 number 1, when we first started doing rate review I asked Don and a couple other people from Blue Cross what's your batting average on your actuary. You know if your actuary says it's going to be 102 feet, a year later to go back and see was it 102 feet or were they wrong, and at the time everyone kind of stared at me like no one had ever asked if economic weathermen are ever rated on their accuracy or weather women because we haven't run into the male actuary version yet unless Dave is on the phone still.

So the point being that I like to know how well we do not just in setting a rate to the future, but how well we did and how close we got because it's the job of the three parties here to get to the right number as Jackie so eloquently said. So when I look at the chart here on number one, and I look at 2014 and perhaps this, you know, some of this includes -- this is individual small groups and '14 was the first year of the Affordable Care Act. That's why I use it. You came out within a half percent. You were negative half a percent to what would have been dead on minus the contribution to reserve.

Is that sort of a whimsical way to look at that?

MS. GREENE: I'm not sure what you mean dead on.

CHAIRMAN GOBEILLE: If you wanted to get the price right, you would come out at zero.

MS. GREENE: Well --

CHAIRMAN GOBEILLE: Meaning you took in the right amount of money to pay your payroll, pay your medical claims, pay your pharmaceutical claims. At the end you have no money left over for anything else other than a little bit for reserves if we said

you could do that.

MS. GREENE: Right, and so the little bit for reserves --

CHAIRMAN GOBEILLE: Didn't happen.

MS. GREENE: It didn't happen.

CHAIRMAN GOBEILLE: So my question is was that due to our team's -- all three parties here not getting the number right or was that due to additional cost due to the implementation due to the Vermont Health Connect and the Affordable Care Act?

MS. GREENE: It's any number of reasons. Claims, again, I can't emphasize enough that the job the actuaries -- what they think 2016 is going to be and then when 2016 gets here claims will be different, costs will be different. It will all be. So all those things washed out together to be an actual result that was about a point different than the expected in 2014, which is not bad.

CHAIRMAN GOBEILLE: Well it was in the right direction.

MS. GREENE: And L&E on page 238 in their opinion Section 14 calculated the average of the four years shown there, and you know at any given year you're going to be a little bit higher a little bit lower, but over time the actual was minus 1.0

percent and the expected was minus 0.8 percent. So it really is a long haul type game because in any given year, especially with 2014 with the implementation and the extension of old plans into 2014, I'm actually pretty surprised that it did come so close.

CHAIRMAN GOBEILLE: That's my point as well. I'm surprised that -- I'm encouraged by the fact that it appears that this process is accurate.

MS. GREENE: Right. I would like it to be a slight positive instead of a slight negative as the CFO, but that's true.

CHAIRMAN GOBEILLE: Well that is also our goal. So that is how we do your rate. So we're off by a little bit. I think the HCA might say we we're off in the consumers' direction maybe a little bit on price, but that's pretty close. I mean for government work, right?

MS. GREENE: I don't really want to comment on the government work part.

CHAIRMAN GOBEILLE: But I think this is an important point for people to understand because they hear about rate increases and they wonder where the money's going, and why are they a 2.4, 2.7, 2.8, 8.6, 7.2. All these numbers flowing around. What

I'm trying to find out is are we being accurate through this process, and from the charts that I'm seeing we're pretty close, and where we failed we failed to the affordability side not to the -- meaning if it's a negative number, it was more affordable than it should have been theoretically.

MS. GREENE: Yes. 2015 will help with another data point.

CHAIRMAN GOBEILLE: So the next question I have, and this is just kind of your opinion maybe, there's quite a bit written on page 222 about the 51 to 100 group, and we've talked about it a little bit this morning. This is the -- I feel like we're back in 2014 all over again. We're -- neither insurer and none of the parties really know what's really going to happen with all these people, but you say in your response that it could have a .5 percent downward pressure on rates if everyone that could were to move in.

Now I don't believe everyone will. I know quite a few business owners that are choosing otherwise. So I know it won't be a hundred percent, but can you just talk a little bit about that today because I think it's important for the public to hear that and for everyone to understand what Blue Cross

thinks about this.

MS. GREENE: Sure, and I would also like to also reserve the opportunity for Paul to comment as well because I think it's important.

CHAIRMAN GOBEILLE: If you want to wait.

MS. GREENE: No. I'm always willing to share my opinion. The 51 to 100 population of employers, one of the things that I think people forget is that there's currently a lot of employers who are already self insured in that size group. So it's not as if everyone's currently insured and they are thinking they might have to be self insured to quote unquote avoid the exchange, and we sort of know through our sales and marketing and account management folks that they are fielding almost every client who has the premise of paying more on the qualified health plan than they are currently paying, they are actively pursuing other options.

So you're absolutely right it's an assumption. None of us are going to be exactly right because history will tell us what that ends up being, but we, in moving into the HCA program where the small groups had coverage and they all had to make a decision as to which plans or maybe they dropped coverage, we feel as though that these, especially

the 51 to 100 groups that have broker advisors, are very much going to do what's in their best interest financially, and I acknowledge the points that were made in the various back and forth and HCA opinion that many small employers might be risk adverse and not want to go there, but if they are faced with a real increase to health care premiums versus something that their broker can help them navigate, it's very possible, and we've seen it happen already, there are a lot of self insured smaller groups.

So that's why we chose the assumption that we chose, and history will tell us what actually happens.

CHAIRMAN GOBEILLE: Okay. And so my next question I asked of MVP yesterday and I would like your thoughts on it and perhaps Paul's thoughts on how it impacts rates, and that is our hospital budgeting process.

My take on it, I said yesterday, was that we have three pieces that have to happen in a regulated year. One is our work with Vermont Health Connect, the qualified health plans and that work, that informs your work, and then there's the hospital budgets, and it appears to me that they are out of sync, and so I've specifically been trying to figure

out how we could fix that easily, avoiding a statutory change and possibly doing it through a rule or something, but can you talk a little bit about how important it is for you to know what the commercial ask is -- that's what I call it. That's probably not the technical term -- in the hospital budgets in order to influence the design of your medical trend.

MS. GREENE: It's very important. I mean we do, and forever we have had to make assumptions about what we will achieve in terms of contracts because it's not just the commercial ask within the budget, but then by health plan and carrier each hospital has to do a negotiation, et cetera. So it's actually got a longer tail on it, I think, than the actual budget decision.

So I commend your goal of trying to get the sequence worked out, but it's very challenging, but -- and Paul can comment on the specific numbers, but when we filed our 2015 rates we made assumptions and then of course the budgets were settled and then the actual contracts were agreed, and they turned out to be I think about a percent or so, a little bit more than a percent higher than we expected, and that does kind of carry into the following year's rate filing.

So if we could figure out how to match that up better that would be great, but I think it would require a pretty significant change to the timeline on the hospital side of things.

CHAIRMAN GOBEILLE: So I might be hearing you wrong, but what I hear you saying is that, for example, this year let's say the commercial ask is 4.3. Now the Board hasn't even heard the cases yet so I'm just throwing out a number. I would have thought historically it was going to be a 5.5 to a 6. A 4.3 to me is lower to me than I thought it would have been which is good, but that's just a budget. There's no reconciliation process, and so what you're describing is if it is a 4.3, then how do we reconcile that through you, the purchaser of health services, so that that translates into an accurate actual instead of it being budgeted and then a 4.3 becomes a 5.3 in the example you use?

MS. GREENE: I mean we would be willing to -- because we know our contracting folks do a lot of analysis on the budget so they know if a budget approval has a certain amount in it, that is much better than not knowing what the commercial ask is. Absolutely. I'm just saying that the 4.3 might not end up being exactly 4.3 by the time it comes to our

particular relationship with that hospital, but certainly knowing 4.3 versus I think in our rate filing for 2016 we've based the hospital and provider contract increases on last year's actual results. So that's just our baseline. So if there's an improvement on that, we would love to be able to incorporate that assumption into our rate filing.

My other point was just more of a logistics. It doesn't actually turn out to be exactly the same in any event.

CHAIRMAN GOBEILLE: Well and I would like to think that as we evolve we could reconcile that, meaning if the hospitals say it's going to be a 4.3, there needs to be a reconciliation mechanism once you have contracted that says they did what they said, and we're at the end of our three years of hospital budget guidance and so we've now got to come up with what we want to do for next year, not the year we're just in now, but for next summer's hospital budget festival we've got to think that through, and the Board has already talked about this being, you know, sort of a new -- the new frontier of not just NPR but commercial ask.

MS. GREENE: And we would be happy to work with you on timing and what would make sense.

CHAIRMAN GOBEILLE: That would be helpful. Thank you.

MS. HENKIN: Jessica, do you have any questions?

MS. HOLMES: Well actually a lot of my questions were answered from my colleagues here, but I guess I'll just ask a big general question.

7 to 8 percent increase in premiums is obviously not sustainable over the long haul. Health care costs can't keep outpacing inflation and economic growth, and I think about the levers we have to use to sort of reduce premiums and make insurance more affordable. I think about lowering administrative costs, lower unit costs, and reducing utilization. Utilization that's not cost effective anyway.

So I'm wondering if you could just talk a little bit maybe broadly about strategies that Blue Cross Blue Shield is using to sort of tackle each of those, and then in the sense what you feel most optimistic about your ability to move the needle on those and what you feel like, you know, less optimistic keeps you up at night. Trying to project forward, if you had a crystal ball, for next year are we going to be seeing these same rate increases each

year or what can we be doing?

MS. GREENE: I'm an optimist by nature so my optimistic view is through working with the various provider communities, including Blueprint and all of the players in health care system, to come up with ways to pay for outcomes and to make sure, to Dr. Ramsay's point, that preventative and wellness is being funded as part of the equation and all of that should improve both the utilization, the unit cost or price increases.

I'm less optimistic about especially with the pharmacy piece in there. We do what we can on the pharmacy side, but it is a smaller piece of the overall, but I do think that the looking at ways and shared savings programs and payment reforms that we have some bundled payment pilots that are going on that say, you know, a certain type of set of procedures should cost this much, and we measure both the cost and quality and hold people to that so that we can kind of focus on the highly frequent procedures, et cetera. So it is kind of chipping away at that over time.

As I said earlier in the testimony, we don't have direct control over that, and it really is down to good collaboration and partnership with the

provider community.

MS. HOLMES: The administrative costs tend to be low and that's commended by my colleagues. Are there other things that you're doing to sort of lower those administrative costs even further?

MS. GREENE: Yeah, I think each year we do a rigorous budget exercise. We're actually in the middle of our budget exercise for next year, and we are -- just as an example we are testing all of our fixed costs and doing a zero based justification. So we chip away at that each year and year out. The vast majority of our costs, however, are people costs, and you know the service and the quality work that we do requires that we have expert people, well trained people. So that will remain.

MS. HOLMES: Thank you.

MS. HENKIN: Nothing else? Con.

MR. HOGAN: Dr. Ramsay made a really interesting statement on the tension between what insurance companies do and what primary care is all about. You used one example New Beginnings I think -- Better Beginnings. Theoretically in your mind where is that service best provided, either through primary care or through the insurance companies?

MS. GREENE: I would say the primary

care definitely. I mean if the programs -- if the community of Vermont health care providers, and I mean in the broadest sense of health care providers including community services and some of the other services that can be brought to bear, if everyone was sort of working together on a program that we know to work because of the outcomes, there's no reason why Blue Cross Blue Shield of Vermont has to spend money on that.

MR. HOGAN: And that's kind of opening the door to, you know, maybe some kind of a special exercise to, you know, as we become more integrated these opportunities grow. Would it make sense for the insurance companies' growth to go through kind of an exercise at creating an inventory of everything they do on the quality side and then over a period of time making judgments about where they best could be served? Because up to this point we're all doing our separate things. Can we integrate this work?

MS. GREENE: I think there's lots of opportunities for that. I think -- I also think there are working groups in place now that are beginning to do a lot of that work, and I know our chief medical officers are working with the provider community to look at things that are working and what

can we sort of say okay we like that, go ahead and you're on your own, and where there might need to be a pilot. So there's no -- nothing to be lost by taking an inventory of what's out there.

MR. HOGAN: Okay. Thank you.

MS. HENKIN: Anything further of this witness?

MS. HUGHES: I would like to reserve the opportunity to call her on redirect or rebuttal if necessary.

MS. HENKIN: And I just want to remind people in here if you haven't signed in, there's a sign-in sheet. You can do it on your way out, but there is a sign-in sheet if you're here. Even though we know who you are, I probably won't remember. So please do that. You can call your next witness.

MS. HUGHES: Oh thank you. I will call Paul Schultz.

PAUL SCHULTZ,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HUGHES:

Q. Can you state your name for the record?

A. I'm Paul Schultz.

Q. And where do you work, Mr. Schultz?

A. I work for Blue Cross Blue Shield of Vermont.

Q. And can you give the Board a snapshot of your professional background and experience with Blue Cross and before that?

A. Yes. I've been working as a health care actuary for nearly 20 years. I graduated from Purdue University with a Bachelor's in Actuarial Science. I've been a member of the American Academy of Actuaries since 2000 and a Fellow of the Society of Actuaries since 2001.

I've been working for Blue Cross Blue Shield of Vermont for about two and a half years, most recently in the role of chief actuary where I have oversight of the actuarial and underwriting functions. As part of that I have the responsibility of this rate development and the all rate developments for our various products at Blue Cross.

Q. So exhibit 1 and 2 have already been admitted into evidence, and I was wondering if you could tell us if you're familiar with those exhibits?

A. Yes, I am.

Q. And how are you familiar with them?

A. I supervised their preparation.

Q. And can you walk the Board through how exhibit 1 was prepared?

A. I can. So as with any rate filing you need to start with a projection of allowed claims. So what we did in order to do that was to start with the actual 2014 experience of members in our qualified health plans combined with the 2014 experience of members in our other small group and individual products that were available on a transitional basis in the early part of 2014. So all told that's about 800,000 member months of experience. We transformed that experience and reflected the EPO network, which is the network for our QHPs, and then projected it forward to 2016.

Once we completed that projection we then had to do a transformation from allowed costs to paid claims, and so you do that through a number of what are called allowable factors, and those mainly include actuarial values, which is the amount the plan is expected to pay of the total allowed cost as opposed to what's paid through the member cost sharing. So all told that comes to over 90 percent of the claims dollar as Ruth testified.

To that we add a number of other items. Administrative costs are from there. That was part of Ruth's testimony as well. We use a similar process there. We start with 2014 base experience, and then trend that forward to 2016 to reflect wage increases and inflation, and we add in costs from our various vendors and it comes

to about 6.3 percent of the overall premium.

Another thing we have to add in are the various taxes and fees that arise at the state and federal level. Those are a little bit over 4 percent of premium. It's offset in 2016 by a federal subsidy in the form of a transitional reinsurance program. That subsidy is worth about 2.7 percent of premium. So fees on a net basis are 1.4, and finally we add the contribution to reserves of 2 percent. Again Ms. Greene testified pretty extensively about that, and that comes to a hundred percent of the premium dollar. There's no profit in the rates. We're a local non-profit company so there is no profit.

Q. So as you develop the filing did you have specific objections in mind -- excuse me, objectives in mind?

CHAIRMAN GOBEILLE: You could answer both if you would like.

A. It may take a while to get through the first part. Our specific objectives were to develop the most affordable and competitive rates possible while using assumptions that are reasonable both individually and in the aggregate, and using methodology as prescribed by state and federal rules and instructions.

Q. So aside from the components did you make any assumptions in developing the filing?

A. We had to make a number of assumptions. The most important of those, and we've already talked about it a little bit, is trend. Trend consists of a number of components, both utilization, which we define as including intensity of services as well, and then what we refer to as unit cost trends which are the increases in the amounts providers are paid. So those things we take a look at and we develop assumptions for that both for medical costs and for pharmacy costs. We look at the two of them separately, and then we consider them -- cobble everything back together and we have an overall health care cost trend. That's far and away the biggest assumption.

Another key assumption has to do with population morbidity. So we started with 2014 base experience. We expect the population to look a little different in 2016 than what we had in 2014 and that's true in a number of different ways. For one we added about 6500 new members at the beginning of 2015. We don't know what their experience looks like, but we can look at their demographics and we can see that they tend to be younger than the average member that was on our plans in 2014. So we're assuming they will be healthier as well.

We took a look at members who left our rolls either during 2014 or as we transitioned into 2015, and what we noticed when we looked at that was a little bit

surprising. They tended to be the more expensive members who left. That's unusual in that people who are using a lot of services tend to want to keep their insurance, but we found that they did not. Our -- what we're presuming is that a lot of them found that they were eligible for Medicaid and so ended up on the Medicaid rolls rather than ours. So we made the assumption these folks would not be coming back to our plan in 2016, and through doing that we were able to lower our premiums by a couple points.

A few other population morbidity assumptions are in there as well, but continuing members, we talked about the new members, those that left. Those that continue as well. They are two years older in 2016 than they were in 2014 so we need to reflect that.

We included an assumption for plan selection, and we included another item that we talked about already the definition of small group will change in 2016 to include employers of 51 to 100 employees. So we also made an assumption as to how that would impact the rates.

So those are probably the two most meaningful assumptions. There are a number of other ones as well. We had to make assumptions as to the amount of the risk adjustment transfer that we'll receive in 2016 and the fees associated with that. We had to make assumptions about transitional reinsurance, what would be the

recoveries that we would receive from transitional reinsurance. I described that federal premium subsidy earlier. It technically works a little bit differently than that. So we had to make assumptions as to how much money we would receive from that program and what the fees for that program would be.

Another key set of assumptions has to do with paid-to-allowed ratio which includes a number of components as well. Includes the actuarial value at a member level for each benefit plan. We have to take a look at this for each individual benefit plan and project of the total allowed costs how much will be paid by the plan, how much will be covered through member cost sharing.

There's also something that we call a family tiering adjustment. That's a little bit unique for Vermont. We don't have age rating and Vermont defines the tier factors between single, couple, member, and children and family, and so when we look at the actuarial value of a family plan, for example, that may have aggregate deductibles, we can see that actuarial value is a little bit different than the tier factors defined by the State of Vermont. So we make adjustments to reflect that. That's actually a downward adjustment of premium of around 3 and a half percent. So if we didn't make that, we would

be collecting much more premium than we really needed. So that's a key part of the transition from an allowed to paid claims.

Finally, there's benefit enrichment adjustments which essentially say folks that have richer coverage tend to utilize that benefit more just because they have richer coverage. So that's factored in as well.

The last kind of set of assumptions that we put out there are those that are used to project things like administrative costs from 2014 to 2016. So what will those wage increases be, what will inflation be, those sorts of things, as well as federal fees. We need to project those from a 2014 known amount to what we think will happen in 2016.

Q. I wanted to circle back with the trend on drugs, and can you briefly address the various driving factors in the RX trend for 2016?

A. Yes. So there were some questions on this earlier. The shift from brands to generic certainly play into that. I tell you that our generic utilization in Vermont is already well above 80 percent. So it's -- when we think about diminishing returns it's not -- you know it's not just because of so much we have done already. It's because literally there's a mathematical maximum we can reach here, and as we're proposing getting into the

mid 80's and eventually reaching 100 percent we can't make it 120. So that will necessarily slow down over time.

The other thing feeding into pharmacy trend that's very meaningful is specialty trend. What we've seen is a lot of the new medications coming out are for specialty drugs that are not utilized by a great many members but are very expensive when they are utilized. Hepatitis C treatments, for example, are -- the medication is doing wonderful things for helping people with that affliction, but it's exorbitantly expensive, and so that has a very large impact on our pharmacy trend.

Q. And how about the Vermont specific law on RX maximum out of pocket?

A. That law we've seen very much play into the generic dispensing rate discussion we have had earlier. What we've seen there's a low $1,300 maximum out of pocket on pharmacy spend in Vermont. That's a state law. What we've seen is that once members hit that out of pocket generic utilization kind of goes out window and they start using brand drugs much more heavily.

When they look at -- we have some preferred brand medications and some that are non-preferred brands. We look at clinical effectiveness and we also look at the cost of those products. So the non-preferred tend to be much more costly, and we also see once that maximum out of

pocket is reached that members who are using brand drugs tend to use more non-preferred brand than they did when they were -- when they had some sort of cost sharing. When they had some sort of skin in the game. So that maximum out of pocket does absolutely impact pharmacy utilization and ultimately pharmacy trend.

Q. So what was Blue Cross's original rate increase request to the Board?

A. We filed 8.4 percent on average.

Q. And was that original request supplemented later with additional information?

A. It was. It was supplemented after state law created some changes to the Blueprint program that then found their way through the Blueprint manual.

Q. And is that found in exhibit 2 in the binder?

A. Yes. That's exhibit 2. New average rate increase is 8.6 percent rather than the 8.4 percent once we reflected those Blueprint changes.

Q. So are you familiar with the recommendations that have been made by the Board's actuary Lewis & Ellis?

A. I am.

Q. And is exhibit 14 of the binder a copy of those recommendations?

A. Yes. That's right.

Q. And could you briefly describe what the

recommendations were?

A. I can. Three of the recommendations had to do with refinements of our methodology that we proposed after discussion with Lewis & Ellis about our initially filed methodology. One of those had to do with the way we were projecting forward unit cost trend, which is increases in the amounts providers are paid specifically for facilities.

A second had to do with reflecting the membership growth that we saw from 2014 to 2015 on our QHP block of business reflecting that in our projection of administrative costs from the base period to 2016, and the third had to do with a methodology we used to project what the federal insurer fee would be in 2016. Those three changes collectively had an impact of about a half a percent downward on rates.

The fourth change has to do with information that we received well after the date of the initial filing on the risk adjustment program. We found that we were receiving a substantial risk adjustment transfer payment to us for 2014, and we feel it's appropriate to reflect that in the 2016 rating as well. L&E agreed with that and so that's an additional downward adjustment of .8 percent to the rates.

Q. And do you agree with the four recommendations

that you just reviewed?

A. Yes. We agree with all four.

Q. So are there any areas of disagreement with Lewis & Ellis on this filing?

A. There are none. After these four adjustments they opined that the remainder of our assumptions are reasonable and appropriate, and that the rates were neither excessive nor inadequate nor discriminatory.

Q. And I'm going to ask you to refer to what we've labeled exhibit 22 and Martine will provide the Board with a copy of it. So, Mr. Schultz, can you please identify for the Board what exhibit 22 is?

A. Exhibit 22 is a restatement of our rates after these four Lewis & Ellis recommendations that we agree with.

Q. And can you give the Board the bottom line so to speak?

A. The bottom line is an average increase of 7.2 percent. You probably will have seen in the L&E opinion that they said 7.3 percent. It's a little bit different because of all the co-variances among these four things. They are not simply additive, but they impact each other in interesting and convoluted ways. So we end up with something slightly over 7.2 percent.

Q. And can you walk us through what the 7.2

percent represents?

A. I can. So as Ruth testified, the majority of that has to do with increases in the amounts providers will be paid. I do want to clarify a little bit of her testimony when we look at how -- so there's two parts of this. One is what do we expect to happen from 2015 to 2016, and Mr. Gobeille had a question earlier about how the hospital budget plays into that and whether we can do that in a way that allows us to have better information. I would agree with Ms. Greene's testimony there, but we need to make an assumption as to how that would increase.

The other part of that is a rebasing in 2015. In last year's filing we had an assumption as to how costs would increase from 2014 to 2015, and now that we're part way into 2015 we have a better viewpoint into what is actually going to happen, and what we're seeing is about a 1.1 percent higher unit cost trend than what we anticipated.

What I want to clarify is that all of that really is on the pharmacy side. So pharmacy cost trends are much higher than we thought they would be. When we look at the hospital budget review it's actually very close, at a very slight good guy, if you will, compared to what our assumption was for the 2015 filing. So we had a little bit of a good guy there, but more than offset by

the pharmacy prices going up very significantly, and the use of specialty certainly plays into that as well. We're seeing both more utilization and higher prices on the specialty side. So that all plays into the 7 and a half percent.

We also heard a little bit of testimony about the cost shift. That certainly plays into it as well. When we see the hospital budget increases, those in total will be lower than what's passed along to commercial because government programs, Medicare and Medicaid, pay something that's much lower than what providers really need as an increase, and so commercial, including QHP, are left to kind of foot the bill for that.

So that's at 7 and a half percent. It is offset by the renegotiated pharmacy contracts that Ms. Greene also testified about. That brought the number down by nearly 2 percent. So that was -- that certainly helped the premiums. There are a few other kind of important factors. I've talked a little bit about transitional reinsurance. So that's the federal subsidy of exchange rates. It is a transitional program as the name would indicate. So the amount of the subsidy reduced from 2014 through 2016. It goes away entirely for 2017. So when I'm back next year part of the reason for the increase next year will be the fact that federal subsidy goes away,

and as those federal subsidy dollars go away more of the total cost of coverage is shifted to members through the premium.

So that caused about a 1.7 percent increase to rates this year. In addition to that we had some plan design changes to make the benefits richer. So again it's a tradeoff between member cost sharing versus premium. As you have more member cost sharing you can have lower premiums, but the opposite is true with -- particularly with the change, the federal change the way the maximum out of pocket works for family coverage that we had to incorporate. We had to incorporate it on a plan-by-plan basis. It impacted some plans much more than others. For example, the standard bronze CDHP was impacted by nearly 6 percent because of this federal change. So our rate for that plan is quite a bit higher because of this change. In aggregate the weighted average across all plans this caused about a 0.8 percent increase in rates.

There were some other plan changes. There's the concept of leverage, which is that if you keep your cost sharing exactly the same but the total cost of care goes up, that means that the amount that must be shifted to premium is going to have to increase as well because the member cost sharing stays the same. Total increases those dollars have to go to premium.

Those changes are offset by plan changes that are made to keep plans within certain medal levels. That's part of the ACA. We need to keep -- a silver plan needs to remain silver over time, and if we never change that benefit design, if we never increase deductibles or out of pockets, what have you, it will continually get richer and richer until it will no longer be considered a silver plan. So we have to keep it within that silver framework. So there were changes both to some of the standard plans and to our non-standard plans to keep those plans within the proper medal level. All told those plan changes were worth about 1.1 percent.

A couple other things that changed administrative costs. While they stayed about the same as a percentage of premium, if you look at them on a per member per month basis, they are higher. So that's an increase of about .7 percent if you look at it on a per member per month basis.

In terms of contribution to reserves, one of the many ways that Blue Cross has been supportive of health care reform in Vermont is through in past filings requesting a contribution to reserve that is lower than that we would normally request. Unfortunately that's not a viable long term strategy. So this year we've requested the amount that we feel is necessary to maintain an

appropriate level of reserves using guidance from our regulator such that the reserves are sufficient to cover both growth in health care costs and potential adverse events. So we're requesting a 2 percent contribution to reserve this year. It was 1 percent last year. So that's a 1 percent difference in rates.

I know I'm throwing a lot of numbers out there, but this kind of circles back to the question Dr. Holmes asked earlier about that 7.2. That's much higher than inflation and so forth, and I would completely agree with that, but what I do want to point out is that we have these things like the federal subsidy going down. So that's not increasing the total cost of the coverage. It's a shift from federal dollars helping to pay for the total cost to member premium paying for the total cost. Same thing with the plan changes.

So when you take a look at both those things that takes the 7.2 down to something that's in the low 4 percent, and last year if you look at Blue Cross requesting a CTR, there was less than what we felt we would normally ask for. That's another percent there. So now we're getting down into the range that I think is more consistent with inflation, and I think a lot of the programs that we've talked about to try to keep the costs of care down, whether that's things we're doing or things

that providers are doing, are reflected in that.

So a lot of this increase has to do with changes in the way we're kind of divvying up that total dollar that's the overall cost of care.

Q. Were there any things that you assumed that would mitigate the overall impact?

A. We did. I talked about the population morbidity assumptions, and so we made some specific assumptions there regarding the health of the new members being healthier than members we already had. We made assumptions again about the members who left. So when you consider that along with all the other various assumptions that we made that brought rates down by about 1.8 percent; and the final thing that had a significant impact on rates was that .8 percent we talked about for the risk adjustment program. That risk adjustment program was put into place to discourage issuers from favoring or trying to attract members who have good risk at the expense of members who have poor risk. So that program was put into place to transfer money from carriers who have a low risk population to carriers with a high risk population as a means to level of playing field, and they did that so that carriers wouldn't back away from trying to attract and serve the members who are higher risk and may not be in as good of health.

So as I mentioned earlier we expect to receive 2.7 million dollars of transfer payments for 2014 to reflect the fact that we are serving a membership that has higher risk. Without knowing any better information about how that might change from 2014 to 2016 we feel it's appropriate and necessary to reflect that in rates for 2016, and we did so by using the same percentage of premium that we received in 2014. We'll assume we'll receive that same percentage of premium as a risk transfer payment in, in 2016. So that brings rates down by .8 percent and something that we felt was important so that the intention of the program, which is to level the playing field for insurers, can actually be realized.

Q. So the 2.7 million is that government dollars or where does that money come from?

A. That money comes from other carriers on the exchange, and in our case we only have two. So that's going to come to us from MVP. MVP will pay that money to the government who will then hold on to it for a little while and then send it on to us.

Q. And is that subject to sequestration at all?

A. It is subject to sequestration. What we understand is that something in the order of 7 percent will be subject to sequestration, but we do expect to receive that money once the federal government's in a new

fiscal year. So we do expect to get the full 2.7 million, just not right away.

Q. So when you spoke earlier about L&E's recommendations was this one of their recommendations as well?

A. That's correct. Yes.

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

A. Yes, I am.

Q. And do you believe this filing meets those standards?

A. Yes, I do.

Q. And we can review them, and I know Michael will go over this as well later I'm sure with L&E, but in your professional opinion are the rates being requested after modification by the recommendations by L&E, are they excessive?

A. They are not excessive.

Q. Are they inadequate?

A. They are not inadequate.

Q. Are they unfairly discriminatory?

A. No, they are not.

Q. Are they reasonable in relation to the benefits?

A. Yes, they are.

Q. And do they meet the other statutory standards that Ms. Greene went over earlier?

A. Yes, they do.

Q. So I want to turn to exhibit 15 -- sorry, 16, and can you identify for the Board what that exhibit is?

A. That is the NovaRest report on our rate filing.

Q. And did NovaRest address all the issues, the same issues that L&E addressed?

A. Yes, they did.

Q. And are they in agreement with the L&E recommendations?

A. Yes, they are.

Q. And did they -- did the report contain any additional suggestions for this rate filing?

A. It did. It included a suggestion that we assume that at least half of the employers of the 51 to 100 size who would be financially disadvantaged by enrolling their employees in QHPs would choose to do so anyway.

Q. And so do you agree with that analysis?

A. I do not.

Q. And why do you disagree with it?

A. NovaRest asserts that nationally actuaries expect the transition to self insurance for employers of

this size to be gradual and incomplete, and that may well be true nationally. The Vermont marketplace is very different from the national marketplace in quite a few ways.

We heard some testimony on this earlier. We know that employers of this size almost universally work with brokers in Vermont. Brokers have been encouraging these employers to move towards self insurance even before this choice in 2016. They have been doing so for a number of reasons, but control over benefit design and avoidance of certain premium taxes and fees seem to be kind of foremost among those reasons. There is a pretty well developed marketplace in Vermont for self-funded groups of smaller size. Our competitor CIGNA has a level funded product that kind of to our dismay has proved to be very popular among groups of this size. So this product includes both specific stop loss and aggregate stop loss, both of which at very low attachment points that reduce a lot of the risk that an employer might face in choosing to become self funded. So we've seen a lot of employers go there.

We know that a number of brokers in the state have or are developing relationships with captive insurers, which is another way to provide kind of additional reinsurance coverage around a self-funded

product for employers of a smaller size.

Now that we're getting into the 2016 renewal season I can share with you that we're receiving a lot of requests from brokers for employers to change their renewal date to an early renewal in December rather than a January 1 renewal date. Employers can do that if they have a valid business reason for doing so, and the effect of that is that they can retain their insurance, their fully insured product through November 30th of 2016. It effectively puts off for 11 months their need to make a decision between self funding or going to QHPs. So we're seeing all of this happen in the Vermont marketplace, and as a result we think that the movement toward self insurance for employers of this size in Vermont will be much swifter and in many ways has already been much swifter than what we may see nationally.

So for that reason, especially if we look at assuming that employers who would be disadvantaged would move to the QHP anyway, to realize that quarter percent of savings you have to assume that at least some employers who would be significantly disadvantaged financially to move to the exchange would do so anyway, and we just don't see that happening in this market with some of the self funded alternatives that are out there and being promoted heavily by brokers.

Q. And was there another suggestion in the NovaRest opinion?

A. There was. The NovaRest suggested that our CTR could be reduced without threat to our solvency.

Q. And do you agree with that suggestion?

A. I don't agree with that suggestion either. There is certainly a long term threat to our solvency if our CTR is continually reduced below the level that we're requesting.

Q. So why does Blue Cross have reserves?

A. Reserves are a consumer protection. So reserves allow us to maintain the financial strength that's necessary if there is a significant adverse event that will allow us to continue to pay claims on behalf of members.

Q. So can you describe what an adverse event would look like?

A. Sure. There are a number of examples. Regulatory action is one. There could be a utilitization shock. So that could be a flu pandemic, for example, could create a pretty significant run on utilization. We don't rate for that. So should that happen that money would come out of reserves.

There could be an increase in the cost of services, and probably the best example of that, that we

may have seen for a while is there's a new class of drugs called PCSK9 inhibitors. It's an injectable cholesterol medication that is expected to be approved later this year, and we don't really know to what extent it's going to be prescribed by providers. If clinical trials come back very favorably, we could see some widespread utilization of this drug for people who would normally be on statins.

Q. So is that included in your projections?

A. We do include the cost of PCSK9 in our projections, but only for a specific genetic disease for which it's likely to be prescribed. So just a small amount of what is the potential utilization. We received a report from our pharmacy benefit manager that was opining that the utilization could be as much as 10 percent of the statin using population, which now that would have a huge, huge impact on rates.

So if you start literally pricing for potential adverse events, rates could become very expensive indeed. So rather than directly pricing for something that has the potential to happen, what we do is to include that as part of our contribution to reserve. So that contribution to reserve covers yes the increases in health care cost that's required to maintain our solvency at a current level, but we also need something to

cover these potential adverse events that we don't price for directly but we still need to have the financial strength to be able to pay for those should they occur.

Q. So if an adverse event were to happen and the company is not given the CTR that would be required to cover that, how long would it take for rates to catch up with that kind of a situation?

A. With our robust review cycle in Vermont it would take about two years from the time we identified the need for that rate change until the time it was actually approved and implemented.

Q. And if a CTR was approved only to cover trend each year, do you have any opinion as to what would happen to the company financially?

A. In the very long term the company would be likely to become insolvent because these adverse events do happen. So if we only ever covered trend, ultimately we wouldn't have enough money to pay for the adverse events.

Q. And I think there was testimony about this earlier, but so over the last 4 to 5 years what has been the actual experience on CTR?

A. We referred to the Lewis & Ellis report earlier, and we've since learned some additional things about the transitional reinsurance program and the risk adjustment program. So the overall average over the last

four years of what we've realized has been a negative .4 percent contribution to reserves.

Q. And do you think that's helpful?

A. Ideally we would like that to be certainly a positive number. So I would say that if we look at it objectively, over the past four years the rates as modified and approved by the regulators have been inadequate.

Q. So in your opinion what is the minimum CTR required for this filing?

A. 2 percent.

Q. And are you familiar with, and now we will go back to exhibit 15 which is the DFR opinion, are you familiar with the Department's solvency opinion?

A. Yes, I am.

Q. And can you briefly describe what their opinion was?

A. They have opined that our solvency is appropriate and necessary, our level of solvency, and they have opined that rate components should not be adjusted downward, and rate components would include things like CTR should not be adjusted downward unless the Board's actuary opines that the rates are excessive.

Q. And going back to exhibit 14 did L&E express an opinion on CTR?

A. They did. They found --

MS. RICHARDSON: Objection.

MS. HENKIN: We are going to have these witnesses, if we could, go through this quickly, but I will allow him to answer this question at this time.

A. They opined that a 2 percent CTR was reasonable and appropriate and did not recommend changes to it.

Q. So they did not find that a 2 percent is excessive?

A. That's correct.

MS. HUGHES: Thank you.

MS. HENKIN: Is that it for this witness for you?

MS. HUGHES: Yes.

MS. HENKIN: I'm going to allow for a break now because we are already at 11 clock. We're going to come back and we'll continue with the HCA and the Board's questions of this witness and move on. It's 11:01. We're taking 10 minutes. So we are going to be starting right on time at 11:11. Thank you.

(Recess.)

MS. HENKIN: Okay. It's 11:11 and I did

say we would be on time. We do seem to be missing some parties, but we do have a witness, the parties, and the court reporter, and the Board. At this time I'm going to allow for examination for the Health Care Advocate's Office. Lila.

MS. RICHARDSON: Thank you. I'm just going to ask one or two brief clarifying questions because of the time that the hearing has already taken.

CROSS EXAMINATION

BY MS. RICHARDSON:

Q. I had a question to clarify the administrative costs and percentage of premium. My understanding from the filing and from your testimony --

MS. HENKIN: And I'll ask everyone to please -- we did turn up the volume. I know I'm kind of loud, but everyone please speak into the mike so we can hear you.

BY MS. RICHARDSON:

Q. So my understanding from the SERFF filing and from your testimony is that you did not develop the administrative cost as a percentage of premium?

A. That's correct. Yes.

Q. And it's a per member per month cost instead?

A. It is.

Q. It is. So is it accurate to say that if the total increase has been reduced from the time that you filed to what's agreed to at this hearing, that the percentage of premium represented by administrative costs has gone up?

A. It has. Part of the reduction, though, was a reduction or projection of administrative costs.

Q. So it's a combination of those two factors?

A. Yes.

Q. There's a slight downward adjustment for that?

A. Correct. So if memory serves, the initially filed admin costs would have been 6.4 percent of premium, and now after the adjustments it lands at 6.3 percent.

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

MS. HENKIN: Okay. Then we'll go to the Board and I'll start over here at this time.

MS. HOLMES: Okay. Great.

MS. HENKIN: Dr. Holmes.

MS. HOLMES: Thank you. Actually as a first time Board Member through this your explanation was really, really helpful clarifying. Thank you for that. As a professor I will tell you, you should become a professor some time because that was really good. Yeah.

So a couple questions for you. One of them was involving actually this utilization trend, 2 percent, and I'm just trying to get an understanding of where that number comes from. Particularly I think yesterday we heard from MVP it was 0 percent was what they were assuming, and so I'm just trying to get a handle on where that number comes from, particularly in light of the fact that you think that your population is going to be healthier so -- with the younger population. That's my first question. Why don't I start with that.

MR. SCHULTZ: Okay. I think I have three parts to my answer. First, in terms of the healthier population, because of those changes we rated explicitly for that. So those were completely separate from the utilization trend assumption, the separate factors. It's all multiplicative so it all lands in the same place, but it was separate from the utilization trend.

One thing that I think makes our utilization trend a little different from what you might see in some national publications and so forth, Dr. Ramsay referred to it earlier, is that we include the intensity of services as part of that trend. So what we really want to do is separate provider cost

increases, provider payment increases, and do that very kind of discretely because our overarching assumption there is that increases will be the same as they were last year. So if we use that discrete assumption, we can kind of move unit cost off to the side and say okay it's a very precise development based on what we've seen. If we do expect any changes, we will modify that according to our expectation, but that's kind of its own development. So we put the other two pieces, both the number of services and whether those -- those services are more or less expensive, those both fall into utilization trend.

The other thing that's a little bit different is that we developed our utilization trend based on the continuing population. So it's not on our entire exchange block but just those who have been on our books for a number of years. We were able to track that population, and so it's a little bit different for that reason. For example, in our large group filing we filed a 0 percent utilization trend as well, but here we're looking at restricting our projection only to members who we kind of know a lot about and who are continuing to be with us rather than accounting for some of those ins and outs that

are more typical. So we did end up with a 2 percent utilization trend, which is a little bit higher than what we've seen in some other filings and so forth, but that mostly has to do with the definition of how we're coming up with that, and it really works in conjunction with what we've done with some of these other base period type assumptions. So we're able to lower the baseline and recognize a lower baseline, but a slightly higher trend with taking you out to 2016.

MS. HOLMES: So it might be slightly upwardly biased if you're looking at your continuing population and not accounting for the fact that your new influx is healthier and your outflow was more likely to be Medicaid higher --

MR. SCHULTZ: Right.

MS. HOLMES: But that's accounted for in the base is what you're telling us?

MR. SCHULTZ: Exactly, and then some of those other adjustments. So rather than kind of baking all of that into trend we have the explicit 2 percent trend adjustment, which if you look at it on its own might be a little upwardly biased, but then we add in that adjustment for new membership and we put in that adjustment for the membership that left,

and so in total we get to an answer that we think makes sense for 2016.

MS. HOLMES: It all washes out. Okay. And your intensity question utilization comment reminded me something about the membership expectations that you have. So at some point in the filing, early in the filing it said you expect membership to remain at current levels, and then later on, you know, in the June 30th response there's a discussion about the increase in membership which that translated into the lower, you know, administrative costs because of the increase in membership. So I would love a little bit more detail about, you know, where you're thinking the increased membership is coming. Maybe it's coming from these 51 to 100 to some degree, but maybe other places, and also to the extent we do know MVP is making a marketplace here and trying to gain market share, how does that factor into what you really do now think about, you know, projected enrollment and how do those membership numbers impact your assumptions about administrative costs and CTR needs basically? So that was a big question.

MR. SCHULTZ: That is a big question.

MS. HOLMES: You can break it apart.

MR. SCHULTZ: Right. Step by step here. In terms of the new membership there are two sources. One is the 51 to 100 that we expect to transfer into QHPs. Secondly, the 6500 members that we talked about that's increased membership we actually saw in 2015. So remember we're using 2014 base experience. Okay. So the new membership we've -- we know those people are there, and when we say we expect current membership to remain the same, by current we mean what we're seeing as of a certain date in 2015 that I think was sometime in April.

MS. HOLMES: Okay.

MR. SCHULTZ: We took a slap shot at membership and said okay here's the people who are here now. We don't expect that to change as we projected 2016. It's still more people than we had in 2014.

MS. HOLMES: Okay.

MR. SCHULTZ: As far as MVP goes I'll reiterate Ms. Greene's testimony that at the time of the filing we have no knowledge what MVP is going to do or not do or either whether they will file. So we're developing this based on our own block and our best understanding what we think is going to happen in terms of what we can affect and what we do know at

the time.

Now that we've seen what MVP has done it's kind of an interesting question. So it is certainly true their rate increase is a fraction of ours, but their rates are not necessarily lower than ours. They are still higher on some of the richer plans. They are lower on the bronze plans. So it will be interesting to see, as Ruth commented, with the Blue Brand and the national network that we have, the Blue Card and with the award winning customer service that we have, how that's going to play in keeping members or whether we'll see a lot of price shoppers.

Actuarially I will say I have some concern about the sort of the tilt we are seeing. We're seeing our more expensive plans at a lower rate than what MVP has and their less expensive plans are at a lower rate than ours. That's kind of interesting to me in terms of how that could have happened from an actuarial pricing perspective, and that could cause additional movement of some of the those lower risk members toward MVP. If anything, that could really exacerbate what we're seeing in terms of the risk adjustment, and inasmuch as that risk adjustment transfer in and out can be reflected

in rates I think that does level the playing field between us and MVP, but if that is one sided, then risk adjustment only does so much. It can't overcome all of the influence the better risks will have versus the poor risk just in terms of payment. It should flow into rates as well, which is why we decided to put it into our rates.

So it will be interesting to see kind of how it all plays out and it will factor into our rate development for next year for sure.

MS. HOLMES: Okay. One -- this is a small question, but one of the administrative costs I noticed that you had assigned the same administrative per member per month cost across all plans, and I'm just curious because I would imagine that a catastrophic plan would have lower administrative costs than a platinum plan where people are generating more transactions. So there's more bills and more all of that. So how does all that factor into the premiums at the end of the day?

MR. SCHULTZ: That has to do with the instructions that we're supposed to just use the same administrative cost, and we develop based on a PMPM. We don't develop as a percentage of premium. So we do assign that same PMPM across all plans.

Your point is an interesting one. Arguably, at least, some services are claims related. So it's something other carriers occasionally do. MVP actually switched from a percent of premium to a PMPM this past year. So there are different ways to go about it.

MS. HOLMES: I feel like I have another question, but I'm going to pass on and find it. Those are the three off the top of my head. Thank you.

MS. HENKIN: Let's go down to Con at the end.

MR. HOGAN: Just a general comment. I was interested, I may have it wrong, but I was interested that the recommendation by L&E does not include the standard of affordability; is that correct?

MR. SCHULTZ: I actually don't remember so I'm referring to that exhibit. Right. That's -- affordability is not part of their actual recommendation.

MR. HOGAN: So I probably should hold this question for the L&E actuary which I will. I'll wait for you. Okay.

MS. RAMBUR: Thank you very much. Just

a couple of questions. One, obviously the issue of contribution to reserves is a debate today and I just want to clarify for the record reserves can only be used for claims; is that correct? They cannot be used for administrative structure or anything else; is that correct?

MR. SCHULTZ: That's correct.

MS. RAMBUR: So they are reserved specifically for claims, and you testified that in the very long term contribution to reserves less than requested will create insolvency in the very long term. So could you just define the very long term a bit more?

MR. SCHULTZ: We don't know to be honest. I mean so these adverse events, there could be a flu pandemic around the corner next winter or we might not get one. We haven't had one for a number of years. We might not have one for another 20 years.

PCSK9 is a big scary thing actuarially thinking. That would have an enormous impact on our RBC well into -- well not well into, but in triple digits in terms of an impact if it comes in on the lower end of the utilization range we were given by our PBM. So that one maybe that will transpire next

year. Maybe it won't, and depending on what happens, because these are just big infrequent but really weighty events, you don't really know. If we knew it was going to happen next year for sure, we would rate for it. If we knew it was likely to happen next year, we would rate for it, but we don't know what will happen with PCSK9. So we took our best guess at what we know will happen and the rest will kind of play out in the clinical trials and the prescribing patterns of cardiologists.

There might be another wonder drug around the corner that -- a cure for cancer that might cost a whole bunch of money, but man if we can cure cancer, certainly we're going to end up paying for it, but since we can't reflect that sort of thing in rates unless we know about it in advance, that could also create a huge sort of shock. So the answer is I don't know.

MS. RAMBUR: Somewhere between 1 and 50.

MR. SCHULTZ: Somewhere between 1 and 50.

MS. RAMBUR: So a piece that just seems a bit of a discrepancy to me, and perhaps I didn't fully follow it, there is a fairly substantial risk adjusted transfer coming from another carrier.

MR. SCHULTZ: Yes.

MS. RAMBUR: And you are presuming, if I heard correctly, presuming similar transfer in the future.

MR. SCHULTZ: Yes.

MS. RAMBUR: But you also testified that you're expecting your population to be younger and therefore healthier. So that seemed a little inconsistent to me.

MR. SCHULTZ: Yeah. We -- that's a very good point. What we don't know is how MVP's population might change over time. We have absolutely no insight into that. So we can only assume that as members who are leaving our rolls and going to Medicaid we can -- we assume they are going to Medicaid. We don't actually know why they have left our plans, but that's our best guess. We can only assume that same sort of thing is happening to MVP. We can -- but of course we don't know. It's their book.

Same thing with the new membership. We saw some new membership. I would expect that MVP saw some new membership as well in 2015, and we don't have any insight into what their new membership would look like, but I would guess again that it's

similarly healthy compared to the rest of their population just as our new membership is.

So yes we think our membership will be a little bit healthier, but there are factors that without any other knowledge of MVP's book we would expect those same factors to apply to them in a proportional sort of way. So that's why we assume that the adjustment would remain proportional to premium moving forward.

MS. RAMBUR: And I have one more question if you can bear this. This is a three on-ramp question so it's not a complicated question. This is more so I understand this fully.

So you've testified that you expect a population to be younger and therefore healthier which is logical, and we heard yesterday about two different approaches to looking at the demographic profile and both make sense. One is over 12 months and one is a snapshot, and in the snapshot it was an older population that's only 2 years older, and so the conclusion was that that's not substantive which also makes sense to me.

So my question is, just so I understand, how much age delta does it take for it to make a difference? When you say your population is younger,

I'm trying to understand that assumption in terms of how much -- how much change in a profile does it take to really impact rate either up or down?

MR. SCHULTZ: Gosh, I wasn't here yesterday so I didn't get to hear all the questions.

MS. RAMBUR: It has nothing to do with that. It's so I understand. You know, for example, if you're looking at the age of the work force, if it's 42 versus 44, it's not a difference. If it's 32 versus 42, it's a difference. I'm just curious how large a magnitude in general it takes to make a difference.

MR. SCHULTZ: I would say if my population went from an average age of 42 to an average age of 44, I would want to rate for that. I think it's enough to make a difference. Is that a 10 percent difference? No. But it might be worth a percent or something a little bit more or less than that. Yeah absolutely.

MS. RAMBUR: I guess I'm looking more at your assumption that yours is going to be younger. So you're confident enough they are younger enough to make a difference.

MR. SCHULTZ: Yeah, and that particular assumption, again, that's not a 5 or 10 percent

adjustment to the rates. It's a relatively smallish number of people compared to the block that we have, and they are a little bit younger, and so it's less than a percent this downward adjustment for the new people, but I would want to adjust for all those things. I kind of want to come up with, as Ruth put it, the best answer possible, and so I want to look at every piece of data that I can look at, and if I have an average age that's changing over time or if I have new members who are coming in who are younger than my existing block, I want to make sure I capture all of those things.

MS. RAMBUR: Thank you. I was just wanting to understand the demographic issues. So thank you.

MS. HENKIN: Dr. Ramsay.

DR. RAMSAY: Thank you, Mr. Schultz, for your presentation. I want to go back to this unit cost increase which is really the biggest factor in the medical trend, and you described this as primarily being an increase in what you paid to providers.

MR. SCHULTZ: Yes.

DR. RAMSAY: 4.4 percent. Is that an average based on your contracting or based on -- I

mean I can't go out to an independent practice in Richmond and have this on the record as saying well guys good news you're going to get a 4 and a half percent increase in your payments this year.

MR. SCHULTZ: Right. So that's correct. That's an average across all different services. The hospitals, professional services, and pharmacy is in there as well. We know the pharmacy trends are particularly rampant these days.

DR. RAMSAY: Where -- and what else is in that unit cost increase? Is it inflation? Is there inflation? Is there operating expense? What else is in that?

MR. SCHULTZ: Part of it is a rebasing from what we expected to happen from 2014 to 2015 to what we're seeing actually emerge in 2015. So of the 7.5 about 1.1 is due to the rebasing and about 6.4 percent is a unit cost trend moving forward.

Now Mr. Gobeille mentioned earlier that hospital budgets are coming in, and it looks like the commercial ask may be lower than last year and that's great news, and that would have been great to know at the time that we prepared the filing, but in the absence of that information we assumed that it would be the same. So with the cost shift that number

becomes quite a high number in terms of commercial increases.

DR. RAMSAY: In terms of the cost shift, again this is a timing issue, but you know the Legislature did have us -- did allocate a small -- a Medicaid bump this year which should have an effect, I'm assuming, on next year's rates.

MR. SCHULTZ: Yes.

DR. RAMSAY: We will see that.

MR. SCHULTZ: Yes.

DR. RAMSAY: And that is directly in line with reducing this cost shift of what you attribute about a 1.7 percent of the premium to the cost shift, correct?

MR. SCHULTZ: That number strikes me as about correct.

DR. RAMSAY: Okay.

MR. SCHULTZ: I don't have it in front of me.

DR. RAMSAY: Don't worry. It's in here. So I've been practicing in Vermont for over 30 -- well 34, 35 years and I'm constantly intrigued. First I'm troubled by this solvency thing being constantly held over our head like a big hammer. Oh my God, you know, and I agree there's nothing more

important than having commercial insurers who my patients depend on to pay their claims being solvent. I agree.

I have lived, again practicing 34 years, I have not yet seen the kind of flu epidemic and in that 34 years the CDC has certainly got a lot better about prediction, okay. They didn't do well last year, but on balance that technology has improved for preventing that kind of task.

Around the PCSK9 inhibitors I think it's laudable that your pharmacy director, and Brian and I spoke many times about this, reached out to the cardiologists, but more so in that population of Vermonters who have the highest utilization of health care services, Medicare over 65, we have the lowest based PMPM rate, one of the lowest in the country. So our doctors and our patients do not engage quickly in new technologies. I mean that's why we can do so much in this state because of the providers they don't buy into direct consumer advertising like they do in many other states.

So that's -- I'm just trying to counter some of the -- you talk about membership growth as being a risk, but everything we see nationally is the Affordable Care Act has been a boon to commercial

insurers. I mean you've got new members. You've got 46 percent of your new members in silver plans which are potentially subsidized by federal and state. I mean this is a market boon from what I see.

You talk about new technology. I read the journals. I'm not seeing anything about major new technologies. I'm seeing a lot of movement in terms of biologics and I know you should worry about that, but we're not going to cure cancer next year. I mean it would be great. You talk about regulatory action as a threat. I mean I'm a regulator. Okay. How -- do you think I am going -- you know how I've already stated I feel about the solvency of our commercial insurers, but we're going to allow a regulatory action to really threaten your solvency? I mean those things I just have to try to make sense out of those arguments.

Lastly, aside from maybe one or two long term care insurance products, I cannot remember a health insurance product becoming insolvent in this state in the years that I practiced here. Do you know of any?

MR. SCHULTZ: No. We would like to keep it that way.

DR. RAMSAY: Yeah I know. Trust me, we

want to keep it that way, but I'm just pointing out the historical perspective here; and then lastly around -- we heard testimony around the range of risk based capital, and we heard about how quickly rates would -- how it would take two years for rates to respond to a major event that threatened your reserves.

Let's take the other tack here. Your risk based capital goes to 750 to 800 to 850. How quickly does that translate back into what Vermonters really want to see which is a moderation in their growth of their premiums? Give me your ideas about that.

MR. SCHULTZ: Without addressing any numbers specifically.

DR. RAMSAY: Right.

MR. SCHULTZ: If we found that our risk based capital were running above our range, then we would absolutely take that into account in the contribution to reserve that we are requesting.

DR. RAMSAY: Within the next year?

MR. SCHULTZ: Yeah, the next filing that was available. Yes. Absolutely.

DR. RAMSAY: That's all I have.

CHAIRMAN GOBEILLE: I'm all set.

MS. HENKIN: Anything else from the Board? Anything else?

MS. HUGHES: I do have one follow-up question.

MS. HENKIN: Please speak up and into the mike.

REDIRECT EXAMINATION

BY MS. HUGHES:

Q. Did I understand your testimony earlier to be that reserves, which are sometimes called free surplus for traditional domestic companies, can never be used for administrative costs?

A. As far as I'm aware they can be used directly.

MS. HUGHES: Okay. Thanks.

MS. HENKIN: Anything else?

MS. RICHARDSON: I just had a question. You said directly. Can you just embellish that a little bit?

MR. SCHULTZ: I don't think we can say oh we're running over our budget for this year we'll just take that out of reserves. It all -- it's a bit of a difficult question to answer because it all kind of comes from the same bucket eventually, right. We have a rate, we have costs, we have claims, and we're either running above or below that.

CHAIRMAN GOBEILLE: So not to talk to you about this but to talk to the public that's here because you can't really talk about this, I think what's important to remember is that there has been state action involving an insurance company in our state, and that the way that it works we don't wait until there's no surplus and no employees and no filing cabinets left to go in and rescue an insurance company. It's a systemic approach by state government where the state actually takes over the company and runs it for a period of time using surplus at that point for whatever is deemed necessary to take care of the member benefits, and so the company wouldn't have any say at that point because probably the Board of Directors and the CEO would have been sent packing and probably this happened last maybe when you were around.

So it's a complicated regulatory enforcement mechanism that happens when something like that happens, and it wouldn't be up to the current actuary as to where the money went. So I don't want to leave the public thinking that that's the way it would work, and we can talk about it. They just can't. So you were totally on solid ground.

MS. HENKIN: Anything else? Anything else from the HCA?

MS. RICHARDSON: No.

MR. HOGAN: Just a quick comment. Your testimony was very clear and very helpful.

MS. RICHARDSON: Yes. Thank you.

MS. HENKIN: Thank you, Paul. Next we'll hear from the Department of Financial Regulation about the solvency.

CHAIRMAN GOBEILLE: Or we won't hear.

(Mr. Chieffo was duly sworn.)

MR. CHIEFFO: Good afternoon everyone. Again good late morning. My name is Ryan Chieffo C-H-I-E-F-F-O. I am an Assistant General Counsel for the Department of Financial Regulation. I'm Commissioner Donegan's designee here today for the hearing.

The Department's role here for these rate review -- for this process is to provide the Board with our analysis and opinion on whether Blue Cross's rate as filed how that may affect their solvency. This role is defined in statute, along with your role as well, as part and parcel of the whole review process. It is also consistent with a larger solvency and regulatory role that the

Department has for all insurers that operate in Vermont, and that is to ensure the solvency of the insurers, the stability of the insurers, and the stability of the insurance market, and that the Department views and I think can be viewed objectively as a vital consumer protection function.

As has been pointed out there is -- it's exceedingly rare to see a Vermont insurer to become insolvent, and the Department in its role, which it's had for many years, along with a comprehensive effort of state government, as Mr. Gobeille pointed out, I think takes a lot of pride in that, and it's important that it stay that way.

Blue Cross for its part is one of our Vermont domestic insurers. It also insures the lion's share of Vermonters in the commercial major medical market, and so I think that really points to why our solvency analysis is quite rigorous.

Solvency is a complicated dynamic and prospective analysis. The prospective idea is very important and I think it speaks to the value that the Department provides in that arena -- in the solvency arena. I think it does a disservice to Vermonters to view solvency from purely historical terms even if that is, you know, a publicly available annual

statement only six months old. You're still looking at information that's purely past, and things are, as we've talked about, quite dynamic.

I think the value that the Department provides is that we have access to the company, to the books and records of the company, to the executives of the company, to management, to the actual physical space in the company through our examinations and on-site examinations. Additional reporting, reporting on demand, you know, governance, material transactions, just a whole host of tools and information at our disposal that goes beyond financial reporting that allows the Department to understand and monitor solvency on a going forward basis, and how that solvency might move in the future; and as we have heard a lot about it's very difficult to pin that down. It's almost impossible to pin down an exact correct rate for any given 12 month period, and then add on to that unpredictability. You know all of these potential unforeseen events ranging from utilization, you know, the mysterious flu pandemic or any other unexpected event along those lines, membership, you know, those all factor into why it's difficult to pin down solvency, but at the end of the day, you know,

insurance is a risk business; and, you know, as Dr. Ramsay pointed out, we don't -- and Dr. Gobeille -- Mr. Gobeille in Vermont --

CHAIRMAN GOBEILLE: I love DFR, man.

MR. CHIEFFO: Maybe that wasn't subtle enough. But we don't wait until it's too late. We don't wait until, you know, Vermonters who rely on strong stable insurance companies to pay their claims are in real financial trouble.

So I think that was recognized by the Legislature when they came up with the current framework for rate filings and rate reviews. You know everyone here plays a very important role, and I think the Legislature recognized that if a solvency analysis of these companies were as straightforward as taking a previous financial statement, annual statement, isolating a risk based capital ratio and then just pointing to that as solvency or as a proxy for solvency, you know I don't think the Department would be needed. We know that everyone can attain that information.

We've talked about whether it can be spoken about here. I think the value that the Department adds is in the additional rigor and analysis and access and information that we have to

color our understanding of solvency. That being said, you know with respect to today's matter the Department submitted our solvency opinion for the rate, the initial rate as filed, and the conclusion to that opinion was that the rate would likely have the effect of maintaining the current level of Blue Cross's solvency, which the Department finds to be both adequate and necessary.

Subsequently, as has been spoken about, the actuaries agreed to a number of things that lowered that rate to I believe it's 7.2 percent average increase, and that does not change the Department's conclusion. A 7.2 percent average increase will likely operate and maintain Blue Cross's current level of solvency, again which the Department has a range within that risk based capital solvency band which we find to be appropriate and necessary, and I'm happy to take any questions about our solvency opinion.

MS. HENKIN: Let's go to the Board here. Con, I see your hand up first.

MR. HOGAN: If the Board were to reduce the 7.2 percent further, what is the process for DFR weighing in?

MR. CHIEFFO: I don't think there is a

specific process laid out in statute. We have not been asked at any point since the current framework has been in place to opine on a final rate after it has been changed by the Board. I think the DFR would absolutely be willing to accommodate any requests for more information or an additional opinion. We're always happy to weigh in, do our part.

MR. HOGAN: Thank you.

MS. RAMBUR: So as you probably heard me say yesterday I think of these domains and responsibility that we have so DFR has a responsibility for solvency, and we as the Board have the responsibility for solvency and affordability, and we look at rate increases. So that rate increase, whatever it is, ends up being the floor for the next year.

So in thinking about this it's two wings, right. So if we look at contribution to reserve going from 2 to 1, that makes it potentially more affordable. Are you prepared at this point to talk about your advice on solvency with that or would that take additional analysis? I think similar to your question because your responsibility is solvency, and if I were in your shoes, I would say the more the better because the more there is

reserves the greater the cushion for solvency, but we have this teeter totter that we're on.

MR. CHIEFFO: If I can hope to better understand your question --

MS. RAMBUR: My question is could you comment now, would you find one percent to be a threat to solvency?

MR. CHIEFFO: I don't think I can comment on that specifically. There is a lot of analysis that goes into it. You know what I would point out is that I suppose in a vacuum, you know, having our role narrowed to solvency and providing an opinion for your benefit of solvency could I suppose in a vacuum indicate the more the better.

What the Department won't do is advocate for an increasing rate to promote solvency. You know, with what you're saying I suppose taken to an extreme it should be a thousand percent every year without fail. You know that would certainly, you know, help solvency. The Department for many, many years before the current framework was in place was in your shoes to a large extent with affordability and making sure rates were not excessive, were not inadequate, were not unfairly discriminatory, et cetera, and further there is -- there is a role for

the Department as regulators with respect to insurance that goes beyond this particular rate review process, and that does speak to aligned incentives for the Department along with the Board. You know we don't want to see rates be too high. We don't want an unstable market. We do want Vermonters to have access to good and affordable insurance.

You know it is for you to decide here today and with all the information before you how to balance some competing interests. Our role for your benefit is to speak about the solvency, but I don't think that the Department is on an ever upward trend.

MS. RAMBUR: Thank you.

DR. RAMSAY: Well you answered my question. I was just going to ask is there a ceiling and you said there is a ceiling for DFR that -- to risk based capital or to your understanding of the concept of solvency. So I'm reassured.

MR. CHIEFFO: Maybe if I could even, you know, add to that. You spoke before to Mr. Schultz about that, and I think in addition to Blue Cross opining that they would seek, if their risk based capital level and their overall solvency, you know, were increasing beyond the range that the Department has agreed to for Blue Cross and has monitored very

closely for many years, the Department would demand, you know, that something be done. We would ask them and we would have them sit down with us and understand how they do plan to get into the range. You know I think that's fair to ask, and I think that as much as, you know, we're happy to sound the alarm when things get to the low end of the range and certainly beneath the range, it is our responsibility as well to stay within the range we've set for good reason. It's appropriate and it's necessary, but we don't want to be on an ever upward trend.

DR. RAMSAY: Thank you.

CHAIRMAN GOBEILLE: You basically just answered my question which was for the people here, you know, sort of in your own words your role is not just simply to send me a letter every year on Blue Cross's rates in this case. It's to monitor this at all times, and if there's ever an issue, you're the fire department as I see it. We are not, and so I think it's important that the public understand that, that if it was ever to drop below a level that you thought it should not go below, that you do take action and you have a role in this that is almost managerial at some point if that was to happen to an insurer. Not to say that is the case with Blue Cross

at this point at all, but just so that people understand your role is not just simply to drop in once a year and say don't cut their rate.

MR. CHIEFFO: And that's correct and I appreciate that clarification, and I would add that what you're describing is defined statutorily. We do have that role when things get bad. I would say that we also have the ability and the authority to help mitigate any circumstance that might cause it to get bad. So, you know, more informally before we get to the point where there is official supervision or actual rehabilitation of a company where the Department is coming in potentially axing management and taking over, there is a lot of access and ways the Department has to influence, you know, a company that will help it avoid that scenario.

CHAIRMAN GOBEILLE: Thank you.

MS. HENKIN: Dr. Holmes.

MS. HOLMES: I'm set. Thank you.

MS. HENKIN: Okay. I'll allow -- I'm sorry. We went to the Board first on this, but if you have questions.

CROSS EXAMINATION

BY MS. HUGHES:

Q. So you heard the testimony earlier about the

four agreed modifications to the rate bringing it to 7.2 percent?

A. Yes.

Q. And does it continue to be the Department's opinion that the requested rate component should not be further reduced unless L&E, the Board's actuary, makes a finding that that would lead to excessive rates?

A. Yes. Everything about our opinion maintains -- remains the same. So yes.

Q. And were you provided a copy with the NovaRest report?

A. I have seen -- I think there was an updated report as of a few days ago and yes I have seen that.

Q. And does the Department agree with Ms. Novak's assessment of Blue Cross's CTR request in this filing?

A. No. We do not for two reasons. Specifically, you know, that there is sort of an open ended, you know, recommendation that the CTR might be lowered. We just generally disagree. As has been discussed up to this point, you know, there's been an aggregate I guess over the past four or so years of actual unexpected CTR, and you know overall level of income to what's been spent out that has been a net negative, and what we need to see, what the Department wants to see in this case is aligned with Blue Cross which is a slight positive.

Speaking about, you know, what is the very long term and how that might impact solvency, you know, if nothing else were to adversely shock the system to say, you know, it may be a number of years that these slight decreases on that may do anything to solvency, but those slight decreases coupled with an unpredictable event of any sort, you know, exacerbates that possibility. You know there's always risk. Even a very, very healthy, even a very net positive over many years there is still risk of some major event. So we would generally like to see that be positive, and the 2.0 percent, which I think was stated to be something around 1 percent of the actual rate increase, you know, should not be changed.

More fundamentally, though, you know to the extent that the contribution to surplus is influenced by the actuarially defined derived portions of the rate we certainly welcome the actuaries to weigh in on that. The Department does not use actuaries in its solvency analysis, and so to the extent that contributions to surplus is influenced by those portions that actuaries can speak to we are happy with that and we welcome that. However, to come at a contribution to surplus recommendation from solvency and have an assertion that solvency is strong, certainly solvency is strong based on a risk based capital ratio, we take issue with that. You

know as I've described, you know, maybe until everybody's ears hurt, the Department has access to a tremendous amount of confidential information, and we zealously guard that information as confidential because of its risks to the market should it become public. That information allows us to do our job and understand and monitor solvency, and to have the actuary without access to that information also opine on solvency I think is inappropriate, and I think presents an inadequate picture for the Board.

So in that sense certainly I think that we disagree with the NovaRest actuary's opinion on the contribution to reserve from that perspective.

MS. HUGHES: Thank you.

MS. HENKIN: Lila, do you have any questions?

CROSS EXAMINATION

BY MS. RICHARDSON:

Q. I had one question based on your testimony about the range again. I'm not speaking about any particular RBC values. Did I understand you to say that DFR has agreed with Blue Cross Blue Shield that this is an appropriate range for them, the range that was testified to by their witnesses?

A. Yes. That's correct.

MS. RICHARDSON: Thank you.

MS. HENKIN: Thank you very much.

MR. CHIEFFO: Thank you all very much.

MS. HENKIN: At this time we are going to continue, although it's getting close to noon. The next witness is going to be Jackie Lee from L&E, and, Michael, I'll turn that over to you.

MR. DONOFRIO: For the record I'm Mike Donofrio, the Board's General Counsel. I will briefly examine Jackie Lee who is the Board's contract actuary just to establish sort of who she is and the work that L&E has done for the Board in this case, and then Ms. Lee will be available for questions from both sides and from the Board Members.

MS. HUGHES: May I make a suggestion? We are willing to take administrative notice or have you take administrative notice of Ms. Lee's testimony yesterday about her background and qualifications if the Health Care Advocate is of similar mind.

MS. RICHARDSON: I don't believe her qualifications and experience have changed significantly since yesterday, so I agree that would be -- except for testifying at one more hearing. So I would agree that would be an efficient way for the Board to proceed and we are in agreement with it.

MS. HENKIN: That's great. Thank you.

JACKIE LEE,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DONOFRIO:

Q. Could you just state your name and occupation for the record please?

A. Jackie Lee and I work for Lewis & Ellis as a vice president and consulting actuary.

Q. How long has Lewis & Ellis been engaged by the Green Mountain Care Board to assist the Board in its rate review function?

A. Since January 1, 2014.

Q. And over that time about how many filings have you reviewed?

A. In 2014 we performed 25 rate reviews. In 2015 we have completed 6 and we have 3 ongoing including this one.

Q. Great. Could you explain how Lewis & Ellis staffed the review of the rate filing before the Board today?

A. Sure. To staff this review we have several levels of reviewers. The first, who we call our primary reviewer for this filing, was Josh Hammerquist. He is an

Associate in the Society of Actuaries. He has worked on all Blue Cross Blue Shield rate filings since January 2014. We have established this standard so that we can gain efficiencies on the filings and also develop a good working relationship with the actuaries at Blue Cross Blue Shield of Vermont.

During that time he is generally the primary correspondent with the actuaries at Blue Cross Blue Shield of Vermont, and he reviews their -- he writes their letter -- the letters to the company asking questions about the initial filing and any other correspondence that we had with them in writing, and reviews their responses.

We will pick up the phone and talk to them about their responses and have verbal communication with them on a fairly often basis throughout this time frame. Most of that correspondence is clarification, and if there is anything that arises during those conversations that we feel need to be clarified further in writing for our use, the Board's use, or anyone in the public or Health Care Advocate, we then will submit another inquiry letter with those questions so that they can be documented. That explains why we have so many letters back and forth for clarification on certain topics.

Next level of review is myself. I review both Blue Cross's filings and MVP filings and have done so for

every filing since 2014, and my role is to get down into the issues with Josh in this instance for this filing, make sure that we both agree on any potential recommendations or issues with the filing, and provide a first level of overall consistency between the two carriers, or where we have CIGNA outside of the Affordable Care Act filings make sure there's consistency throughout the State of Vermont and their filings.

The final level of review is David Dillon. He makes sure that we agree with all of our recommendations. We work with several states, as discussed yesterday, that he helps identify that are federal interpretations of the law, and other generally accepted actuarial practices are consistent throughout all the states that we work with, and make sure that our recommendations are in line with what we would do in other states, but also being very specific to what the issues are directly in Vermont.

When we do a review of our filing we review all assumptions. There are a lot of them and there's a lot of data in their filings. We review everything that we can to understand it individually, make sure that we agreed with each assumption individually, but we also take a step back and look at everything in the aggregate to ensure that the final rates and the final overall decision and rate increase or decrease of the filing is appropriate

and reasonable.

Q. Thank you. Are you familiar with the documents in the binder in front of you?

A. Yes, I am.

Q. And do you remember earlier exhibits 1 through 17 were admitted into evidence?

A. Yes, I do.

Q. Have you had -- in the course of your work on this case have you reviewed all of those documents?

A. Yes, I have.

Q. Including the analysis from Miss Novak on behalf of the HCA?

A. Yes, I have read that too.

Q. Okay. Can I point you to exhibit 14 please which is the Lewis & Ellis analysis?

A. Yes.

Q. And I assume you are very familiar with that document?

A. Yes, I am.

Q. Could you turn to page 2?

A. Okay. I am on page 2.

Q. Okay, and you see under the table there's the standard of review section there?

A. Yes, I do.

Q. And I apologize to everyone because I'm going

to repeat myself verbatim from yesterday, and I'm sort of picking up on Mr. Hogan's earlier question about affordability. In performing the analysis you've described for the Board would you agree that L&E's role is to assist the Board in determining whether a number of statutory elements have been met?

A. Yes, it is.

Q. And now I'm going to read you that list of statutory elements just to confirm that in performing this work Lewis & Ellis is assisting the Board in making sure each of these items is met in the filing. So it's determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory?

A. I agree.

Q. So the opinion provided by Lewis & Ellis in this document encompasses those statutory elements. Is that fair?

A. It is fair.

Q. Okay. Thank you. Let's move to page 10 of the document please. The pages that we've skipped over lay out your kind of step-by-step analysis of the filing, correct?

A. That's correct.

Q. And on page 10 you've provided a series of recommendations, right?

A. That is correct.

Q. Just to kind of move more quickly would you just read what the four recommendations Lewis & Ellis provided were?

A. Sure. We recommend reducing the total allowed trend to 7.2, reduce the administrative cost to $28.43, to use an alternative method to calculate the insurer fee which reduces the percentage to 2.6, and increase the premiums for -- to account for the risk transfer payment which is an overall decrease to the rates of .8 percent.

Q. Okay. And are those the same recommendations that we've already heard testimony about from Blue Cross's witnesses?

A. That's correct.

Q. And as we've heard, and I just want to confirm from the source, Blue Cross Blue Shield, as well as the HCA, agrees these recommendations should be made to the rate, right?

A. Yes. As far as I'm concerned both parties agreed to all four of these.

Q. Okay. And I believe Mr. Schultz testified that the -- let me back up. The report states that after

the modifications the anticipated overall rate increase will reduce from 8.6 to 7.3 percent, right?

A. That's what the report says. Yes.

Q. And I think Mr. Schultz testified that when they ran the numbers the result was 7.2 percent. Do you remember that?

A. Yes.

Q. Does that -- was his testimony -- was anything about his testimony inconsistent with the analysis you've performed?

A. No. They have a much more sophisticated way of calculating their rate increase than we do. We make estimations based on what we're hearing in the filing and then generally rely on the actuaries at Blue Cross to put a fine tooth comb through it and make sure it's completely accurate. So it is not uncommon for our estimate to be slightly different than their's.

Q. So does the 7.2 increase that resulted from Blue Cross Blue Shield implementing these recommendations in your opinion satisfy the statutory standard that I read with all those words in it?

A. Yes, it does.

Q. Thank you. And you had an opportunity to review the DFR solvency opinion that we've just heard some testimony about, right?

A. Yes.

Q. And does anything about that change or alter L&E's opinion?

A. No, it doesn't.

Q. And you've also had an opportunity to review the HCA's report, right?

A. Yes.

Q. And same question there. Does that in any way alter L&E's opinion?

A. No, it does not.

MR. DONOFRIO: I have no further questions. Thank you, Ms. Lee.

MS. LEE: Thank you.

MS. HENKIN: Ms. Hughes.

MS. HUGHES: I will be very brief. Thank you very much. That's it.

MS. LEE: Thank you, Ms. Hughes.

CROSS EXAMINATION

BY MS. RICHARDSON:

Q. I have one quick clarifying question about the difference that seems to occur with some of the mathematical calculations that you're doing __

A. Yes.

Q. __ in the final rate adjustment. Can I refer you to page 4 of the report which is 233 in the binder?

A. Yes.

Q. And the section total allowed medical trend at the bottom?

A. Yes.

Q. Okay. That indicates that the original trend was 7.4 percent and your recommendation is a change to 7.2 percent?

A. That's correct.

Q. And then turning to page 239 in the binder you talk about the net effect of reducing to 7.2 percent as a negative .3 percent.

A. Yes.

Q. Is that part of the same --

A. Yes.

Q. -- phenomenon you were describing before?

A. Yes. I don't have a calculator with me, but how that, I would imagine, that .3 percent was calculated was taking 1.074 -- or pardon me. 1.072 divided by 1.074 minus 1, and unfortunately it does not add and subtract in the same fashion that one is multiplied. That's math unfortunately.

Q. The ultimate --

A. Yes. Same issue.

Q. -- recommendation is that the changes that you have indicated should be made that would result in a 7.2

percent rate at the end rather than --

A. Our calculation shows 7.3, but that's, once again, because we took 1 plus all of the changes, multiplied them out, subtracted 1, whereas Paul Schultz's or Martine's process was they went back to their exhibits, actually made the changes in the appropriate places, and then their final exhibit that they -- exhibit 22 was an actual calculation. So that is the difference. Their's is much more precise than ours.

Q. And the 7.2 percent final rate is more accurate?

A. That is the more accurate based on their calculation.

MS. RICHARDSON: Thank you. No further questions.

MS. HENKIN: I'll go to the Board. I'll start now with Alan.

DR. RAMSAY: No questions. Thank you, Jackie.

MS. HENKIN: Betty.

MS. RAMBUR: No further questions. Thank you.

MS. HENKIN: Con.

MR. HOGAN: Mike Donofrio answered my question through Jackie so I'm satisfied.

MS. HENKIN: Thank you.

CHAIRMAN GOBEILLE: All set. Thank you. Great work.

MS. HOLMES: Thank you.

MS. HENKIN: Thank you very much, and we're going to still continue and power through so I hope everybody is ready for that. We only have one more witness for the day.

MS. RICHARDSON: So the HCA would call Donna Novak.

MS. HENKIN: And I'll just start with I would like to assume, because we do have a CV in the packet, a resume for Ms. Novak, we can probably also streamline here the qualifications of this witness and that's what I would like to do here also. I hope I don't hear any objections to that.

MS. RICHARDSON: That was our intention. We had discussed it earlier.

MS. HENKIN: Thank you.

MS. RICHARDSON: The only thing that I would note is that it's the same CV that was presented yesterday in connection with the MVP hearing and it's exhibit 16 of this filing.

MS. HENKIN: She's testified once more since then.

MS. RICHARDSON: Right, but other than that there are no changes.

MS. HENKIN: Thank you.

DONNA NOVAK,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. RICHARDSON:

Q. Just to get us oriented could you not go through your entire CV but state your name and address?

A. Donna Novak, 156 West Kalle Guija, Sahuarita, California.

Q. And where are you employed?

A. At NovaRest Consulting. NovaRest, Inc.

Q. And did you perform review of the filing in this matter?

A. Yes, I did.

Q. Could you describe the procedures you followed in performing your actuarial review and analysis of the filing?

MS. HENKIN: And also speak into the mike please.

A. First I reviewed the original filing. I received that along with the exhibits associated with it. I reviewed it making note of anything that I thought might

be an issue where I needed further explanation about. Then I reviewed the Lewis & Ellis objections as they came in and the responses as they came in noting if any of the answers either answered my original issues or resulted in a rate change, there were a number of those, and then some of my issues still were not answered so I submitted questions that were then forwarded on to Blue Cross Blue Shield.

I believe I only had one set of questions. I might have had two. I don't actually remember right now. I think I only had one set that I received answers from and then I prepared my report of my findings.

Q. And can I refer you to exhibit 16 in the binder?

A. Yes.

Q. And is that the report that you prepared that you just referred to?

A. Yes, it is.

Q. I think your first answer went through some of this material, but could you summarize the sources of data and information that you used in preparing your report and doing your analysis?

A. The original filing, the objections, the answers to the objections, the Department of Financial Regulation solvency report, the annual statement, the 2014

annual statement of Blue Cross Blue Shield of Vermont and their supplemental health care exhibit.

Q. And did you also review the actuarial opinion from Lewis & Ellis?

A. Yes.

Q. So just referring to the exhibit list at the front of the binder, exhibits 1 to 17, are you familiar with those?

A. Yes, I am.

Q. Do you have any process of peer review as part of your analysis of the filing?

A. Yes, I do. Another senior actuary with my firm, Rick Diamond from Maine, did a peer review of this filing and he reviewed all of the objections as well as my report.

Q. Okay. And are the data and the information that you relied on in preparing your testimony the type that is reasonably relied on by actuaries in reviewing health insurance rate filings?

A. Yes.

Q. My binder is kind of falling apart here so if I can just take a minute so that I don't -- you've identified exhibit 16 as your report. Did you come to any conclusions after reviewing Blue Cross Blue Shield of Vermont's filing?

A. Yes. There were three identified and agreed upon adjustments in the objections that I concluded were appropriate. There was an additional adjustment in the Lewis & Ellis report that was reasonable in my estimation, and then I had one additional concern that I opine on in my report and that was -- dealt with the impact of the previously large, now considered small, group range of 51 to 100.

Q. Okay. Did you also come to any conclusions about Blue Cross Blue Shield's solvency as part of your analysis?

A. Yes. I did a very basic estimate of impact of lowering the contribution to reserve on their solvency and felt that it could be lowered.

Q. Okay. We'll go into those specific findings in more detail. I just wanted to review the Lewis & Ellis opinion exhibit 14 page 239 of your binder. Just to clarify that we're all talking about the same thing there's a section that is labeled recommendation?

A. Yes.

Q. And you indicated that you had reviewed and agreed with Lewis & Ellis recommendations?

A. Yes.

Q. Are the ones listed in that paragraph the ones that you're referring to?

A. That's correct.

Q. So you agree with the recommendations and the associated rate reduction --

A. Yes, I do.

Q. -- that is involved with them? Okay. I would now skip a few pages since that's not -- you have agreed to all the Lewis & Ellis recommendations, and turn to again exhibit 16 your actuarial report, and I'm going to direct you to pages -- bottom of page 251 to page 252 in the binder, which are pages 6 and 7 of your report. Are you there?

A. Yes.

Q. Okay. Is this part of the report the section where you discuss the issue of Blue Cross Blue Shield's assumptions about what will happen with the new part of the small group market?

A. Yes.

Q. Try to move through this quickly. Could you read the first paragraph on page 252, the top?

A. Okay. That was from the actuarial memorandum Blue Cross Blue Shield. Says in 2016 the definition of small group will change to include groups with 51 to 100 employees. These groups will either have to offer QHPs or move to a self-funded alternative. We assume that only groups that would realize lower premiums by choosing QHPs

would join the risk pool.

Q. And just to repeat you prefaced it by saying this is a quote from the actuarial memorandum from Blue Cross Blue Shield about the assumptions that they made in the filing?

A. Yes. It is from page 9.

Q. Okay. Then I would ask you to read the next paragraph of the report beginning with although groups.

A. Although groups of 50 to 100 employees may ask for a quote on self-funded product, many of the groups will be risk adverse enough to stay with the insured product. Also many small groups will not have the staff or knowledge to take on the issues that accompany being self funded, although many actuaries speculate that eventually many healthy groups will opt for self funded and then when someone becomes sick the group will purchase in the guaranteed issue coverage market on the exchange. They also believe that the migration to the self funded will be gradual and not complete.

Q. Does that paragraph summarize the issues that you have or the concerns you have about the assumption Blue Cross Blue Shield made in its filing?

A. Yes.

Q. Okay. And are you recommending any adjustment to the rate as filed as a result of the analysis that

you're making about this assumption?

A. Yes. I'm recommending a .25 percent decrease.

MR. HOGAN: Would you repeat that?

A. I am recommending a .25 percent decrease.

Q. And could you explain how you developed that .25 percent reduction recommendation?

A. Well I didn't divide .5 which had been the estimate provided by Blue Cross Blue Shield of what the impact would be if the whole healthier population entered the QHP. What I thought about was what percentage of the small groups would actually choose to go self funded versus remain with an insured population.

In other states, especially in other years, couple years ago, I would have expected a very, very small percentage to go self funded. I worked at Trustmark Insurance Company and we had designed a partially self-funded product just for this purpose and it didn't sell like hotcakes, but I realize that there are a lot of creative self-funded products out there now, and in answer to my question to Blue Cross Blue Shield I believe Mr. Schultz answered many of the same arguments he testified to that Vermont's different and so I accepted that. That Vermont has maybe a more active broker community that is presenting these products and has some products in the marketplace.

So then I thought well does that mean that so few are actually going to remain in the insured market that I don't even need to bring this issue up, and I really felt that having worked with small groups, I worked placing insurance when I was with Mercer for a while, and we -- in trying to solve the problem with the uninsured, I've worked with small groups in that arena, they still are risk adverse and they have a tendency to stick where they are, and this is a new decision for many of them, or if it's an old decision these groups are the ones that decided to stay insured and not going go to the self funded. So I thought well no I don't think it's going to go that far.

So not knowing if it was going to be a lot or a few I had no choice but to pick the middle, and taking into consideration morbidity and percentage of groups and everything I still felt that would have been my best guess. We don't know what's going to happen, but that was my best estimate and my recommendation.

Q. Okay. You just referred to the fact that you listened to testimony from Paul Schultz today about this issue and you heard what he testified to?

A. Right. It was very similar to what he said in answer to my objection.

Q. And when you referred to your objection you're

referring to one of the objection letters from Blue Cross Blue Shield?

A. July 1.

Q. July 1 response. Okay. Did the testimony today change your recommendation about this particular point?

A. No.

Q. Now moving to the next part of your recommendation I would direct you to page -- everybody to find page 254 of the binder. We'll be referring to that.

MS. HENKIN: Can I ask both Lila and Donna to speak up and clearly. Your voices are trailing off and people can't hear.

BY MS. RICHARDSON:

Q. Yesterday you testified some about your experience in reviewing the solvency of health insurance carriers and your work. Did you review that experience again?

A. Okay. I actually did the modeling for the health risk based capital formula as part of an Academy of Actuaries project. We developed the original recommendation for health risk based capital for the Association of Insurance Commissioners which they took with minor modification and implemented.

I, working at Blue Cross Blue Shield

Association, monitored the solvency of Blue Cross Blue Shield plans that were getting into the monitoring levels that Blue Cross Blue Shield Association has monitoring their plans and the impact on their solvency.

I headed the group at the Academy of Actuaries until very recently called the Solvency Work Group that worked with the National Association of Insurance Commissioners with recommendations on how to handle the new risk to solvency presented with the implementation of ACA.

Q. In connection with this filing did you review any materials to try to assess the solvency of Blue Cross Blue Shield?

A. Yes. Their 2014 financial statement.

Q. And is there a particular part of the 2014 financial statement that you worked with in developing your analysis and recommendation?

A. I looked at a number of parts, but the one that had the most impact on would be the five-year financial data, financial historic financial data.

Q. And I direct you to page 268 of the binder, which is page 23 of your report, and ask you if that's the five-year historical chart that you're referring to?

A. Yes, it is.

Q. And just to clarify terminology when you talk

about financial statement are you referring to the 2014 -- something that's sometimes called the 2014 annual statement --

A. Yes.

Q. -- Blue Cross Blue Shield? Okay. And looking at that historical data chart on page 268 is there particular information in that document that's relevant to your analysis about solvency?

A. There are two rows, row 14 which is the total adjusted capital and row 15 which is the authorized control level risk based capital.

Q. Okay, and to back up one step is this chart and annual statement a public document?

A. Yes. Absolutely.

Q. Do you have access to those documents for different insurers?

A. For all the insurers. Yes.

Q. So why are the two lines that you have indicated, lines 14 and 15, relevant to analysis about solvency?

A. When calculating the risk based capital percentage the total adjusted capital is the numerator and the authorized control level risk based capital is the denominator.

Q. And you're referring to something called risk

based capital. Can you explain briefly what that is?

A. Risk based capital percentage is the ratio of the total adjusted capital. There's minor adjustments to the balance sheet capital, and a measure of the risk that the company is taking on that measure of risk is determined by a very complicated formula. It's primarily driven though by health care claims. It's -- I might add too it's a regulatory tool that many regulators use as one of their tools to determine if there's a problem with solvency or if there's a potential to have an insolvent situation.

Q. Now I would like to go back to page 254 of your report in the binder, and ask you if you could explain what the chart is in the middle of that page without reading any particular numbers contained in that chart because they have been labeled confidential.

A. Absolutely. It reiterates the two rows from the five-year historic data, but then it also performs the division in order to determine the risk based capital percentage.

Q. And did you make those calculations in the way you have described?

A. Yes, I did.

Q. I would like -- still staying with page 254 of the binder I would like to ask you to read the first

paragraph of your report on page 254?

A. Since Blue Cross Blue Shield of Vermont's solvency level is strong and improved in 2014 over the level in 2013 and will improve with the receivables from the reinsurance risk adjustor receivables, our reduction in the rates would not be a threat to the Blue Cross Blue Shield of Vermont solvency.

Q. And again we will skip over any numbers in the actual chart and ask you to read the paragraph immediately following the chart beginning with in fact.

A. In fact, we believe that their contribution to reserve could be reduced from 2 percent filed without threat to their solvency.

Q. Did you base those conclusions on the analysis that you performed in the chart?

A. Yes.

Q. And do the two paragraphs that you just read summarize your conclusions about how the solvency of Blue Cross Blue Shield relates to an appropriate amount of contribution to reserves for this filing?

A. Could you repeat that question?

Q. Okay. Did these parts of the report summarize your conclusions about what contribution to reserves is appropriate for the filing, the two paragraphs you just read?

A. I don't think these actually state what I think a contribution to reserve should be. I mean I don't think I opine on a particular level of contribution to reserve. Just that it could be reduced.

Q. Okay. And that's your -- a summary of your opinion about contribution to reserves?

A. Right.

Q. Could you explain why you believe that the contribution to reserves of 2 percent could be reduced as you've stated in your report?

A. I'm sorry. I don't have the citing, but the actual annual opinion I believe stated that a 1.52 percent contribution to reserve would maintain the current level of solvency or risk based capital. I'm sorry. I didn't include that cite in here. So to maintain it, it could be reduced from 2 to 1.52, and then additionally I did a very basic calculation of what further decreases could be allowed and still stay well within the range, the target range.

Q. Do you believe that it's necessary for Blue Cross Blue Shield to maintain solvency level from the current levels shown in the chart?

A. To maintain that exact level?

Q. That exact level. That same level.

A. No, I don't think it's important they maintain

that exact level.

MS. HENKIN: Can I ask again that you speak up? There's also a truck behind us.

A. I'm sorry. It echoes in my ear so much, but I'll let it echo.

Q. I'm going to just for everybody's review of this making sure that we have the information on the appropriate pages, could I ask you to turn to page 38 of the binder, and is this page the source of your understanding that Blue Cross Blue Shield says that contribution to reserves of 1.52 percent would be required to maintain RBC level?

A. Yes. I found it in the second paragraph of that page.

Q. And this refers to contribution to reserve level based on the original filing; is that correct? This is an actuarial memo from the original filing?

A. Yes.

Q. Is it accurate to say that if the medical trend has been reduced as a result of the agreements that have been made after the Lewis & Ellis analysis that that level could be reduced slightly?

A. Any impact on claims levels because that drives risk based capital including lower trends would, right, would require a lower risk based capital -- would

lower the risk based capital requirement.

Q. So is it your opinion that, again summarizing the analysis that you have done, that the level of solvency as reflected in the RBC is high enough that Blue Cross Blue Shield could reduce their contribution to reserves and still stay financially strong and within the RBC target levels that they have testified to?

A. Yes. They could.

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

MS. HENKIN: Ms. Hughes.

MS. HUGHES: Thank you.

CROSS EXAMINATION

BY MS. HUGHES:

Q. So, Ms. Novak, how many major medical filings have you prepared for participants in the Vermont marketplace?

A. Prepared none.

Q. And have you worked with any Vermont brokers on getting insurance coverage or self-insured programs put together for anyone in the 51 to 100 category?

A. I've received information from the attorneys at the Health Plan Advocates. They had some discussions with brokers. I have not had personal discussions. I used the information they provided to me.

Q. So your answer is no you have not worked with brokers in the 51 to 100 category in Vermont?

A. I have not had any contact with brokers. No.

Q. Are you familiar with the extent of early renewals that took place in 2014 in Vermont?

A. Not the specifics, but I understand that there were as in many, many states.

Q. And are you familiar with the DFR bulletin on early renewals that was issued in 2015 with respect to the 2016 calendar year?

A. No, I don't believe I've seen that.

Q. And are you familiar with any captives that have been used by groups to procure stop loss or other coverages to compliment their self-insured programs in Vermont?

A. I'm aware through the answer to the objections, as well as Mr. Schultz's testimony, that they exist. I'm not familiar with their exact names or signs.

Q. Are you familiar with the take uprate for the CIGNA level funded products that are out there?

A. Only as generalized by Mr. Schultz's testimony.

Q. So you're not personally familiar with that take uprate?

A. No. I am not.

Q. And you stated that you worked for Trustmark on self insured take up, and the question I have is, is Trustmark engaged in business in Vermont?

A. No, it is not, and it was a partially self-funded product. That was what it was called, and they did not -- at the time I worked for them and I do not believe today that they offer insurance in Vermont.

Q. Looking at CTR do your calculations include any impact for 2015 as we know it to date?

A. My calculations were very basic, were not detailed at all, and they gave me a comfort level where I did not seek any further detail.

Q. So do you have access to any of the confidential information that Mr. Chieffo referenced earlier today in his testimony for the Department?

A. I wouldn't have access to any confidential information except as was presented for this hearing.

Q. And is it your understanding that the Department uses more than lines 14 and 15 at a given point in time to perform a solvency evaluation of a domestic company under their jurisdiction?

A. Absolutely.

Q. So they would do that for Blue Cross. They wouldn't just look at lines 14 and 15 and do division?

A. Absolutely.

Q. Okay. So is it your testimony that -- strike that. The number that you referenced on page 38, Blue Cross's explanation as far as maintaining the current level of solvency, was that a comprehensive number or was that directed simply at medical trend?

A. What it says is that a contribution to reserve of 1.52 percent is required merely to maintain the RBC levels in light of medical trend.

Q. So could there be other things that would also impact maintaining insurer solvency and RBC?

A. Yes.

MS. HUGHES: Thank you.

MS. HENKIN: I'll go to the Board now. Jessica, do you have any questions?

MS. HOLMES: I don't. Not at this time.

CHAIRMAN GOBEILLE: I'm all set.

DR. RAMSAY: I just have one, Ms. Novak, about, you know, again back to page 254, and under the filing of the risk based capital you state in fact we believe the contribution to reserves could be reduced from 2 percent filed without a threat to their solvency. But to zero? To reduce it by a tenth? You know there's no -- maybe I missed this, but did you have an opinion -- could you opine on what you believe would be an acceptable decrease

given your background?

MS. NOVAK: My very basic estimate of how much lower the rates could go, and especially the contribution to reserve and still stay within the range, they could go down to zero percent. I'm not recommending that. I'm just saying that it would not take them out of approximately where they are now and in the range that they have targeted.

DR. RAMSAY: But you don't recommend that?

MS. NOVAK: I'm not making a recommendation on the contribution to reserve.

DR. RAMSAY: That's all.

MS. RAMBUR: So my understanding from your testimony or I'm inferring that in your opinion risk based capital is a valid watermark proxy for solvency; is that correct?

MS. NOVAK: Yes.

MS. RAMBUR: And I can infer from the DFR testimony that RBC in isolation is not an adequate proxy for solvency. So could you talk about that discrepancy for me?

MS. NOVAK: I could tell you what I think other issues are, but DFR might be able to add to that. Risk based capital doesn't consider

solvency. It doesn't -- I'm sorry, liquidity. It doesn't consider liquidity. Risk based capital as a percentage doesn't really look at the total dollar amounts. So the dollar amounts represented by a particular percentage of risk based capital might logically be threatened in smaller companies. Risk based capital is retrospective. It looks in the rear view mirror and so it doesn't take into consideration, especially in a start-up company, it doesn't take into consideration what could happen in the coming year. So those are some of the things that I think a more detailed analysis --

MS. RAMBUR: Despite those limitations you still conclude the RBC level is the basis of your recommendation.

MS. NOVAK: In a stable company with strong liquidity it would -- it would certainly be my favorite point and I don't think some of those other issues would impact my decision, but I think they should be considered.

MS. RAMBUR: Thank you.

MR. HOGAN: No questions.

MS. HENKIN: Anything else of this witness? Thank you.

At this time I just want to note there's

quite a few people who have come in. I want to make sure that if you are here to give a public comment you both sign in your name on the sign-in sheet and you sign up for public comment, and I believe we should begin them now since -- are we done with the testimony at this point?

MS. HUGHES: Yes, we are.

CHAIRMAN GOBEILLE: I knew that you had reserved the right to call so I did not want to assume.

MS. RICHARDSON: We do not have any additional witnesses.

CHAIRMAN GOBEILLE: Okay. Thank you.

MS. HENKIN: I asked this yesterday, it was declined, but if anyone has a closing statement, does either party have a closing statement they would like at this point?

MS. HUGHES: We'll do any follow up in writing. Thank you.

MS. HENKIN: And speaking of writing we did decide on the due date for the memos and that is next week, and is there any question about that at this point?

MS. HUGHES: August 4.

MS. RICHARDSON: My understanding was

August 4 at noon.

MS. HENKIN: Thank you, and for the people who are here there will be a decision out on this on the 13th of August is the Board's deadline to have a written decision by that time and public comment ends today at end of day. That can be done online or, as I said before, there are people here to comment today, and I don't know -- Kelly has the list. Can you tell me approximately how many people are on the list at this time?

MS. MACNEE: Seven.

MS. HENKIN: Okay. And what I would like to do is tell the people who comment this is not for questioning of any of the witnesses, the parties, or the Board. This is purely public comment concerning these -- this rate hearing. I would like it to remain within that scope. I would also like, because there are people still coming in, you to limit your comment time to no more than two minutes please. I know that sounds like not much time, but we do have other people that are coming in to speak and it will give you an opportunity to present what you need to, and you do have the opportunity also to present the Board with your written comments whether you do that online or by paper today. Dale Hackett.

MR. HACKETT: Good afternoon. After listening to I think pretty much the whole morning the one that I picked up on was -- there are so many issues I can't comment on all of them, but solvency seems to be the key issue, and the more I thought about it I got intrigued because it seemed like we're talking about a level of solvency for a company that is insuring people that don't have even the chance for that kind of solvency in their life. A pandemic that may never happen. I also have a volcano down in Ascutney that if you want to insure for that in case it ever explodes, but in people's lives they don't have that kind of solvency around health care. They don't have a savings account, or they might have a savings account and it will be wiped out as soon as they get sick. I can't think of anybody, except for maybe somebody extremely rich and in some cases that wouldn't even be true, they don't have this kind of solvency. So can I overextend solvency.

There's another factor too. Some of the people that in the testimony said have left and gone to Medicaid, is Medicaid solvent? How much of their solvency is going to go to Medicaid, and Medicaid is not solvent. I just wanted to broaden the perspective. Solvency of people and the consumer and

their health care is far beyond the solvency we've been talking about this morning, and that's the more important solvency, and we need to remember the greater solvency issue may be elsewhere. We as consumers are going to have to pay that solvency. My two minutes are up.

MS. HENKIN: That's fine.

MR. HACKETT: I'm done. There's plenty more and thank goodness because I don't like commenting all the time, but I do want to participate. I do try and participate, but I love to see other comments.

MS. HENKIN: Thank you very much. We appreciate your participation, Dale, and I do have -- if you are still signing in, Kelly Macnee is in the back, but I do have the list here. Jamie Contois.

MS. CONTOIS: It's Contois.

MS. HENKIN: I'm going to apologize.

MS. CONTOIS: I didn't know what your practice was so I made five for the Board.

MS. HENKIN: We have one more board member.

MS. CONTOIS: So my name is Jamie Contois and I live in Putney, Vermont, and though I have been in practice to speak out on national health

care reform and state reforms, I always get nervous and my voice shakes so I'm just preparing you.

I'm a new mom. My son and my spouse are down at Skinny Pancake eating while I'm up here. My 19-month-old on my hip would probably wreak havoc on the mike system as I try to testify. So I wanted to just say that I have been insured under the private Blue Cross Blue Shield plan. My spouse was insured under Catamount. We have now switched over to Vermont Health Connect and have the gold standard plan through Blue Cross Blue Shield.

I was shocked when we got a rate increase this year of approximately $1,500 on top of the over $16,000 we were already paying per year out of pocket. We are not receiving subsidy or financial support for this. We now pay over $18,000, about $18,500 for health insurance. If you calculate in our deductible, it is nearly $20,000 annually.

In our family's income -- I worked for five years on national health care reform. I worked very hard. I looked at the public policy. I looked at the income of the top executives in the insurance industry. I looked at international debates about how this work needs to be done and how you can transform a health care policy over to something that

is sustainable and affordable for everyday working people.

We have stepped backwards in the State of Vermont. We are stepping so far backwards right now. My spouse who was diagnosed with type one diabetes at four years of age is starting to talk to me about going to the higher deductible plan that has worse benefits. We're looking at not being able to afford insurance as we are starting a family in our beloved state.

So I really appreciate the gentleman who spoke before me because I know how to think like an institution and I know how to think about solvency. I also have helped start businesses that know how to make things work internally by moving money around and not passing the buck to the consumer. So because I looked at all your bios and was super impressed at the genius in the room and the comprehension of what you guys have heard over and over and over again, whether it's in this room or whether it's in your personal lives, I ask you to deny the rate increases that are requested today because we will go from paying 22 percent of our income to 25 percent of our income. That does not include housing or food or any of the other basic things that we need. We're

looking at a day care now. I mean this cannot stand in the State of Vermont. It is unethical. We have been a national leader in health care and that has changed.

So I ask you for us to make a health care system that we can be proud of and where we can be a national leader again and not just to deny this rate increase, but to take your mandate to the next level for what you are created for.

MS. HENKIN: Thank you. Michael Ialeggio. State your name.

MR. IALEGGIO: It's tricky. It's I-A-L-E-G-G-I-O. So yes my name is Michael. I am in a couple weeks going to go back to med school at UVM. Going to be a second year. I have had a lovely summer off, and first I want to say that the two speakers who preceded me were incredibly eloquent and I appreciate their testimony and my voice will also shake a bit because I don't do this much.

As a student this past year I was eligible for Medicaid and I'm extremely thankful to be eligible for Medicaid, but when I heard about this rate increase it made me go to my files, I actually have a file cabinet which is exciting, and pick out my W-2 from the last two years. So the last two

years I was working as a clinician, as a mental health counselor, at a -- which is a job I loved and I made -- in 2013, for example, I made $20,500 as a clinician and that's another issue, you know, but I looked at the numbers and it turned out that I paid, and I remember being surprised about this in the past, I paid $6,413 for health insurance during that time.

So if you just run those simple numbers, it's 32 percent of my wages that I paid to health insurance, and I remember being shocked at that at that time, and then if you just kind of plug in the 8 percent or some other percentage, it shoots up to 35 percent. I think this is just a good reminder that this doesn't work, and I am fortunate enough at this time that I don't have to worry about anything that happens, the decision that is made here, but I'm close enough to the time when I remember such that I can remember when I would have been worried to have to come up with an extra $500, especially given rents in Burlington.

I think we need to think in big terms, which means to say that systematically this doesn't make sense. We all know that. Anybody can look at these numbers that I'm giving you here or the numbers

that Jamie or Julie -- Jamie just talked about before and without having any sort of degree understand that it makes no sense. So why don't we just take that as a starting point and move towards something which makes more sense. So that is what I wanted to say.

MS. HENKIN: Thank you. Sheila Linton.

MS. LINTON: So good afternoon. Thank you for the opportunity to provide my testimony today. My name is Sheila Linton and I'm from Brattleboro. Today we're hearing testimony of whether Blue Cross Blue Shield should increase the rates by 8.4 percent and my reply is no and these are my reasons why.

As a single mother of two children, one of my daughters is in college while the other just entered her teenage years. Both of my children are on my plan through Vermont Health Connect and receiving insurance through Blue Cross Blue Shield. I am over the cap for Medicaid but just under enough for my younger daughter to receive Medicaid or be on Dr. Dinosaur as we call it. My daughter -- my older daughter and I have a combined deductible of $2,400 at the age of only 20-years-old and the $20 co-pays. We currently both have a stack of medical bills amounting to over a thousand dollars of out-of-pocket

costs right now and it keeps on growing everyday.

I'm a check-to-check mom and these additional costs have prevented both my daughter and I from getting the care that we need or when we do get the care that we need falling into debt. In addition to these costs, I was one of the hundreds of folks that made a little more than expected this year. This caused me to have to pay back my subsidies that the state gave me costing me my tax return and me owing into the IRS almost 600 dollars. If Blue Cross Blue Shield rates increase, I can only assume through experience that those costs will be transferred to the people of Vermont while Blue Cross Blue Shield continues to operate under a non-profit status and receive millions of dollars in tax breaks. People are not getting the care that they need. People are going bankrupt. People are dying.

We and you, the Board, have the opportunity to create a system that can help alleviate the suffering of so many people here in Vermont and so many people you will hear from today including my family. I urge the Green Mountain Care Board to continue the path to a truly universal health care system providing health care as a public good where the people pay based on their ability to

pay and reject the Blue Cross Blue Shield's request to profit off of our sicknesses and our deaths.

I also understand that among a few the Vermont Workers Center has provided a full comprehensive proposal as to how we can get this done where over a hundred economists from around the country have signed on. I'm here to work with you and to help to make my request a reality. Health care is a human right and I thank you for your time.

MS. HENKIN: Thank you. Jess Fuller.

MS. FULLER: You will have to excuse me for my limp. I was hit by a car this summer.

I want to begin by acknowledging how inaccessible these open forums are. While I understand health care and financing can be complex the effects of these decisions are simple. Working class people cannot -- are being gauged with an 8 percent rate hike among waves of austerity cuts. Additionally I want to point out the fact this is being held in the middle of the day in the middle of the week and working class people who are on Vermont Health Connect cannot make it here because they are working just to make their ends meet and how unaffordable and how inaccessible this is, and that's really disheartening for me to think this is the

public forum that we are supposedly able to have.

Speaking of that point I have just plenty of friends who just are not able to make ends meet. I'm a student. I just graduated from UVM. I was lucky enough to be able to go to UVM just through an enormous amount of scholarships, but right now I'm facing student loan debt as well as medical debt after, like I said, I was hit by a car. I am fortunate enough to have health insurance, however, my deductible for my one health insurance is $4,000, and being a recent grad who is unable to work that's -- I couldn't afford my rent, I couldn't afford my food. I don't understand why we're perpetuating this system of precarity where we're not even allowing working class people to live in Vermont any longer.

I'm really frustrated to think I moved to this state because I saw Vermont as moving forward with health care reform, and honestly Vermont Health Connect is just a false solution to the system. How can we allow this 8 percent rate hike to actually occur. I can't afford that. I can barely make my ends meet as it stands, and with every wave of austerity cuts that's been put before us in the past year between the Legislature I don't know where we think we're going, but if anything we're being

continuously entrenched in this for profit system, like Sheila just said, that's benefitting off of people like me getting hit by a car my first day of work. I didn't have health insurance in my new job and I'm lucky enough just to be on my mom's health insurance, but I don't know where this leaves us. It's crippling my family. I lost my stepdad to cancer because he didn't have health insurance, and he was a small business owner because he couldn't afford it, and I'm just really disappointed that this is going on and we're allowing this to go on, and we're cutting so many people out of the conversation by doing this in a bureaucratic style in a board room where so many people who are being affected by this are not being heard. Thanks.

MS. HENKIN: Thank you. Phil Lippert. Millard Cox, and if there's another list and you want to bring that up, I can move on to that.

MR. COX: Thanks for this opportunity. My name is Millard Cox. I'm from Ripton and I'm here today to ask you to please deny a rate increase of any amount to Blue Cross Blue Shield for this year. This is because in part the poverty rate in Vermont is increasing in spite of reports that the economy is getting better. There are more children living in

poverty today than there were last year. The state's cutting back on supports for the poorest families in Vermont and increasing the tax rate on those families at the same time. For Blue Cross Blue Shield to even request a rate increase at this time demonstrates to me how tone deaf the corporation is to the true situation in Vermont for working families.

It's a completely inappropriate request. Also it's because I think about the absurdity of paying premiums to a corporation to get health care when that corporation doesn't actually deliver health care. They don't perform any kind of health care. What they do instead is they present impediments to the ability of people to receive health care. They don't provide a service, but we pay for a service. I don't know what the service is. Also it's absurd to me that the company is titled as a non-profit when it's clear that they make tremendous profits, and they pay salaries to their Board -- not to their Board, excuse me, to their officers that puts those officers in the top one percent of income in the State of Vermont, and in 2014 the corporation paid no taxes that I know of. I think they got a 15 million dollar tax exemption.

So I just think it's absurd for

Vermonters to be given -- given a demand that they pay money to a corporation that does not deliver health care in order to receive health care, and to me it amounts to a form of extortion because people who can't afford the premiums are then denied access to health care or else are placed in a situation where they face bankruptcy.

So to me Blue Cross Blue Shield should go away and let us develop a health care system that actually works for Vermonters. The health care system that we have right now works for the insurance companies. It doesn't necessarily work for us. Thank you.

MS. HENKIN: Thank you. Bekah Randall or Mandell. It's Mandell, correct?

MS. MANDELL: Yes. Is it okay if I stand? It will be better for balancing the baby. Can you folks hear me? Hi.

MS. HENKIN: We'll adjust that a little for you.

MS. MANDELL: Hi. My name is Bekah Mandell and I grew up just down the road in Middlesex. After living -- growing up in Vermont I returned to Burlington to live with my husband and our baby son Loren and I'm a member of the Vermont

Workers Center. My husband and I are both entrepreneurs. We are both small business owners here in Burlington and neither of us get health insurance through our work so we are responsible for the full premium and the full cost of the Blue Cross Blue Shield health insurance that we got. So that means the premiums, the co-pays, the deductibles. So our monthly premiums are $465 per person. That includes Loren who is not yet contributing financially to our household.

So that means we pay a total of $1,395 dollars a month in premiums alone. That's before we get to the co-pays and before we get to the deductibles. So that's significantly more than our mortgage, and frankly it's significantly more than we can afford. An 8 percent rate increase would force us to pay more than $1,500 a month for our health care premiums, and a 14 percent increase would cost us nearly $1,600 a month in premiums alone.

A new baby, as I'm sure many of you know, brings lots of increased costs into your lives; child care, diapers, our water bill has gone up because of all the laundry we're doing, and we simply can't afford to pay more for our premiums. We can't afford to pay what they are now. $1,400 is more than

we can afford. $1,500 is a lot more than we can afford. $1,600 I don't know what we would do to be honest. I want Vermont to be a place where I can stay and raise my family and not have to move to a place that's cheaper.

As our family tries to figure out the balance of these high health care premium costs with our other monthly bills I've been thinking a lot about how health care is in fact a human right and it's not a commodity to be bought and sold. My health, my family health, is not numbers on a balance sheet at Blue Cross. It's a real -- it's something that's real in our lives, and so I'm proud of the steps Vermont has taken so far to get us through the universal health care system, and I know we can go farther.

As members of the Green Mountain Care Board you folks are in charge of this awesome responsibility for my son, for me, for the whole State of Vermont to see that we can have a universal equitable health care system, and so I hope that you will take this opportunity to reject the cost increase that Blue Cross is asking for and take concrete steps to move us forward towards an universal equitable health care system for all of

Vermont. Thank you.

MS. HENKIN: Thank you.

MS. MANDELL: I have copies of my testimony if anyone wants to see it.

MS. HENKIN: We can take that and submit it as a public comment for you. I don't have any more names on the list for public comment. Is there anyone else who has not signed up who wishes to speak at this time? If that's the answer that I hear silence, then we will be closing this hearing today and this closes the hearing.

CHAIRMAN GOBEILLE: Thank you. Well first of all, thank you to the parties for coming. We appreciate it. Thank you to everyone who came and testified and to other members of the public who came to watch. At this point I'll accept a motion to adjourn.

MS. RAMBUR: So moved.

CHAIRMAN GOBEILLE: Is there a second?

MS. HOLMES: Second.

CHAIRMAN GOBEILLE: All those in favor, aye.

(Board Members respond aye.)

CHAIRMAN GOBEILLE: All right. Thank you.

(Whereupon, the proceeding was adjourned at 1:15 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 meeting re: Docket Number 08-15-rr at the Second Floor Conference Room of the Green Mountain Care Board, 89 Main Street, Montpelier, Vermont, on July 29, 2015, 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 175 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 31st day of July, 2015.

JoAnn Q. Carson

Registered Merit Reporter

Certified Real Time Reporter