STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-005-20-rr

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

July 20, 2020
8 a.m.

Hearing held remotely before the Green Mountain Care Board via Microsoft Teams on July 20, 2020, beginning at 8 a.m.

P R E S E N T

BOARD MEMBERS: Kevin Mullin, Chair
Maureen Usifer
Jessica A. Holmes, Ph.D.
Robin Lunge, JD, MHCDS
Tom Pelham

STAFF: Michael Barber, Hearing Officer
Susan Barrett, Executive Director
Amerin Aborjaily, Associate General Counsel

CAPITOL COURT REPORTERS, INC.
P.O. BOX 329
BURLINGTON, VERMONT 05402-0329
(802) 863-6067
Email: info@capitolcourtreporters.com

A P P E A R A N C E S

Blue Cross Blue Shield of Vermont

STRIS & MAHER, LLP
28 Elm Street, 2 FL
Montpelier, VT 05602
BY: BRIDGET ASAY, ESQUIRE
MICHAEL DONOFRIO, ESQUIRE

Health Care Advocate

Jay Angoff, Esq.
Kaili Kuiper
Eric Schulteis

Department of Financial Regulation

Gavin Boyles, Esq.

INDEX OF EXAMINATION

EXHIBITS

CHAIRMAN MULLIN: So today we are here for the QHP filings by Blue Cross Blue Shield of Vermont. At the end of the day, there will be a brief opportunity for public comment, but, most importantly, we want everyone to know that there is a time period blocked off for public comment for tomorrow starting at 4:30 on both the Blue Cross Blue Shield and the MVP filings. For the purposes of today's hearing, I'm going to designate Michael Barber, the general counsel for the board, as the hearing officer. And, with that, Mike, I'm going to hand over the meeting to you.

MR. BARBER: Okay. Thank you, Mr. Chairman. Good morning, everyone. Again, my name is Michael Barber. I've been appointed by the Chair to serve as hearing officer for today's hearing. As the Chair said, the purpose of this hearing is to take evidence and argument on Blue Cross Blue Shield of Vermont's 2021 individual and small group rate filing. The docket for this case is GMCB-005-20-rr. The Green Mountain Care Board has jurisdiction over this matter pursuant to Title 18 of the Vermont Statutes Annotated, Section 9375(B)(6), as well as Title 8 of the Vermont Statutes, Section 4062, Subsection A.

Representing Blue Cross Blue Shield of Vermont today are Bridget Asay and Mike Donofrio of the law

firm Stris & Maher, LLP. Representing the health care, Office of the Health Care Advocate, excuse me, are Jay Angoff, Kaili Kuiper, and Eric Schultheis. I also want to recognize the board's general counsel, associate general counsel, excuse me, Amerin Aborjaily, who will be conducting the direct examination of the board's actuaries as well as Gavin Boyles -- I'm not sure he's on -- but the general counsel for Department of Financial Regulation.

MR. BOYLES: I am on.

MR. BARBER: Great. Hi, Gavin. Because we are holding the hearing remotely, before I go any further, I just wanted to check and make sure all the attorneys and all the board members can hear okay and can be heard. So I'm going to call on each of you. If you can just take yourself off mute and let me know if you can hear okay, that would be great. Mr. Chair?

CHAIRMAN MULLIN: Here.

MR. BARBER: Board Member Holmes?

MS. HOLMES: Yes.

MR. BARBER: Board Member Lunge?

MS. LUNGE: Yes.

MR. BARBER: Board Member Usifer?

MS. USIFER: Yes.

MR. BARBER: Board Member Pelham?

MR. PELHAM: Yes.
MR. BARBER: Amerin?
MS. ABORJAILY: Yes.
MR. BARBER: Ms. Asay?
MS. ASAY: Yes. Good morning.
MR. BARBER: Mr. Donofrio?
MR. DONOFRIO: Yes, thank you. I can hear, and I can see you all. Thanks.
MR. BARBER: Ms. Kuiper? If you're speaking, you're on mute.
MR. SCHULTHEIS: She was having some issues with the call-in.
MS. KUIPER: Can you hear me now?
MR. BARBER: Yeah, we can hear you now.
MS. KUIPER: I am sorry about that. Thank you.
MR. BARBER: Okay. Eric, I can hear you. And, Sunnie, can you hear okay?
THE REPORTER: Yes, good morning. Can you hear me okay?
MR. BARBER: As we discussed, if, at any point, you get dropped from the call today, you have my cell phone number. Please just text me, and we'll take a pause while you get back on. We are recording today's proceedings. We also have a court reporter

here to transcribe the proceedings, and we will provide the parties with a copy of the transcript as soon as we receive it.

It looks like we have 53 people in attendance this morning. If we were holding the hearing in person, we would have a sign-in sheet outside the room. Obviously, we can't do that here. You know, since this is a full day-long hearing, people are going to be coming and going. So I'm kind of thinking of skipping the kind of roll call of phone numbers that the board typically does in regular board meetings, but does any party have any objection to that?

MS. ASAY: No objection.

MR. BARBER: HCA?

MR. SCHULTHEIS: No objection.

MS. KUIPER: No, I don't.

MR. BARBER: Okay, thanks. For members of the public who are present, as the Chair said, we will be taking public comment at the close of the proceedings. However, I can't say when we will be able to get to that portion of the meeting. So, if you don't want to sit through what's sure to be several hours of testimony, we're going to have a meeting tomorrow afternoon from 4:30 to 6:30 in the afternoon that will be dedicated exclusively to hearing from the

public on this filing and the other individual and small group filing from MVP.

Information about that meeting and how to participate can be found by going to the Green Mountain Care Board's website and clicking on the rate review tab. Additionally, you can submit written comments to the board via our website and by regular mail, and the board will be taking comments through July 23rd on this filing.

For members of the public who are present, I'd ask that you check your microphones at this point and make sure you're muted. Also, for those of you participating or watching on the computer, please do not use the chat function of Microsoft Teams. That would be very distracting for, for all the participants. And, if you want to comment, please use one of the avenues that I mentioned previously.

Before we begin, I want to remind the board and the parties to exercise caution regarding information that has been marked confidential, as these matters can't be discussed in the public setting. The parties have marked documents that contain confidential materials as confidential in the hearing binders.

And, if it's all right with you, Ms. Asay, or Mr. Donofrio, if you could just describe how the

confidential materials are designated in the binders, because it differs between the carriers in the hearings. So I think it would just be helpful to explain how that was done.

MS. ASAY: Sure. So we've only provided in the binders the full, unredacted copies of exhibits. Each exhibit that has some confidential information in it is marked as confidential, I believe, both on the document and in the table of contents, and then the material within the document that was redacted for confidentiality purposes is highlighted in the document.

MR. BARBER: Okay, thank you. So, as it becomes necessary to discuss confidential materials in the binder, we'll need to go into executive session. We have a separate line for that purpose should we need it. So, Mr. Donofrio, or, sorry, Ms. Asay and Mr. Angoff, the board received exhibit binders on July 15th with 21 Bates-stamped exhibits. After receiving the binders, we received a response to board questions regarding pension losses, which was marked Exhibit 22, as well as a chart marked Exhibit 23, and then an exhibit from the HCA marked Exhibit 24. I just want to check and make sure everyone who need those, everyone who has a binder has those documents. Does anyone not

have those documents?

(No response.)

MR. BARBER: Okay. Hearing nothing, I'll move on. So I understand that the parties have stipulated to the admission of all of those documents. Is that correct?

MR. ANGOFF: Yes, sir. This is Jay Angoff.

MR. BARBER: Okay. I see you nodding your head, Bridget.

MS. ASAY: Yes, that's right.

MR. BARBER: Okay. I also understand that the parties have stipulated to the admissibility of the HCA exhibits, which are not included in the briefs. Is that correct?

MR. ANGOFF: Yes, it is.

MS. ASAY: Yes, that's correct.

MR. BARBER: Then, at this point, I'm going to admit all of these documents into evidence with the exception of Exhibit 22, sorry, Exhibit 23, the graph. I understand it's a chart showing calculations from data published by the Kaiser Family Foundation, and the HCA has stipulated to its admissibility, but I feel like I need a factual foundation for, for that before I admit it. So I understand that can be provided through Mr. Schultz.

MR. DONOFRIO: Yes, that's correct, Mr. Barber. That will take place during Mr. Schultz's direct testimony. Thanks.

MR. BARBER: Okay. Then I'll entertain a motion to admit this document after Mr. Schultz has established a factual foundation for it.

MR. DONOFRIO: Okay, thank you.

(Blue Cross Exhibits 1 through 22 and HCA Exhibit 24 were admitted into the record.)

MR. BARBER: In years past, we have sworn in the witnesses all at once at the beginning of the hearing. Because we're doing it remotely and I can't see everyone, I figure we'd just do that as the witnesses are called. So, at this point, does either party have anything to discuss before we move to opening statements?

MR. ANGOFF: Not for the HCA.

MS. ASAY: I have nothing for the board, unless Mr. Donofrio has something. Nothing for Blue Cross unless Mr. Donofrio has something.

MR. DONOFRIO: No, nothing further.

MR. BARBER: Okay. Then, Ms. Asay, would you like to make an opening statement?

MS. ASAY: Yes. Thank you, Mr. Barber. Good morning, Chair Mullin and members of the board. In

some ways this day will be pretty similar to last year's rate hearing in July of 2019. The board members, the lawyers, and many of the witnesses will be the same, and, likewise, the core of Blue Cross's presentation, the actuarial analysis that supports the proposed rates, will be similar. But the fact that we are in this virtual meeting, not at the State House, is only the most obvious sign that the world is a very different place than it was a year ago. The pandemic has affected all of our lives, the health care system and the economy.

It's tempting to say that, sitting in the hearing room last year, no one could have imagined this, but I went back and looked, and, in fact, at least three times during the hearing last year, witnesses pointed out the risk of an outbreak, an epidemic, or a pandemic. Both Blue Cross and Commissioner Pieciak testified that Blue Cross Blue Shield of Vermont's solvency is critical to its ability to pay claims, regardless of unexpected events, including an epidemic.

Solvency and financial sustainability are long-term propositions. For an insurer, by definition, that means planning for the unexpected. For Blue Cross Blue Shield of Vermont, that means maintaining adequate reserves and requesting rates that are sufficient to

cover the cost of providing health care to our members.

Today, through testimony from Dr. Kate McIntosh, Paul Schultz, Ruth Greene, and Andrew Garland, the board will hear three main themes. First, and most critically, that the rate is actuarially supported. Blue Cross Blue Shield of Vermont has chosen not to dispute L&E's utilization trend. That means there is no dispute on this point. A rate increase of 5.5 percent is necessary given what it costs to provide health care to our members. The board's actuary agrees that the assumptions for administrative costs and contribution to reserves are reasonable, and its analysis shows that these requests are modest when compared to other similar plans.

Health care costs are continuing to rise. Mr. Schultz will discuss some of the primary drivers of these increases in his testimony, and Dr. McIntosh will provide clinical context for one of those drivers, specialty pharmaceuticals.

The board has asked questions prior to this hearing about Blue Cross's pension, recent pension loss. For today I think the key point is that not one penny in these rates is based on the pension loss. What else is not in these rates? There's no accounting for any increased costs in 2021 due to the pandemic,

even though we fully expect that there will be increased costs for things like deferred care, treatment, and a vaccine. The requested increase from Blue Cross Blue Shield of Vermont is lower than that of its competitor.

The second theme that the board will hear is that, both before and during the pandemic, Blue Cross Blue Shield of Vermont has been, has remained a leader and a partner in Vermont's health care reform efforts and the health care system.

Dr. McIntosh will discuss how rapid response to the pandemic and the steps taken to support providers, protect public health, and keep members covered. She'll also discuss examples of value-based programs that are helping to improve the quality of care. Mr. Garland will discuss how Blue Cross Blue Shield of Vermont worked with the Accountable Care Organization to adapt to the pandemic. Ms. Greene will explain why adequate reserves have been crucial to these efforts. Blue Cross has been able to target resources where they are needed most, helping people stay covered, assisting providers, and adapting policies to meet immediate needs.

The third theme that the board will hear is that, as we face another year of substantial uncertainty,

including real uncertainty about future impacts of the pandemic in Vermont, protecting Blue Cross Blue Shield of Vermont's solvency is more critical than ever.

I want to repeat something that Commissioner Pieciak said in his testimony last year:

"An independent and financially sustainable Blue Cross Blue Shield of Vermont is good for consumers, because it certainly can pay it medical claims, regardless of the economic conditions that it might confront in upcoming years. It can pay the medical claims regardless of unexpected events that might occur due to illness, outbreak, other extreme conditions, and a financially sustainable Blue Cross Blue Shield will also have the capital it needs to invest in programs and people and in technologies that will improve the consumer experience and, more importantly, improve consumer outcomes as well."

Every word of what the Commissioner said last year remains accurate and even more important today. This pandemic is far from over, and we don't know how it will play out in Vermont. The actuarial team at Blue Cross Blue Shield of Vermont has worked tirelessly to try and model potential impacts of the pandemic. That modeling, which we've shared with the board, shows a range of potential results.

As Mr. Schultz will discuss in more detail, for claims costs based on the best information we have, the pandemic is likely to have an impact on claims costs that ranges from modestly favorable to substantially unfavorable. Overall, with respect to claims costs, the majority of outcomes are relatively neutral, but, in terms of planning for uncertainty, the likelihood of what some call a windfall for Blue Cross Blue Shield of Vermont is vanishingly small. In contrast, it is not hard to construct an outcome in which Blue Cross Blue Shield of Vermont has to pay substantially higher claims.

The proposed rates don't include additional claims costs related to the pandemic. We have consistently taken the position that part of the function of reserves is to absorb those kinds of unexpected costs. It's important to understand, as Mr. Schultz will explain further, that funding these pandemic-related costs through reserves is no different from providing a rate discount or a rebate. It's critical, however, that the proposed rates be fully funded so that Blue Cross Blue Shield of Vermont has adequate reserves to meet these needs. Thank you.

MR. BARBER: Okay. Thank you, Ms. Asay. Mr. Angoff, do you have an opening statement?

MR. ANGOFF: Yes, I do. Thank you, Mr. Hearing Officer and Mr. Chair and members of the board. The first thing I'd like to do is to express my admiration for the board and the government of Vermont and the people of Vermont for what a great job they have done in containing the coronavirus. This is an underreported story nationally. Vermont obviously has a lot of natural advantages when it comes to containing the coronavirus. It's got a small population. It's got a sparse population, but so it makes no sense to, to compare Vermont to New York or Boston or Albany, but, even compared to other small, sparsely populated states, Maine, New Hampshire, Vermont has done by far the best job, by far the best job in containing the coronavirus. That comes at a cost. Obviously, there's been tremendous sacrifice by Vermonters. There's terrible unemployment. The economy has been devastated. But it has saved lives.

There are a few companies, though, that have benefited because of the sacrifice and the suffering of Vermonters, and one is Blue Cross. Blue Cross did not cause the coronavirus pandemic, but Blue Cross is benefiting enormously by the coronavirus pandemic. It's benefiting in two ways.

First, it's benefiting because there has been so

little coronavirus in Vermont, because the costs to Blue Cross of the coronavirus have been so nominal. And, second, it's also benefiting because people, at great sacrifice, have avoided going to the doctor, avoided going to the hospital. So Blue Cross's traditional costs just aren't there. So bizarrely, perversely, although Vermonters have suffered, Blue Cross has benefited enormously. That's the first thing I'd like the board to keep in mind as you hear Blue Cross once again ask for more money.

The second thing that I'd ask the board to keep in mind is Blue Cross is also the recipient of enormous windfalls over the past couple of years. Do you remember last year there was a little bit of discussion about, Well, were they really going to get all this money that the Trump tax law authorized in 2019 or 2020? And they said, Well, no, we may not get it in 2019. We may not get it in 2020. Well, not only have they gotten what was due them in 2019 and 2020, but a new law was passed to accelerate the refundable tax credits under the Trump tax bill so that Blue Cross, in 2020, is guaranteed to get almost $40 million because of the Trump's tax aid.

In addition, Blue Cross has more money coming to it, about $15 million, based on the Supreme Court's

recent decision in, in the risk corridor litigation and the court of claims decision in the cost-sharing litigation. So that's additional money that Blue Cross has coming to it. There's no uncertainty about that. So that's the second thing I'd like the board to keep in mind as you hear Blue Cross ask for more money once again is that they've gotten an enormous amount of money over the past couple of years from other sources.

The third thing, though, that I'd like the board to keep in mind is the most important, and that is the $40 million that Blue Cross threw away, the $40 million that their policyholders had paid and that this board has authorized, has authorized in the past. Blue Cross took $40 million and burned it up. It went down the drain. That is worth 180 points of RBC ratio. What that means is obviously today Blue Cross has so much money it's not a problem. Blue Cross does not deserve an increase. Without this 180 million drop, they would deserve a decrease. With the 180 million drop, it's probably close to break even.

But how can a company -- you'll hear Paul Schultz talk about how Blue Cross is the steward of our policyholders' premiums and our reserves. You just heard Ms. Asay talk about the importance of maintaining adequate reserves. Well, what Blue Cross, the stewards

of their policyholder reserves, did is make a foolish, reckless investment, invest money not in bonds, not in stocks, but in some very high-flying hedge fund, volatility hedge fund vehicle, which resulted in a $40 million loss in one month. So that's the third thing, and it's heartbreaking. It's heartbreaking, Mr. Chairman, because, but for this loss, policyholders of Vermont would be getting a decrease this year. So that's the third thing I'd like you to keep in mind, Mr. Chair.

And just I'd like to close by saying once again how I admire the board and the government of Vermont and the people of Vermont for how much they have sacrificed in order to contain the coronavirus. Thank you very much.

MR. BARBER: Okay. Thank you, Mr. Angoff. Ms. Asay, Mr. Donofrio, please call your first witness.

MS. ASAY: Blue Cross calls Dr. Kate McIntosh.

DR. MCINTOSH: Can you hear me okay?

MR. BARBER: I can. Are you able to -- I can't see your video for some reason.

DR. MCINTOSH: You may have to pin it to your desktop.

MR. BARBER: Yeah, just one second while I do

that. There you are. Now I can see you. Hi. Kevin, did you have something to say?

CHAIRMAN MULLIN: All I was saying, Mike, was that you were probably going to have to allow a few seconds for each witness so that we can pin them. We are going to have to unpin them when they're finished, probably, to make room for the additional faces that we pin. So and I was letting you go know that it did indeed work once you pinned, once we pinned her, so --

MR. BARBER: It's a good time to ask all the board members. Can you see Ms. McIntosh? Anyone can't see Ms. McIntosh? Hearing none, Ms. McIntosh, are you prepared to take the oath?

DR. MCINTOSH: Yes.

MR. BARBER: Do you swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

DR. MCINTOSH: I do.

K A T E M C I N T O S H, M D,

duly sworn to tell the truth, testifies as follows:

MR. BARBER: Ms. Asay, the witness is yours.

DIRECT EXAMINATION BY MS. ASAY

Q. Good morning, Dr. McIntosh. Would you please state your name for the record?

A. My name is Kate McIntosh.

Q. What is your position with Blue Cross Blue Shield of Vermont?

A. I am the Senior Medical Director and the Director of Quality for Blue Cross Blue Shield of Vermont.

Q. Would you please take a look at Exhibit 13 in your binder?

(Exhibit 13 was shown to the Witness.)

A. Yes.

Q. Is Exhibit 13 your prefiled testimony in this matter?

A. Yes, it is.

Q. Do you affirm that it is true and correct to the best of your knowledge?

A. I do.

Q. Dr. McIntosh, would you please briefly describe your clinical background for the board?

A. So I am a board-certified pediatrician. I had 22 years of clinical practice experience before I came to Blue Cross. I ran a private practice in Middlebury for 16 of those years, and I was the Chair of Pediatrics at

Porter Hospital.
Q. Dr. McIntosh, you provided some statistics regarding the COVID-19 pandemic in your prefiled testimony. I'm going to ask you to update some of those numbers. You indicated that, in June, the number of new infections per day in Vermont averaged between seven and eight. What has been the experience so far in July?
A. For the first two weeks of July, the average number of new infections per day remained between seven and eight, and the range reported by the Vermont Department of Health was between 2 and 17, and these numbers do not reflect any, any of the goings on down in Manchester, which are still under debate. So the average range was between 2 and 17 per day.
Q. In your prefiled testimony, you also gave some information regarding the spread of COVID-19 nationwide. What, what, if anything, has changed since your prefiled testimony was submitted?
A. Since my prefiled testimony was submitted, we've continued to see significant surges of COVID-19 in the states in the west and the south. The number of states seeing a rise in new infections, however, is beginning to spread throughout the country and is not limited just to the states that are seeing surges.

The rate of new infections per day is currently hitting approximately between 60 and 70,000 new cases per day within the country, but we have seen some surges as high as 77 percent as well. I, we don't expect these numbers to change at this point, unless they are going to increase, and the general consensus of Dr. Fauci and some of the other physicians up at the level of the NIH is that we are still within the first wave of this virus, that this is not the second wave, this is a continuation of the first wave, and we haven't even begun to see the end of this yet.

Q. You described in your prefiled testimony that your opinion is that the course of the pandemic in Vermont is unpredictable. Would you please briefly describe, would you please briefly summarize your opinion on that issue?

A. Vermont is not an island. Unlike New Zealand or Australia, we cannot close our borders and allow Vermont to simply coexist by itself. What's happening in the rest of the country is going to affect us, and circumstances can change very quickly if there's an outbreak. The virus spreads particularly easily, and one of the things that is the most concerning about this virus is that it spreads often by asymptomatic spread, and there is new evidence coming out just

within this last week to suggest that asymptomatic carriers may be some of the primary spreaders of, in superspreader events.

The other problem is that nothing has fundamentally changed about this virus since March. We still do not have particularly effective treatments. We have no way of preventing it, except through public health measures, and even though, you know, I think that we, as a country, are beginning to lose interest in the virus, the virus is still present and is still a real and present concern. So fall and winter are a real concern, because, although the virus spreads less outdoors, it does spread more easily indoors and in confined spaces. So, as the cold weather returns, the virus will spread more easily. As schools, colleges reopen, there is a concern that we will see more spread, because you have larger numbers of people in close, in close and confined spaces.

Q. Dr. McIntosh, what has been your role in Blue Cross Blue Shield of Vermont's response to the pandemic?

A. So I've played a role in the pandemic response, including the responses toward providers, toward, toward patients, toward stakeholders, and then, you know, internal policy work as well.

Q. In your prefiled testimony, you provide details about that response. Would you please briefly summarize for the board what Blue Cross Blue Shield of Vermont has been doing during this unprecedented time?
A. Vermont has been a, a real success story so far. We worked very fast as a state and also as a company. I think that the Governor deserves kudos for the rapidity with which he shut down the businesses initially in March, and I also think that, because of our demographics, we were fortunate and we were way ahead of the rest of the country.

I started watching this pandemic in January when it first started as it, and then through February as it marched it's way across the world, and we became concerned pretty early on that this was going to have a major impact on our own company as well as on our members, and our goal was to keep our members safe and to keep our company functioning.

So I don't want to repeat all of the details of what we did to connect with stakeholders and regulators to keep everything moving, but I want to explain how we targeted our resources to areas that were of particular concern. So the first concern, well, we wanted make sure providers could still care for their patients. I ran a practice. I know firsthand what the impact of

this is to these practices. And so my, my first question when all of this started was, How do we help to keep these practices open?

I knew what the challenges were going to be, and so one of the things that we did was I recommended to DFR that they join us in promoting telephone care as a part of, as an extension of audiovisual telemedicine during this emergency so that patients could get the care that they needed and so that providers would be able to keep their doors open, especially these small independent practices who were clearly going to struggle as a result of the pandemic and don't have as, as deep a financial bench to be able to support themselves.

We took many steps in that area to support virtual appointments, make it easier for people to get prescriptions filled, to change policies virtually overnight so that we could remove barriers to care. Our second thing was that we wanted to make sure that we could keep people safe. So we worked with DFR to ensure that people with symptoms could get evaluated without any concern for copays or for cost share associated with their emergency room visits or their office visits or their urgent care visits.

And we wanted to also approve, we approved all

transmission of, of Covid-positive patients, because we wanted to keep family members safe. We wanted patients to start from the hospitals to be able to come home and not expose their family members on the trip home if they needed to continue to be isolated.

We also wanted to support the system as we prepared for what was, and is, still very unknown. So we suspended prior authorization requirements for hospitals so that they could move patients around within between nursing homes and hospitals and between different types of facilities to prepare for any kind of a surge that might come. And we also wanted to keep people covered. It's incredibly important, and we recognize that Vermonters were having difficulty with payments. So we offered flexibility, and we have not, to date, cancelled a single QHP member for nonpayment.

Q. Thank you, Dr. McIntosh. Are you generally familiar with the proposed rate that Blue Cross Blue Shield of Vermont is requesting in this proceeding?

A. Yes.

Q. And, understanding that Mrs. Schultz will address the actuarial basis for the rate in detail, to your knowledge, are increasing drug costs part of the reason for the rate increase?

A. Yes. I know that there are certain categories of

specialty drugs that are definitely cost drivers.
Q. Are you able to provide some concrete examples to illustrate this point for the board?
A. Yes. There are many, but I'll take one in particular. So melanoma treatment is an excellent example. Melanoma used to be a death sentence, and, in fact, when I was a resident, I had a colleague who died very young from melanoma. So I know this personally.

The amazing new treatments for melanoma have made melanoma essentially a chronic condition. This is a miracle drug, and there are many of these out there for all kinds of other treatments. They extend life, they preserve life, but they are extremely expensive, and, because of their nature as a biological agent, they don't come out as generic. So they are, they are, they remain expensive. There are many new oral chemotherapy treatments, for example, on the market that will come available for cancers that never previously had treatments, and this is very exciting, but it is also a real driver of our, of our overall cost.

The other thing that has come over the horizon are the new treatments for gene therapies, which are some of the most expensive drugs out there. Actually, they are the most expensive drugs out there. The first gene therapy has come on the market. It is a treatment for

a condition called spinal muscular atrophy. It costs $2.1 million for a dose of this medication. There are approximately 600 additional gene therapies in the pipeline, almost all of which are likely to be priced somewhere between a half a million dollars and $2 million per dose.

So these are life-saving treatments, which is good news, but the cost of these drugs raise very complex policy issues, and, as you know, these are often discussed in other forums, but for our purposes the costs are real, they're steadily increasing, and we do have to account for them in the rates.

Q. And, Dr. McIntosh, are you familiar with programs that Blue Cross Blue Shield of Vermont is implementing to reduce the cost of health care while maintaining the quality of care?

A. Yes. That's part of my work as the Director of Quality. So, as the Director of Quality, my focus is on value, and value is the intersection of cost and quality. So a high-cost product may produce a high-quality result and the value may be appropriate, or a high-cost product may not produce a high-quality result, and we would consider that to be low-value care.

So one of the challenges and the things we are

really working to do is to remove low-value care from the market, and by doing this we're trying to align the cost of a service and the quality of it so that we can get a sense of where those areas of high-value care are and where those areas of low-value care are.

Q. Is there an example of a value-based product change that you could describe in more detail to the board?

A. Yes. So our new laboratory benefit manager called Avalon is a good example of this approach. Avalon takes an approach to laboratories that addresses, that, that looks for what are high-value tests that are being done and what are low-value tests that are being done, and they use their medical policies, which are beautifully written, by the way, to distribute care as what is high-value for a chronic condition, what is low-value for a chronic condition.

So, for example, it is important for all adults to have their cholesterol level checked at least once, possibly once a year, but it isn't necessary to have a cholesterol level checked six times a year. And the wonderful thing about Avalon is they promote this high-quality care with no impacts on the providers. So the providers are not forced to go through prior authorization or any process like this, but, at the

same time, Avalon is promoting this much more revolutionary approach to high-value care.

In the past our lab reimbursement was pegged to Medicare, and it was a good system, but bringing in a partner with this expertise in lab value is an even better approach, and we're trying to move beyond where the industry is right now in fee-for-service into this high-value model, and we've already seen better outcomes with Avalon, and those savings are reflected in the proposed rates.

Q. With respect to the proposed rates, another element of the rates is administrative costs, and, again, understanding that you're not an actuary, is it your understanding that programs to improve quality may have administrative costs to implement?

A. Yes, they do. The transition from fee-for-service to value requires initiatives, and those, and the cost of implementing those initiatives. As we struggle to balance our needs to keep costs low while simultaneously developing these new programs and these initiatives to improve the value of health care overall, there is a cost to try to move to that value.

Q. Is there an example of a program you could describe to the board where, in your view, the cost of the program is justified by the outcome?

A. Yes. A good example of this program is our Provider Passport program for radiology. So we designed that program to reduce the burdens on the providers while simultaneously prompting best practices. So what we did was there are certain types of specialists who order a lot of tests, and, if they order a lot of high-cost radiology tests, they can qualify for this program.

Overall, if their referral rate of these tests is within best practices with a variance of only 2 percent, so, in other words, if 98 percent of the tests that they order are within best practices for these high, high-cost tests, then we have removed their need for prior authorization.

Now, we know that we will see perhaps a light increase because those 2 percent of their tests that are not within best practices are still going to go through, but we feel as though the value there is greater than the, the value is greater than, than the risk of that increased cost, because we're getting high quality and lower burden on the providers.

We also have a second track where, if you have a, about a 95 track record of best practices, then we waive PA, but we do education to try to explain to the individual provider why it is that the 5 percent of

tests that they're ordering again are not necessarily best practice, and we're hoping that, with that, we will see them move into the 98 percent range.

So what we're doing is we are accruing a little bit of extra cost for the tests that might not be necessary, but we are substantially decreasing provider burden for these providers who are demonstrating that they can come into line with best practices. And providers can move in and out of this program depending on what their track record is.

But the, the monitoring, the education, the continuing education, and the development of these programs all come into the administrative cost, but we feel that the, that the value of this program to decreasing burden and promoting the quality of care, overall quality of care, is worth it.

Q. Thank you. To shift gears briefly back to the pandemic, Dr. McIntosh, did you work with Mr. Schultz and the actuarial team on modeling potential financial impacts related to COVID-19 on Blue Cross Blue Shield of Vermont?

A. Yes, I did.

Q. Would you please briefly describe the role you played in that process?

A. Yes. Well, I reviewed 33 categories of care, and

we assessed whether those specific types of care and the developed, and whether we thought that they were likely to be deferred care or care that had simply disappeared out of the system. So, with each of these categories, we developed a function for the return of care for that service category.

So, overall, we estimated that 56.1 percent of services that were deferred during the slowdown would be made up. And I also assisted in then also developing assumptions about changes in demand for certain claim areas that we're likely to see differently in the future as a result of the pandemic.

Q. Have you read the Oliver Wyman report that was submitted by the Department of Financial Regulation?

A. Yes, I have.

Q. So I want to direct you to Exhibit 10, and specifically Page 7 of Exhibit 10.

(Exhibit 10 was shown to the Witness.)

A. Yes.

Q. Is that the Oliver Wyman report?

A. Yes.

Q. Is there any part of that report that you would like to respond to?

A. Yes. So Oliver Wyman suggested that our model was conservative, meaning that our estimates for the return

of deferred care were too high. I think that they particularly suggested that it, that our estimations of 100 percent in some categories were too high, and I have a couple of responses to that.

So, first, we quickly realized when we started to do the math that major changes like 100 percent, 95 percent, or even 90 percent have really very little impact on the model. So, with some categories of care, it's very like that the return is going to be 100 percent, and in our model it's also in some areas of care that we calculate the return as being zero. Now, maybe some of those zeros are going to turn out to be 2s or 3s or 5 percent, and maybe some of the 100s are going to be 95 percent or 92 percent, but that level of difference doesn't change the outcome enough to matter.

So, second of all, I think that Oliver Wyman may have been thinking about a shorter timeframe than we were. So we were asking the question, How many of these claims are going to return over the next two to three years? So, for example, if your knee is scheduled to be replaced and you're schedule for a knee replacement and then the pandemic intervened, sure, you might postpone that surgery for a few months, but the fundamental reality is your knee sill hurts every time you walk, and, at some point, that pain is going to be

frustrating enough that you are going to go in and you're going to have this surgery done.

So that is part of our anticipation, that we are going to see this catch-up because many of the things that we see deferral on are the kinds of things like chemotherapy, for example, that are not simply going to go away. If you, if you deferred your chemotherapy, you're still going to get your complete course of chemotherapy. If you deferred your knee replacement, you still need a new knee.

And, third, what we're seeing in June is the care did come back. Frankly, I was actually surprised at how high the care returned to things like emergency room. I thought that we were going to see a prolonged session of inhibition where people were going to be afraid to go to the emergency room, but, in fact, the ER has come back above benchmark, and office visits are coming back strongly as well.

We've also seen a surge in mental health claims as a result, probably, of the pandemic and of the stress that people are under. And then, finally, we know that Vermont hospitals and providers are strongly encouraging people to come back, and they're adding hours on the weekend and even and after, you know, traditional office hours to accommodate that higher

demand for those deferred procedures.

Q. If Vermont experiences an increase in Covid infections above current levels, would you expect a similar slowdown in claims as we saw in the spring of 2020?

A. Generally, no. Hospitals across the country are working very hard to figure out how to care for Covid and non-Covid patients at the same time, and hospitals are highly motivated to get their service lines up and running again despite a kind of baseline level of Covid that's going on in the background.

So I think it's going to take a lot more than the, the sort of lower levels that we saw in March and April to prompt the kind of shutdown that happened in March. I think we're much more likely to see an ongoing combination of regular, ongoing care and then outbursts of Covid that are getting treated also separately in the same institution that's figured out how to split their care.

MS. ASAY: Thank you. I think that's all I have for now if I could just have a minute to go over my notes.

MR. BARBER: Of course.

MS. ASAY: Thank you. I have not further questions at this time.

MR. BARBER: Okay, thank you. Mr. Angoff, do you have questions for Dr. McIntosh?

MR. ANGOFF: Yes, I do.

CROSS-EXAMINATION BY MR. ANGOFF

Q. Good morning, Dr. McIntosh. You said that, nationally, there are between 60 and 70,000 cases being reported today of the coronavirus; is that right?

A. That's new cases per day, yes.

Q. Okay. But in, in Vermont, though, it's between 19 down to -- what did you say the range was again, 19 and 4 and 19 and 2?

A. 2 to 17.

Q. 2 to 17? Okay. So what do you attribute the, you know, enormous difference between what's happening nationally and what's happening in Vermont? What do you attribute that to?

A. So I think there are a variety of reasons that we're seeing that difference between Vermont and the rest of the country. The first is that I think we can give credit to the, to the governor that we shut down early and hard, and, if you listened to his report, his, his presentation on Friday, he also refers to that the opening back up of Vermont has been conservative and that we're falling, we're less conservative than the European countries but more conservative than a lot

of the country. And so we're staying in that conservative place, and that's part of why we've managed to not see a stark increase in cases.

But I also think that it's important to remember that we have also been lucky, and we cannot underestimate that. One of the things that I would point you to is in my prefiled testimony I refer to South Korea. South Korea looked a lot like we look now. They, they had the pandemic under control, and then they had an unexpected superspreader event that launched them into an out-of-control wave. So it doesn't take much. It only takes one individual who may not even know they have symptoms in a large gathering to have a superspreader event that changes these numbers. I don't want that to happen. I would like to stay where we're at right now, but we cannot take it for granted.

Q. And so you said the governor deserves credit. I'm sure he does. What about the people of Vermont? Have the people of Vermont done anything differently than people in other states?

A. Not really. I think that there was -- I think that we have -- I think that the biggest thing that we did was we shut down before the cases came to us. If you look at our levels of personal distancing, for

example, or our levels of our loss of mobility relative to other states, which there are lots of, of graphs and websites that, that model these, they do mathematical modeling of this, our decrease in our interpersonal spread has not been particularly different from other states.

We dropped down to about 50 percent of, from our normal movement around. When we shut down, we dropped to about 50 percent. We didn't drop to 20 percent. We were pretty much in line with Mass or with, you know, New Hampshire, Maine, and Connecticut, and we've been coming up just about the same way.

We, I would say that mask wearing, we are not consistent across the state. So I, there are other states where mask wearing is much more prevalent and states where mask wearing is less prevalent. So I think we fall kind of into the middle of the pack.

I think we benefit from our rural nature and from the fact that we closed schools very early. But it, it, we cannot take it for granted. You know, we, we are all the same protoplasm in this state as everyone is in every other state, and Covid will spread in Vermont same way it will spread in Oklahoma or Tennessee, given the opportunity.

Q. Sure, but Burlington's not Oklahoma City,

Burlington's not Nashville, let alone Burlington being New York or Boston. I mean, how much do you attribute Vermont's success in containing coronavirus to the fact that there are, no disrespect meant to any people within Burlington or Rutland, but there are no big cities in Burlington, in Vermont? How much, how much does that contribute to Vermont's success in containing the coronavirus?

A. I think there's a question if lower population density is a positive, but with lower population density also comes smaller academic medical centers and less medical reserve. So, again, what the, the per capita rates are probably worth looking at as opposed to the, the absolute numbers for that reason.

Q. Well, sure. And however way you look, whether you look at per capita or absolute numbers, isn't it the case that Vermont is the best in the country?

A. At this moment, Vermont is the best in the country, but past success is no guarantee of future success.

Q. Well, certainly, but you'd rather have that past success than past failure, wouldn't you?

A. I think we know what to do. The question is whether we will get unlucky and have a superspreader event or whether we will relax too quickly the way the

south did accidentally and see another surge.
Q. So you worked with Paul Schultz on doing the projections of how much the coronavirus would cost Blue Cross over the next year or two, right?
A. I ran the projections for the return of care. I did not run the actual numbers.
Q. Okay. So you just said that today they're between 17 and 2 cases, the range is between 2 and 17 cases per day in Vermont, right?
A. That was for the first two weeks of July. That's not for this moment right now.
Q. Okay. So between 2 and 17 for the first two weeks of July. What did you project would be the number of cases that Vermont would have over the rest of the year, how many per day?
A. We did not. The, the pandemic was not part of our calculations. Those numbers, those numbers are included in the scenarios that Paul Schultz ran, and he can tell you about those.
Q. Okay. Maybe I should ask him, but let me just make sure I understand. You're saying, obviously, Blue Cross came out with a projection that projected, in fact, that it would pay out $339 million in, in 2021, in 2020, sorry. In order to do that, you have to assume, don't you, make an assumption as to the number

of coronavirus cases that would occur each day, don't you?

A. I'm afraid I am the wrong person to have this conversation with, because my role was limited to solely projecting what percent of deferred care was going to return to, that we projected was going to return over the next two to three years. I was not part of the calculation of those numbers. So I would ask you to talk to Mr. Schultz about that.

Q. I will, thank you. In your prefiled testimony, you also say that, as of June 30th -- I find this hard to believe no matter how successful Vermont is -- that the number of Vermonters currently hospitalized for COVID-19 is one. That's not a misprint, right? That was true then, June 30th, correct?

A. That was correct as of June 30th, and, as of yesterday, the number hospitalized was four.

Q. I'm sorry. Say that again.

A. As of yesterday, the number hospitalized was four. So the number will change.

Q. Okay. And do you know, by the way, on June 30th was that one person Blue Cross insured?

A. I don't know that.

Q. Okay. And then, then I guess you don't know what the four people today who are hospitalized, you don't

know whether any of them are Blue Cross insureds?
A. No.
Q. So I'll take you up on your invitation and ask Paul Schultz about the projections of the number of people that will be hospitalized. So you didn't make a projection as to the number of people who will be hospitalized because of coronavirus for the next year, correct? That's Paul Schultz's job?
A. One of the things that I said in my prefiled testimony is that future projections are very difficult to make with regard to coronavirus.
Q. And you didn't make them?
A. No.
Q. Okay. But you did make a projection as to how many people are going to come back and get care that was deferred, right?
A. Yes.
Q. Okay. So how did you do that? For example, in that you, you projected that 100 percent of the people would reschedule all laboratory services, all radiology services, all durable medical equipment. That's like the scooters you see on TV that they sell on late-night TV; that's durable medical equipment?
A. So that's not actually accurate. We didn't do that.

Q. Okay. Would you please turn then, Dr. McIntosh, to Exhibit 17, Page 19?

(Exhibit 17 was shown to the Witness.)

MR. BARBER: While we're getting there, can I just ask does anyone hear an echo?

CHAIRMAN MULLIN: Yes.

MR. BARBER: So, if everyone could just make sure their line is muted, except for Jay Angoff and Dr. McIntosh, that might help.

DR. MCINTOSH: So, as you will see, if this what we did was we looked at chronic illness, and we looked at acute illness. So in our numbers -- and I'm sorry.

MR. ANGOFF: Dr. McIntosh, I'm sorry. I was having trouble hearing you. You were breaking up. Mr. Barber, can you hear?

MR. BARBER: I can hear everyone, but I'm getting a pretty wicked echo.

MS. ASAY: I'm wondering if we should try to figure out who it is if we have Dr. McIntosh mute and Mr. Angoff, vice versa.

MR. BARBER: Yeah. Jay, if you mute your line and then, Dr. McIntosh, could you try speaking?

DR. MCINTOSH: So when we -- it's only slightly better. Sorry. When we did numbers, we

looked at --

MR. BARBER: Why don't, I guess, Christina, do you have any suggestions about that?

(A discussion was held off the record.)

DR. MCINTOSH: So what we did when we were looking at our numbers was we asked ourselves what conditions are going to go away and are not going to come back. So, for example, if a patient was seen in the emergency room and they had, if a patient would have been seen in the emergency room for influenza back in April and they chose not to go to the emergency room, then they were not going to come back in June for that emergency room visit that they missed in April. Does that make sense?

Whereas, so, if they had gone to the emergency room in, in April for a sprained ankle, for a chest x-ray for an acute illness, for a, for anything that was not going to reoccur, if they had had pregnancy care, that was not going to come back because the baby has arrived, they're not going to show up in July for pregnancy care that they missed back in May. Same with the acute care that has to do with acute illness.

But, if they have a chronic disease where, for example, they need regular CAT scans to follow up their illness, for example, they have cancer and they need

regular CAT scans to curtail a recurrence of illness or, if they have an ongoing condition that requires monitoring of blood work, that those were going to return 100 percent, So, or close to 100 percent, and, like I said earlier in my testimony, that 95 percent to 100 percent that, that was not relevant.

So, you know, it's pretty much going to come down in the same way. So those were the sorts of decisions that we made. For example, with immunizations, we decided that immunizations, that we hoped that they would come back all the way. We weren't entirely sure that they would, but we hoped that they would come back all the way, because they're a national concern in the, about the decrease of measles vaccine as a result of the pandemic and concern that we will get concurrent cases of measles along with our COVID-19.

BY MR. ANGOFF:

Q. Okay. Please tell me if I'm causing an echo or if anybody can't hear or I'm breaking up. But, Dr. McIntosh, how did you decide that 100 percent of all lab work would come back and 100 percent of all x-rays? How did you decide that?

A. You mean how did we decide that 100 percent of the chronic x-rays would come back and 100 percent of the laboratories?

Q. No, you don't say chronic. You say 100 percent of both chronic and other radiology is going to come back and a 100 percent of both chronic and lab work are going come back. That, what, what did you base that on? Did you base that on experience? Did you base that on any studies? How did you come up with that 100 percent?

A. So the, when we did our numbers, we did not define that, that acute radiology and other acute laboratories were going to come back 100 percent. So I did not -- I am not the submitter of the article that you're talking about. So I would suggest that you talk to Paul about, about what is on the page. But, when we did our modeling, we assumed that chronic radiology for chronic disease would come back at or close to 100 percent and chronic laboratory monitoring for chronic decease would come back at or close to 100 percent and that acute care which had resolved would not come back.

Q. Okay. So if, if, if this says 100 percent for both, that's inaccurate? That is, if this says 100 percent for both chronic and other, that's inaccurate?

A. So you would have to talk to Paul about the definition of laboratory other, because I cannot make the assumption from looking at this that laboratory other means acute care. So I did not submit this. So

I would encourage you to talk to him about that.
Q. That's fine. I will. Dr.McIntosh, under what conditions, if any, does it make sense to compare the course of the coronavirus in New York City -- strike that.

Under what conditions, if any, does it make sense to use the course of the coronavirus in New York City as an indicator, a potential indicator, of what the course of the coronavirus could be in Vermont?
A. This is a brand-new disease. It is an emerging illness. We know almost nothing about it. It has been in our lives since January or perhaps December of 2019 or January of 2020. The amount that we do not know about this illness is unbelievable. It is, it is behaving in ways that we would never have thought possible.

In May, in March we thought this was a respiratory virus. Now we know that it's much, much more than a respiratory virus. Now we know that it is a vascular virus, that it inflames blood vessels, that it impacts the individual anywhere it touches them, whether it is in their brain, whether it is in their feet, whether it is in their lungs, whether it is in their heart, whether it is in their kidneys. It causes kidney failure, heart failure, long-term stroke, long-term

disabilities, severe illness, prolonged intensive care unit stays, and we know almost nothing about it.

Q. So are you saying --

A. It seems to be naive to assume that we can discount the experience of any state, just as it would be naive to assume that Vermont will be immune because we somehow are special.

Q. Dr. McIntosh, what's the population of Vermont?

A. 600,000 people.

Q. Dr. McIntosh, what's the population of New York City?

A. More than that.

Q. It's about 8 million, isn't it?

A. I don't know, honestly.

Q. People are packed closely together, aren't they?

A. Again, remember, the importance here is not the absolute number of cases; it is the number of cases per capita. Because what it takes to overwhelm our facilities is very different from what it takes to overwhelm the facilities of a much larger metropolitan area.

Q. In the report that you worked on with Paul Schultz -- and, if Paul Schultz is the one I should ask about this, I'd be happy to -- do you know why did you all use New York and Albany and Boston as comparables to

Vermont with 600,000 people rather than New Hampshire and Maine or Nebraska or the Dakotas? Why did you compare Vermont to the places where, that have had some of the worst outbreaks and have the most densely populated populations in the country? Was that a fair comparison? Were they really comparables?

A. So, again, I would defer to Paul for those reasons, but I would reiterate that it is critical for us in Vermont to gather information from every possible area that we can, because we know so little about what this virus is capable of doing.

Q. Okay. Just a couple more questions. Dr. McIntosh, you're projecting that a vaccine will be available in 2021; is that right? By the end of -- what did you say? What are you projecting as to when a vaccine would be available?

A. I'm not sure we put a firm number on a vaccine projection, because I don't know that anyone can put a firm number on a vaccine projection.

Q. Okay. Could you please turn to Page 8 of 14 of your prefiled testimony that's Exhibit 13?

A. Um-hum.

Q. Are you there?

A. No, not quite. Yes.

Q. Okay. So you see the last question, What's the

potential timeline for a vaccine for COVID-19? Then you see there the second, the third sentence says that the prevailing hope is for the National Institute of Allergies to develop and implement a vaccine by the end of 2021. Do you see that?

A. Yes.

Q. Okay. So how realistic is this in your view?

A. It is a prevailing hope. It is a prevailing hope of the National Institute of Health, and it is a prevailing hope.

Q. Okay. Then I assume you don't, you don't believe that that's a realistic probability, a vaccine to be ready to go at the beginning of 2021?

A. Honestly, there are many people much, much smarter than I who have opinions on this, but I am not able to. The entire world is working very hard to find a vaccine solution, but any vaccine solution is, also requires being rolled out, and it is a prevailing hope among the folks who know way more than I do and at NIH that it is the timeline, but I would not even pretend to be enough of an expert to be able to give any kind of projection.

Q. Dr. McIntosh, do you know how much Blue Cross has paid out in 2020 because of coronavirus?

A. I would defer that to Mr. Schultz.

MR. ANGOFF: Very good. Thank you. I have

no more questions.

MR. BARBER: Okay. Next, we'll going to the board and then an opportunity for redirect. So I'm going to call on individual board members just because of the setting. So I'm going to start with Member Holmes.

MS. HOLMES: Okay. Great. How you doing, Dr. McIntosh?

DR. MCINTOSH: Good.

MS. HOLMES: Good. I actually just have one question for you. Thank you for your testimony. I appreciated it. And it was with respect to some of the work that you're doing to remove the low-value care from the system, which I really appreciate. Do you have -- actually, I have a couple questions around that. Do you have an estimate of how much of the care that's currently being delivered you would say is low-value care in Vermont?

DR. MCINTOSH: I would love to be able to have done that modeling for you. I haven't. I think that there there is always disagreement about the definition of value, but modern models of how care health care do range, and, as I think you know, there are ranges of approximations. Some people say it's as much as 40 percent. Others say it's 25 percent.

I also think that it depends on the specialty. There are certain fields where there's more low-value care, and there are certain areas where there's more high-value care, but I do think that this conversation about value is important and we need to have it.

MS. HOLMES: Is that something that -- you said, you know, you wished you had modeled that, but is that something that you, going forward, are going to try to model at Blue Cross Blue Shield, you know, the level, the degree to which there is low-value care and if it varies by specialty, varies by hospital service areas, things like that? Is that something, you know, going forward that you might be doing for modeling?

DR. MCINTOSH: Well, we've already done a fair amount of it. So we've done it for certain service lines, and we've done it -- we did it for laboratory, which is why we went with Avalon. We had done it to a certain degree with radiology, which is, which we have already done, and many of our prior authorization policies are written based on the fundamental data of value as opposed to cost.

We are looking at what best practices are, but there is no cohesive push toward value-based care within the state as a whole, and, and I think it's a wider conversation that we need to have at the hospital

level, at the Green Mountain Care Board level, at the practice level about what this, and at the ACO level about what this move to high-value care really looks like.

MS. HOLMES: Yeah, I hope we can have those conversations. So, I guess, with regard to that Provider Passport for radiology, I'm wondering what proportion of providers in your network have the passport at the, you know, 99, 98 percent level or fit into that, you know, only 2 percent of their referrals were considered not high-value care. What proportion of providers actually have the passport right now?

DR. MCINTOSH: So it's important to remember that the passport program only, we can only look at a pool of providers who order enough high-cost testing to be able to fall into the category. So there are very few, if any, primary care providers on that. So it is, by its nature, a very low percentage, because most of the very high-cost tests are ordered by specialists, so, and most primary care providers don't order enough of these specific high-cost tests that we're looking at to be able to even qualify.

So we had to have a threshold at which we cut it off for, because you couldn't base your decision about whether someone provides high-value care if someone

only orders one MRI a year or two MRIs a year or two MRIs on different subjects, right? It had to be a pool of individuals who order enough of a single high-cost test to be able to see that they were being effective or enough of a series of high-cost tests in a particular category.

So it is, by its nature, already a small program, but it's the kind of program that we really want to be able to push out further, but, again, we need provider cooperation and buy-in to, to be able to have a global conversation about value, and we, and even sort of regulatory buy-in to have a global conversation about value to be able to push these things forward, because it gets tricky when you get to the micro level. You know, it's a great idea at the higher level, but it's tricky at the micro level, and we need everyone to buy in to be able to do that.

MS. HOLMES: Okay, all right. Thank you.

MR. BARBER: Mr. Chair, I see you have your hand up.

CHAIRMAN MULLIN: Yes. I thought that I was supposed to do that. I do have questions. I'll go at this time or whatever you'd like, Mr. Barber.

MR. BARBER: I was going to give you the last shot, but, if you want to go now, why don't you go now?

CHAIRMAN MULLIN: Okay, fine. Good morning, Dr. McIntosh. I was fascinated by your testimony, especially on the specialty drug end. I can show you that I just had my fourth melanoma removed and wasn't even aware that there was a drug that could even treat melanoma, but, you know, when I was a kid, we didn't know what sunscreen was, so that happens.

What level of care in an emergency room would you consider to be inappropriate based on your professional knowledge?

DR. MCINTOSH: I'm afraid I don't understand the question.

CHAIRMAN MULLIN: So for years it's been good health policy to try to encourage some utilizers of emergency rooms to seek primary care oversight instead, and I'm just curious. One of the things that was hit the hardest during the pandemic was the use of emergency rooms. I'm just curious what level that you believe probably shouldn't have been there to begin with.

DR. MCINTOSH: Oh, I see what you're asking. So I, I think what I hear you asking is we saw a significant decrease in emergency room utilization. Of that, how much didn't need to go, and how much was individuals who might have needed care but chose not to

go? I think the honest answer is we don't know yet until we study that, and I think places like New York City that saw a real decrease in their emergency room population are going to need to answer that question in retrospect.

Because you're right. There is this question of how many people end up in the emergency room because they're impatient and don't want to wait until tomorrow or because it's something that's more mild or because it's something that they're scared about but doesn't necessarily need to be seen and could be seen from a phone call or some other visit with a primary care provider and how many visits are critical. We did a grand experiment on New York City, and we are now doing that same experiment in Houston and all over the rest of the country.

But the answer to that question lies in the, in the statistics and the studies of it, because it's a complex, it's a complex question, and I don't have a particular answer for you. There, there are probably standardized numbers of how much emergency room care is felt to be low-value, but I don't have those at my fingertips.

CHAIRMAN MULLIN: Okay. So, likewise, we've heard a number of stories about fear in the minds of

people that should be consuming care and aren't going. Have you seen any professional analysis of what that number could be as far as the population's fear of returning to a medical setting?

DR. MCINTOSH: I don't think that the individuals who are studying that have landed on a particular number yet. There's a lot of chatter about it, and there have been a few changes in the mortality rate from the heavier hit areas that have been put in place, but I, I think that the jury is still out and the actual science has not really had time to do those numbers yet. That will come. We will know that, but it may take several years.

CHAIRMAN MULLIN: Doctor, you testified that you haven't cancelled any QHP members, which is very good, and thank you, Blue Cross, for putting in place that policy. Can you tell us how many members are in arrears currently and how that compares with the normal number would be this time of year?

DR. MCINTOSH: I cannot. I would defer you to Ruth for that, because I'm afraid that is outside my purview.

CHAIRMAN MULLIN: Okay. And you spoke about the current number of cases in Vermont. Can you address the trends as far as hospitalization rates and

death rates?

DR. MCINTOSH: So Vermont was very fortunate, has been very fortunate with Covid. We have had a relatively stable death rate. I think we've maxed out at about 56, and we haven't moved from there for a while. Our hospitalization rates are, are percolating along under 5 right now, but, again, it's important to remember that past success is not a guarantee of future, of future success.

CHAIRMAN MULLIN: Yeah. And, of those hospitalizations, do you have any type of indication of what number of those would be Medicare patients as opposed to commercial insurance?

DR. MCINTOSH: I don't. The numbers of who is hospitalized are coming from the Health Department, and they don't parse it by insurance carrier. So I think that Paul probably has more information for you on that, but I don't have it at this time.

CHAIRMAN MULLIN: So Paul would be the person to ask about the number of people that Blue Cross has seen as members hospitalized?

DR. MCINTOSH: Yes.

CHAIRMAN MULLIN: Okay. I think that's it that I have for questions, Mr. Hearing Officer.

MR. BARBER: Okay. Next, we'll go to Member

Pelham.

MR. PELHAM: Good morning, Kate. Can you hear me?

DR. MCINTOSH: Yes.

MR. PELHAM: Good. So one of the things I struggle with in this whole process is the kind of divergence of goals we have in the all-payer model, especially in this instance, the 3.5 percent total cost of care, you know, and getting to within those guardrails around that number in 2022 and understanding that part of that pathway to that end is our investments in offsetting population health measures.

So I just want to pick one that I've raised before, and it just, if I'm off base, tell me, but, it just seems to me like a big miss, and that has to do -- on, you know, page -- and you don't have to go, you know, go to the filing, but on in Exhibit 1 on Page 16, Blue Cross Blue Shield states that it continues to, and I'm quoting, "Continues to evaluate areas to achieve savings and improve the health and experience of Blue Cross Blue Shield Vermont members".

And one area that I have some concern about is the Vermont's Blueprint of Health sponsor a CDC-recognized national diabetes prevention program, life style change program. The program focuses on nutrition and fitness

to help Vermonters avoid diabetes. Vermont's Department of Health says, if left untreated, up to one in three people with prediabetes will develop diabetes within five years. Prediabetes is treatable, but most people with prediabetes do not know it.

And, you know, I know that Blue Cross Blue Shield has a program for diabetes, which is in your marketing material in your estimated to cost about $7,400 a year with, at least for the bronze plan, $51 a year coming out of the pocket of the ratepayer.

But my question is, Does Blue Cross Blue Shield Vermont's QHP proposed plans support compensated access to diabetes prevention programs or benefits inclusive of nutritional counseling and fitness programs that parallel those recommended by the CDC?

DR. MCINTOSH: So all of our current plans put, both the benchmark and the nonstandard support a wide range of options for diabetes treatment and prevention including nutritional counseling and the wellness drug list, which includes diabetes medications. We also have the Blue Extra Discount on many fitness offerings across the state. We recognize that our plan design can support members in their health and wellness goals.

And you're right. I mean, I think eventually the

goal is to switch to a, you know, is to try to really promote the preventive model. So we are continuing to collaborate with the ACO and with the Blueprint to develop and to offer targeted health programs for members.

Also, this year we're offering new nonstandard plan designs that are, specifically have benefits that are specified for members with a diagnosis of heart disease or diabetes, and so we're trying to kind of take a tailored approach there to try to help with, help with that prevention.

MR. PELHAM: Well, but my focus in the question is not diabetes; it's prediabetes. And so just a simplification. If, you know, I were to go to my primary care physician and they test me, blah, blah, blah, and they say, you know, Tom, you're prediabetic, and, you know, and I say, Well, Doc, what do I do about that, and Blue Cross Blue Shield is my insurer, is there a program that my primary care physician can send me to on an organized basis where I can, you know, get the kind of program that the Blueprint is running but, knowing that the Blueprint is running on a shoestring, I mean, it's, I've talked to people at the ground level in that program, and they maybe get a $1,000 stipend for a multiweek program.

But I don't find in the plan designs that are before us that there is a, an organized program for prediabetes that engages nutrition. I can see the nutrition is, for 90 bucks, you can get a 2 or 3 specialist visits, but there's nothing having to do with fitness, and I'm --

DR. MCINTOSH: So, so the nutritional counseling for prediabetes for individuals who are overweight, there are an unlimited number of prediabetic visits for nutritional counseling for people who are overweight. With regard to, to fitness, that becomes the question of doing a sort of full prediabetic program becomes an actuarial conversation. So the complexity of these chronic illnesses is something that would then have to be placed within the actuarial context of the cost of providing, you know, a fitness benefit.

MR. PELHAM: Okay. And so another area that's connected to this is the Vermont's Benchmark Plan, and, as I understand it, that plan goes back to 2012 or 2014 and basically predates the all-payer model, and it's targeted diseases, chronic diseases, etc. Do you have -- does Blue Cross Blue Shield have any interest in revisiting Vermont's Benchmark Plan to update it so that it is more consistent with the

all-payer model and the goals of prevention embedded in the all-payer model?

DR. MCINTOSH: So, as you know, updating the Benchmark Plan is a substantial process, and there are many stakeholders in it, and we would very much like to be involved in it and support any efforts to do that, but it is also worth noting that health care is moving toward a more tailored approach to medicine, and, given the complexity of individual chronic illnesses in Vermont, it might be preferable to have a variety of plan designed to meet the needs of many different health care profiles rather than to require an identical benefit enhancement for all consumers.

MR. PELHAM: So you don't see much value in reopening the Benchmark Plan and just trying to align, if, if it needs alignment, align it with the goals of the all-payer model?

DR. MCINTOSH: It's such a complicated model that I think I can't -- I don't think I would trust myself to say whether I agree or disagree at this time.

MR. PELHAM: Okay. And I had one more in your area. I thought that we were going to be asking questions all at one point in time, so I'm scrambling here a little bit, and, if I can't find it in writing, I can remember what it was.

I was looking at the $600 kind of a, you know, it was a -- no, that might not -- no, that's not you. Sorry. That's not you. I'm confusing you. So that's, that's good for me. Thank you for your answers.

DR. MCINTOSH: All right. Thank you.

MR. BARBER: Okay. Board Member Usifer?

MS. USIFER: Thanks. Good morning, Dr. McIntosh. I just have a couple questions really talking about the drugs that you were talking about earlier, and I guess the first one is, Do you have an idea, a ball park estimate, of what, what we spend on specialty versus generic versus how they're dispensed? Because I think, when I was reading through this, you know, basically, most of the prescriptions are generic versus the specialty, but do you have any perspective on what those percentages might be?

DR. MCINTOSH: So it's important when thinking about specialty drugs to understand that there are specialty drugs that are considered biologic and specialty drugs that are not considered biologic, and the biologic drugs did not have generics. So I want to put that out there, because some of the most expensive drugs do not have generics.

Most of the specialty drugs come through the medical channel and not through the pharmacy channel,

because these are drugs that are infused often in hospitals or doctor's offices or in outpatient settings, but they will come through the medical benefit rather than the pharmaceutical benefit, but not all of them. Some of the specialty drugs like the oral cancer therapy will come through the pharmacy benefit.

MS. USIFER: Okay. And, just talking about cost-saving initiatives and programs, you had on page, Exhibit 1, Page 164 there was discussion about the Civica RX, the joint venture which looks to be, I think, in 2022, potentially, and will be introducing certain generic drugs. It said, you know, this should be a significant benefit to Vermonters with the cost for generics, and I just want to get an idea if you had any perspective on what that would do to cost, what type of savings that would be. I don't know if that would be your area or someone else's area to talk to.

DR. MCINTOSH: Yeah, I'm going to leave the actual conversation about numbers to Mr. Schultz. But I, I do think that, you know, Civica RX is an exciting venture that we would like to be able to pursue. Again, this is one of these areas of innovation that we would like to be able to go down to be able to bring it in, to administer it, and to pass it on to the state of Vermont. But, as far as the actual numbers, I will

defer those.

MS. USIFER: Okay. And do you know of any other programs that you're involved with that could bring significant savings, whether it's through admin costs, you know, and when those would take place?

DR. MCINTOSH: Again, I'm going to defer that to Mr. Schultz, because, I mean, there are a series of things where I am looking at value, but there are not necessarily things that I'm looking at with particular, a eye particular eye to cost. So I will defer the cost questions to the finance folks.

MS. USIFER: Okay. Thank you. That's all I have. Thanks.

MR. BARBER: Okay. Board Member Lunge.

MS. LUNGE: Thank you. Hi, Dr. McIntosh. I hope you're well today. On the topic of cost-containment initiatives, in Exhibit 1 on Page 37, there's a discussion about a delay from some 2019 programs that you, well, witnesses from Blue Cross, not you personally, had spoken to last year, and those included reducing inpatient emergency, I'm sorry, inpatient readmissions, reducing ED admissions. I'm wondering if you're the right witness to speak to the, the delay in those programs.

DR. MCINTOSH: I am probably not,

unfortunately. I'm sorry.

MS. LUNGE: No, that's okay. I'm happy to ask someone else about that. On the discussion of the lab benefit, you testified that the lab benefit manager, Avalon, didn't use prior authorization as the mechanism for improving and promoting high-value tests and discouraging, if you will, low-value tests. So what exactly are they doing to do that? Is it educational? How does that work?

DR. MCINTOSH: So Avalon, it's important to say that Avalon has two business lines, and, at this time, we only use one of their business lines, and the business line that we use does not have prior authorization as a part of it. And, yes, it is an educational approach. Their medical policies are applicable to their laboratories, and their laboratory, they work to educate their laboratories, and the laboratories work to educate the providers on what constitutes high-value care.

MS. LUNGE: Okay. So they're not themselves reaching out to the providers; they're reaching out to labs, and then it's between the lab and the providers? Okay.

DR. MCINTOSH: Correct.

MS. LUNGE: Okay, thank you. I just wanted

to clarification so I could understand how it was actually working. In your prefiled testimony, which is Exhibit 13, on Page 13 you talked about the suspension of prior authorization for home infusion to allow increased utilization of that benefit during the emergency. However, home infusion was one of the cost-containment programs that was noted as being put on hold. Can you speak a little bit about the home infusion program, whether you've seen increased utilization in that area, and the future plans for this?

DR. MCINTOSH: So home infusion, there's a home infusion process or the home infusion process, the ability of a member to receive their infusion at home, is different from what was referred to as being an initiative that was put on hold. So the ability to receive home infusion exists in Vermont, and what we waned to do was to open that ability within Vermont in the, in the course of the pandemic, but that's not a, a sort of project to increase home infusion, which is what was being referred to before.

As to utilization and increased utilization, I'm afraid I don't have numbers on that --

MS. LUNGE: Okay.

DR. MCINTOSH: -- at this time as to what, as

to whether there was an increase in home infusion during Covid. But we do believe that home infusion ultimately is safer for the member, because they aren't exposed to things they might catch in the hospitals, and that was true before Covid, and it's doubly true now.

MS. LUNGE: Okay. And can you explain how the, the -- I mean, I understand how home infusion is available in Vermont, but what is the difference between that and the program that was put on hold? That's still not clear to me.

DR. MCINTOSH: So I have not been involved in the design of the program that was put on hold, so I'm afraid I can't speak to that.

MS. LUNGE: Okay, thank you. Sorry. I'm also finding my questions. I wanted to turn to telemedicine for a moment and some of the efforts that Blue Cross has done to open up the telemedicine, including the phone availability during the pandemic. In your prefiled testimony -- again, I believe it's on Page 13 -- you spoke to the preferred telemedicine provider. That should be on Line 6. Is that Amwell?

DR. MCINTOSH: Yes, that is.

MS. LUNGE: Okay. And is Amwell a national provider? What can you tell me about Amwell?

DR. MCINTOSH: Amwell is a national provider, but I think that it's important to note that the percentage of visits that we have with Amwell is in the very, very low single digits. It's less than 5 percent, and it, we did not see a substantive increase in the COVID-19.

So in the vast bump of, of, in telemedicine -- I think I actually presented those slides several months ago -- the vast increase to millions of dollars that we have seen in the utilization of telemedicine, we have really, we have not seen an increase in the use of our external vendor. So the telemedicine increase that we have seen has been overwhelmingly and almost exclusively Vermont-based providers providing telemedicine.

MS. LUNGE: Great. All right, thank you. So I'm glad, actually glad to hear that Amwell is not highly used, because my next question was going to be, How do you ensure that there's a connection back to the primary care provider, which I know that's something that you are passionate about as a former member of our Primary Care Advisory Committee.

DR. MCINTOSH: So, yes, Amwell does send those records on, but, at this point, it really has been a nonissue, well, or, rather, you have to get

permission, right, for the records to be sent on. So that, if the patient provides approval, that can happen, but the patient has to provide approval. And, but the vast majority of telemedicine has not applied. It has really been local Vermont providers providing care to Vermonters.

MS. LUNGE: Great. How, how did you take telemedicine into consideration when you were looking at the deferred care numbers and the model for Covid?

DR. MCINTOSH: We really didn't. The telemedicine, what is interesting about telemedicine is there are very specific areas where we have seen almost no decrease in care. Mental health, for example, is one of them. They made a very rapid shift to, to mental health. But, when it comes to trying to distinguish whether a provider is going to provide care by telemedicine or by office visit in person, we didn't really take that into account, because there is the, the payments are on par. The audiovisual telemedicine, and the office visit are on par.

So the volume of patient visits, the volume of patient visits -- and there was a little bit of a dropoff, and we did compensate for that to say that we thought people would be coming back into the office or become more comfortable with telemedicine, but, beyond

that, we really didn't, we really didn't sort of say, Is telemedicine going to impact us in any particular way?

MS. LUNGE: Okay, great. Thank you. Let me just check my notes, and I think I'm almost done. So, when you testified a few minutes ago about the surge in mental health claims, that includes the telemedicine claims?

DR. MCINTOSH: Absolutely, yes.

MS. LUNGE: Great. And then what is your source of information for providers adding hours on weekends or evenings?

DR. MCINTOSH: So we have had reports from various hospitals, from private practices that we've talked to regarding, specifically with regard to procedures that extra hours have been added, you know, surgical suites, you know, being run on the weekends, things like that.

MS. LUNGE: And how many providers did you speak with?

DR. MCINTOSH: I don't have those numbers, because I did not do that initial outreach. I will have to defer.

MS. LUNGE: Okay. Thank you. Okay. I'm done. Thank you. I'm all set.

MR. BARBER: Okay. Thanks, Robin. Do any board members have follow-up questions before I turn it over to Ms. Asay for redirect? Not seeing any takers, okay, Ms. Asay, do you have any redirect for Dr. McIntosh?

MS. ASAY: Just briefly, thank you.

REDIRECT EXAMINATION BY MS. ASAY

Q. Dr. McIntosh, if you could take a look at Exhibit 6, Page 47 in your binder, please?

(Exhibit 6 was shown to the Witness.)

A. Yes.

Q. So this is a, is this a different version of the chart that Mr. Angoff was directing you to?

A. Yes, it is.

Q. And, if you look at, just for example, the percent rescheduled services for laboratory and radiology, could you look at those numbers, please, briefly?

A. Yes.

Q. And what do those numbers say?

A. Those numbers show that chronic laboratories are expected to come back at 100 percent, and other is expected to come back at zero percent --

Q. How about --

A. -- and that radiology chronic is supposed to come back at 100 percent, and for radiology the other is

supposed to come back at zero percent.
Q. And how do those numbers comport with your understanding of your input into the modeling?
A. These numbers are consistent with the input into the modeling that we performed.
Q. Would you leave it to Mr. Schultz to explain the difference between this chart and one that Mr. Angoff directed you to?
A. Yes, I would.
MS. ASAY: I have nothing further at this time. Thank you.
MR. BARBER: Okay. Thank you. Mr. Angoff, looks like your video's off, but do you have any redirect or, sorry, recross on that, on that issue?

RECROSS-EXAMINATION BY MR. ANGOFF

Q. Just one. Dr. McIntosh, do you know which chart is right, the one that I showed you or the one that Ms. Asay showed you?
A. I would leave it to Mr. Schultz to describe the difference between the two charts, but what I will say is that Exhibit 6, Page 47, is consistent with the conversations that he and I had and what I've described to you earlier as our thought process.
Q. And Exhibit 17, Page 19, that is not consistent with what you understand the survey that you

participated in to be based on?
A. Again, that chart was not submitted by me, and, therefore, I will leave it to Mr. Schultz to explain that chart in particular.
MR. ANGOFF: Okay. That's all I have.
MR. BARBER: Okay. I got some feedback that we should take more breaks this year. So we're going to take a break to 9:55, just get a drink of water, stretch our legs before we move on to the next witness.
(A recess was taken from 9:48 a.m. to 9:55 a.m.)
MR. BARBER: Okay. I think we have everyone. Okay. I take it that Mr. Schultz is the next witness.
MR. DONOFRIO: That's correct.
MR. BARBER: Okay. So let me just give folks a minute to pin him if that's your preference.
MR. DONOFRIO: Sure. And I'll be conducting the examination if you want to swap me and Ms. Asay.
MR. BARBER: Are you good, Kevin?
CHAIRMAN MULLIN: Yeah.
MR. BARBER: Okay. So I'm going to start by swearing in Mr. Schultz.

P A U L S C H U L T Z,

duly sworn to tell the truth, testifies as follows:

MR. BARBER: Okay, Mr. Donofrio.

DIRECT EXAMINATION BY MR. DONOFRIO

Q. Thank you, Mr. Barber, and good morning to the board and Mr. Angoff and good morning, Mr. Schultz. Would you please state your name and occupation for the record?

A. Good morning. My name is Paul Schultz. I am the Chief Actuary for Blue Cross Blue Shield of Vermont.

Q. Did you prepare and submit prefiled testimony in this matter?

A. Yes, I did.

Q. Would you identify your prefiled testimony by exhibit number in the binder?

A. Yes. My July 7th prefiled testimony is Exhibit 11, and my July 13th supplemental prefiled testimony is Exhibit 15.

Q. Was all the testimony contained in those two exhibits true and correct to the best of your knowledge at the time you submitted it?

A. Yes, it was.

Q. And is it so today?

A. Yes, it is.

Q. Thank you. I'd like to ask you a few questions to quickly recap the rate filing that's under review in this case. Were you responsible for preparing Blue Cross Blue Shield of Vermont's 2021 Vermont individual

and small group rate filing, which is currently under review?

A. Yes, I was. The filing was prepared under my supervision, and I am familiar with all aspects of the filing and the underlying rate development.

Q. And did you certify the filing?

A. I did. At the time of, at the time of the filing, I certified that it meets all applicable actuarial standards of practice and that it also complies with all applicable state and federal laws and regulations, and that certification still holds true today.

Q. Would you please summarize the proposed rates contained in the filing?

A. Yes. The rates as proposed would produce an average increase of 6.3 percent.

Q. And would you please summarize the key drivers that resulted in the, the proposed rates?

A. Yes. One of the key drivers again this year was specialty pharmaceuticals. That accounts for about 3.7 percentage points of the total of 6.3 percent rate increase. As we heard from Dr. McIntosh, these are drugs that save lives, they improve quality of life, and in some cases they improve long-term affordability, but they are very expensive. Specialty drugs account for about two-thirds of what we pay for all

pharmaceuticals at this point. It's a staggering number. And that is split pretty evenly between the medical benefit and the retail pharmacy benefit.

In the absence of state or federal legislation that limits the cost of these drugs, we do need to include them in the premiums. This is one instance where we are prioritizing access to care over affordability. More broadly, in the, in the, we would be filing a trend increase of about 9.2 percent in the absence of actions Blue Cross took to mitigate that rate increase and in the absence of the repeal of the federal health insurer fee. Actions Blue Cross has taken working in conjunction with our lab and pharmacy benefit managers saved about $5 million from the proposed premiums.

Q. Mr. Schultz, on July 14th Michael Barber, the board's general counsel, sent a letter to Blue Cross setting forth some questions that Board Member Pelham had provided in advance to allow Blue Cross some advance notice to prepare for those questions. Did you have a chance to review that document?

A. Yes, I did.

Q. In, in Board Member Pelham's fourth question, it was a three-part question, and I'd like to ask each part so that you can provide some, some testimony in

advance to Board Member Pelham in the event he wants to follow up during his, during questioning time of the board.

The first part of his question asked has -- and I'm reading verbatim now, quoting from the document -- "Has BCBSVT observed over the past year and in its current trends analysis that the relationship of the cost shift to trends affecting premium rates has improved or deteriorated?"

What is your response to that question?

A. Yes, we've seen that premiums have continued to deteriorate because of the cost shift. We were able to use data that's published by the Green Mountain Care Board to estimate that 35 percent of all commercial payments to hospitals are due to the cost shift, and, if we were able to fully eliminate the cost shift for Vermont hospitals, premiums would be lower by about 17 percent.

Now, of course, the cost shift also impacts Vermont independent physicians, out-of-state providers, ancillary services, retail pharmaceuticals, but we don't have any public sources of data available that would help us estimate those impacts on the premium.

Q. The second question within Board Member Pelham's Question 4 asks, and I'm going to read verbatim again

here, "Is BCBSVT tracking Medicaid caseloads given the economic impacts of COVID-19 to gain insight into possible changes in the cost shift driven by higher Medicaid caseloads?"

What is your response to that question?

A. So, as part of this filing, we filed unit cost increases under the assumption that hospital commercial rate increases would be approved at the same level they were approved last year. If, in fact, commercial rate increases are approved at a higher level, whether that's because the cost shift is increasing due to a higher Medicaid caseload or for any other reason, then these rates would also have to be increased as Lewis & Ellis recommended.

Q. And the third part of Question 4 asks, and, again, I'm reading verbatim from the document, "If so, what actions might BCBSVT take or recommend to mitigate the impact of the cost shift on commercial insurance costs and rates?"

What is your response to that question?

A. So Blue Cross understands that the Green Mountain Care Board grapples with the cost shift every year as part of the hospital budget review, and we are supportive of any action that the board takes to reduce or reverse the cost shift.

Q. Question 6 in the document we received from the board asks whether Blue Cross, whether BCBSVT can reconcile the difference between the cumulative operating loss of $31,626,277 for 2015 to 2019 shown in the actuarial memorandum and the cumulative underwriting loss of $19,393,749 shown in Line 11 of the supplemental health care exhibit, which is Exhibit 20 in the binder. What is your response to that question?

A. Yes. So the supplemental health care exhibit is prepared based on statutory accounting. When we assess the performance by line of business, we base that upon gap underwriting results. So those two different accounting treatments give rise to a number of, of relatively small differences in results, but what's driving over 90 percent of the difference is that, for the supplemental health care exhibit, issuers are required to display an allocation of federal income taxes within the lines of business.

The reason for that is that the MLR calculation, which includes an adjustment for those taxes, is driven off of the supplemental health care exhibit. However, it wouldn't be appropriate when you're assessing performance by line of business to include the federal income taxes in that assessment. So we look at the gap

underwriting results instead.

Because federal income taxes has been, have been negative for Blue Cross over that five-year period, the loss reported in the supplemental health care exhibit is a lot less than the loss that's reported in the actuarial memorandum or through underwriting results.

Q. Mr. Schultz, if I could direct you to Exhibit 9 in the binder, please.

(Exhibit 9 was shown to the Witness.)

A. I'm there.

Q. And could you just identify that for the record?

A. That is the Lewis & Ellis actuarial opinion.

Q. Please turn to Page 23 of that document, and direct your attention to the recommendations section that's just about halfway down the page. Do you see that?

A. I do.

Q. Does your supplemental prefiled testimony, which is Exhibit 15 in the binder, regarding Lewis & Ellis's recommendations still accurately reflect Blue Cross's position with respect to these items?

A. Yes, it does.

Q. Would you please summarize the proposed rates as modified according to Lewis & Ellis's recommendations?

A. Yes. As modified according to the Lewis & Ellis

recommendations, these rates produce a 5.5 percent increase as compared to 2020 rates.

Q. And, with respect to the, the fourth bullet under the recommendations, the utilization trend, would you please explain why Blue Cross is not arguing against that recommendation today?

A. Yes. So Lewis & Ellis recommends that the utilization trend is reduced to 3 percent from the 3.6 percent that was incorporated into the filing. Both Lewis & Ellis and Blue Cross agree that it is necessary to normalize for population morbidity changes when performing a utilization trend analysis, but we disagree on the best way to do so. So, in light of the current social, economic, and health crises and to streamline the hearing, we are electing to forego a complex actuarial argument between two assumptions that are similar and both reasonable.

Q. And what is Blue Cross's position regarding the, the third bullet, which is entitled "Consider Updated Hospital Budget Information"? What is Blue Cross's position with respect to L&E's recommendation in that regard?

A. So we agree with this recommendation inasmuch as additional information becomes known about hospital unit costs. For instance, the July 31st hospital

budget submissions, that information should be incorporated into these rates. Because we haven't seen the hospital budget submissions, we don't know what kind of impact that's going to have on rates.

We have been able to do some sensitivity testing. As I explained in my prefiled testimony, each 1 percent increase above last year's approved commercial rate would require an increase of about .4 percent in premiums in order to fund that additional hospital revenue.

Q. Mr. Schultz, I'd like to turn to the modeling that Blue Cross has done around the COVID-19 pandemic. To begin, would you just please briefly recap Blue Cross's purpose in performing the modeling?

A. Sure. So it's impossible to know with certainty what kind of impact the COVID-19 pandemic is going to have on our claim costs in 2020, let alone in 2021, because nobody can foretell how the disease is going to progress, but what we can do is to model a number of scenarios and to calculate how those various scenarios would impact Blue Cross's medical claim costs and, in turn, its RBC. That's what we've attempted to do with this model.

Q. And are the results of the modeling process contained in an exhibit or exhibits in the binder, and,

if so, would you just, just give us the exhibit numbers, please?
A. Yes, they are. The, our original modeling is part of Exhibit 6, and our addendum to that modeling, our refreshed modeling, is in Exhibit 17.
Q. Now, you don't need to turn to the individual pages, but did you hear the testimony earlier during Dr. Kate McIntosh's testimony regarding some confusion between information that appears at Page 47 of Exhibit 6 and at Page 19 of Exhibit 17? Do you know what I'm talking about?
A. I do, yes.
Q. Can you clarify what is shown on those two pages, please?
A. Yes. So probably the easiest way to do so is to let you know that the exhibit, I'm sorry, the, the table in Exhibit 17 is mislabeled. So I want to take this opportunity to apologize to the board and to the parties for that. Totally my fault that that document is mislabeled. So, as we're looking at the assumptions that we made for each individual category, the place to find those correct assumptions is in Exhibit 6.
Q. Now, does that mislabeling that you described have any effect on the results shown in either document? I'll stop my question there.

A. No, it does not. The 51.7 overall result that is in Exhibit 17 is accurate, and the modeling that we did stemming from that result remains accurate. The, the problem is simply one of mislabeling. It is not a material issue.

Q. Would you please describe how you created and ran the model?

A. Yes, so, as Dr. McIntosh testified, I and my team worked with her to develop assumptions as to the portion of return in care that's, I'm sorry, the portion of deferred care that is expected to return. Under my direction, my team also worked to develop assumptions for a myriad of other things, such as the existence, duration, timing, and severity of a second wave, the timing and efficacy of a vaccine, and the frequency and cost of testing, among a host of other variables.

For each of those variables, we defined parameters or instructions for a stochastic model, and we did that by defining a range of reasonable results and a statistical distribution within that range. So, informed by the statistical distribution, the stochastic model then selects at random a point within the range of reasonable results. It does that for each assumption and then calculates the overall impact to

Blue Cross's medical claim costs and, in turn, its RBC.

We ran 10,000 simulations for each of 5 different scenarios as to the existence and severity of a second wave. This included a scenario where there is no second wave of illness or deferred care. This also included a scenario where the second wave looks exactly like the first wave did in Vermont, in other words, the best, the best job in the country of, of having low infection rates and low treatment costs, and we included 3 other scenarios as well at varying degrees of severity so that we could understand how each of those impacted claim costs or RBC. Finally, we ran 10,000 additional simulations where the severity of the second wave itself was a random variable.

Q. And does Exhibit 17 reflect the, the most up-to-date results of the modeling process you've described?

A. Yes, it does.

Q. Would you please describe the results?

A. Yes. So, in, in terms of claim costs, what we're finding is that our 2020 claim costs are likely to be fairly significantly lower than what we had anticipated, but the 2021 claim costs will be higher to an equal or greater extent. Altogether, over the entirety of the two-year period, the results range from

a slightly favorable impact on medical claim costs to a significantly unfavorable impact on medical claim costs, and, specifically, we found that there were really no scenarios where we would have a windfall, if you will, from significantly lower claim costs over the entirety of the two-year period.

Q. And could you describe the modeling results in terms of impact on Blue Cross's risk-based capital ratio?

A. Yes. The results to, with respect to RBC were similar. They really vary from a slight increase to a slight decrease by the end of 2021. Notably, of the 60,000 simulations than that we ran using a very broad range of assumptions, zero led to an impact of RBC that was an increase of more than 75 percentage points.

Q. Does the modeling incorporate all impacts to RBC of the COVID-19 pandemic?

A. No, it does not. The model focuses on the medical claim cost impacts to RBC. There are a host of other impacts that we describe within our response that's in Exhibit 6. Those include things like retail pharmacy utilization that we've observed as running much higher than expected through June. There are advances that we paid to providers. There's uncollectable premium that may result from the extension of grace periods;

suspension of fraud, waste and abuse activities; and, of course, the pension losses. Taken collectively but setting the pension losses aside, all those other items collectively reduce RBC by about 70 percentage points.

Q. Please describe your approach in setting the assumptions that, that form the basis of the modeling.

A. Sure. So wherever we could we used Blue Cross-specific data or Vermont-specific data to develop or assumption, our assumptions and to develop our ranges. For example, for deferred care, returning care, and treatment costs, we used information that was gathered from Blue Cross Blue Shield data and from our hospital contracts. We then vetted these assumptions against ranges that have been published in other national actuarial studies to verify that the ranges were reasonable.

Where we didn't have sufficient data in Vermont or within Blue Cross Blue Shield of Vermont, we borrowed ranges from these national studies or other published literature. We also vetted these ranges against what we do know about Vermont and about Blue Cross Blue Shield data to verify that it's appropriate to use those ranges when doing a projection that's specific to Vermont.

Q. And, in this context of creating and, and

selecting these assumptions, what does the term "conservatism" or "conservative" mean?

A. In that respect, a conservative assumption would be one that produces more unfavorable impacts to RBC than a best estimate assumption.

Q. And did you incorporate conservatism or conservative assumptions in the way you just defined that term into the assumptions that feed into the model?

A. No, we didn't. That would be antithetical to what we were trying to accomplish with the modeling. If we had put our thumb on the scale, if you will, we may have come up with answers that, that had a maybe a 25 point worse impact on RBC. But those 25 percentage points wouldn't have changed any of our conclusions. So it was our intention to, to use the best estimate, the best assumptions we could come up with and not to include any conservatism.

While we're confident that there was no conservatism in our original modeling, we did do a lot of work between the original modeling and the addendum to eradicate any perceived conservatism that might have still existed in the model.

Q. So, if you sought from, from the original model to the updated model, if you sought to eliminate any

conservatism that, that might have crept into the original model, why is it that the, the updated results appear slightly worse?

A. That's because we also incorporated June data. June data became available in time for us to do the, the modeling addendum. It was not available at the time we did the original modeling. And what that June data showed is that June is emerging at a level of medical claims that is higher than what we would have expected from historical norms. We weren't expecting medical claims to be higher than benchmark levels until July. So this was rather surprising to us. But what it shows is that Vermont hospitals and providers are already operating at or above capacity.

When we incorporated that data into our modeling, what it showed is that our estimate for the total amount of care that has been deferred is only about $20 million for these insured lines of business. That $20 million is about 90 percentage points of RBC. So, when we incorporate that, when we incorporated that lower amount of deferred care into the model, that produced less favorable results relative to RBC.

The other piece of information that we incorporated was the recent guidance on testing from the Vermont Department of Health. Based upon that

guidance, we actually reduced our assumption for the incidence of testing, but the cost of testing increased, because we would be adding the cost of an office visit to most testing that Blue Cross has to pay for.

Q. Mr. Schultz, are you familiar with Exhibit 10 in the binder, which is DFR's solvency opinion and the accompanying Oliver Wyman report to DFR on that topic?

A. I am.

Q. Did Oliver Wyman have an opinion about the existence of conservatism in Blue Cross's modeling? And this would have been the initial model, correct, given the time?

A. Yes, that's right. They, Oliver Wyman, did perceive some conservatism within our modeling, particularly with respect to our assumptions as to the amount and timing of returning care. They also alluded to studies performed by other issuers that resulted in a more favorable impact to RBC than our modeling showed.

Q. And would you explain whether you disagree with that opinion and, if so, why?

A. I do disagree with that opinion. Specific to the portion of care expected to return, the assumptions that we are using are very well-aligned with

assumptions that have been published in other national actuarial studies such as the one published by Milliman and also a Society of Actuaries study.

In terms of the timing of that return of care, before we had ability to, to see the June data, it's certainly understandable that we may have doubted that Vermont providers might be operating above capacity as early as July. Now that we can see the June data, we see that, in fact, that began happening in June. So we feel quite confident in the assumption that that will continue into July.

With respect to what other national carriers are, are seeing, I can't comment on those studies, because I don't have any access to them. What I can say is that this modeling represents a reasonable range of results based on best estimate assumptions specific to Vermont and to Blue Cross Blue Shield of Vermont.

Q. And do the results of, of Blue Cross's modeling lead you to conclude that any decreases are warranted in the proposed rates?

A. They do not. The modeling shows that the impact to RBC over the entire two-year period is expected to be relatively small in the upward or downward direction. The modeling also shows that claim costs in 2021 are likely to fairly significantly outpace the

2021 claim costs that are included in this filing. Because of those results, we cannot responsibly reduce these premiums below actuarially sound levels.

Q. And do the modeling results lead you to conclude that an increase in the proposed rates would be warranted based on the results of the modeling?

A. The answer here again is "no". Blue Cross has committed to shield Vermonters from the additional costs related to the pandemic by paying for those costs out of surplus rather than passing them along through premiums. This is a, not a typical approach for an issuer to take. At the time we initially filed, we didn't have enough information to estimate what kind of impact the pandemic was going to have on 2021 costs, but we did know enough to believe that it was likely to be an upward impact on claim costs.

So what we, what we filed at the time, we were able to satisfy actuarial standards of practice, because we had been instructed by senior management that any increase in claim costs due to Covid should be offset by an equal and opposite decrease in CTR such that we get back to the same answer. Now that we have the benefit of our Covid modeling, we are able to actually do some, put some estimates together and see what that actually would have looked like.

So we can see, based on the Covid modeling, that 2021 claim costs are expected to be at least $9.6 million higher than what we had within the initial filing. So, if I were to refile today, in the absence of the, the direction from senior management to offset any increases with CTR, I would have filed a 9.7 percent rate increase, but, because of that directive from senior management, I would have lowered the CTR to negative 1.6 percent, and that would have gotten me back to the same 6.3 percent that I originally filed. All of this is before consideration of the L&E recommendations.

So, to say that a little bit differently, Blue Cross is absorbing 3.2 percent of premiums in order to shield ratepayers from increased costs due to COVID-19 in 2021. That is no different from a 3.2 percent annual premium discount, and it's no different from a $10 million rebate.

Q. Now, does the modeling that you performed provide any insight into the current revenue shortfalls that providers are experiencing right now?

A. Yes. What the modeling shows specific to Blue Cross is that we, we cannot look at the unexpected operating gain that we experienced from March through May in isolation. When we are considering 2021 rates,

it's important to take a longer view of the, the ultimate impact of the pandemic.

Similarly, in terms of hospital budget revenue, of course, it's important to recognize and manage the hospital revenue so that Vermonters have access to the right care at the right time in the right place. But, as we're making regulatory decisions about hospital revenue, again, it's important to not just look at where we are in a moment in time, but to consider our best estimate of what's going to happen over the next two years due to the pandemic.

So, specifically, we saw in looking at the June data in our modeling that care from March through May that had been deferred is already returning. Vermont hospitals are already operating above normal capacity. Obviously, that's going to have an impact on hospitals' revenue outlooks, and it's important to consider a long-range viewpoint on that impact as opposed to just looking at a particular point in time and drawing conclusions based on what's emerged to date.

Q. Would you please turn to Exhibit 1, Page 163? And that I'm using the red page numbering down in the lower left-hand corner of the page.

A. Yes, I'm there.

Q. Okay. What, what document are we sort of in the

middle of here?
A. We are in the middle of one of the attachments to the original rate filing, the original actuarial memorandum.
Q. Which attachment?
A. Attachment C, I believe.
Q. Thank you. And do you, in the middle of the page, do you see the table there on Page 163?
A. I do.
Q. Would you please explain what that table represents, what it shows?
A. Sure. So this table shows historical financial results for Blue Cross Blue Shield of Vermont within the individual and small group line of business, the topic of the rate filing today. I can talk about each, each column in the table. The file contribution to reserve is just what it says. It's the CTR that was included at the time of original filing for each of those years.

The approved contribution to reserve is our best estimate of our expected CTR after rates had been reduced for reasons other than those that were actuarially sound. For example, if our CTR was explicitly reduced, that would reduce our expected CTR. If other assumptions were reduced but in a way that

diverged from actuarial soundness, that also would impact the approved contribution to reserve or our expected contribution to reserve.

To the right of that we have the actual contribution to reserve. Now, these numbers are going to be different from what you'll find if you look in our financial statements, and the reason for that is one of timing. What we've done is to reallocate any events that arose for a particular year but weren't recognized until a later year.

By way of example, in our 2015 financial statements, we recognized a $4 million favorable true-up for 2014 transitional reinsurance. That $4 million, for purposes of this table, was removed from 2015, because it actually arose from experience in 2014. So we moved it into 2014. This allows us to have kind of a true view of what performance was on a year-by-year basis.

Q. And does the table show the final 2019 numbers as, you know, based on the information available to you today?

A. No, it doesn't. This table was published before we received from CMS quite recently the final amount of the 2019 risk adjustment transfer from MVP to Blue Cross. That transfer is actually a little bit less

than what we had anticipated at the time of filing. So our 2019 actual result as known today is negative 0.7 percent as opposed to the negative 0.4 percent that's reported in this table.

Q. Does the table include the anticipated income or recovery from lawsuits that Blue Cross Blue Shield of Vermont is currently engaged in against the federal government, the risk corridors case and the cost-sharing reduction case?

A. Yes, it does. It includes both. So, even though those cases haven't reach a conclusion, we did include the expected settlement amounts within this table. Specifically, that's the risk corridors amounts in 2015 and 2016 and the CSR settlement amounts in 2017 and 2018.

Q. What can you conclude by comparing the approved and actual columns of this table?

A. Well, a few things. For starters, I can conclude that my team has done an amazing job of accurately predicting what costs are going to be in these lines of business. I can see that, over the past three years, we haven't been off by more than three-quarters of a percent in any one of those years. It's a very strong result. Because of that accuracy in our projections, we can see that any rate cuts that are below

actuarially sound levels lead to rate inadequacy.
Q. Who covers the shortfall when rates are inadequate?
A. Policyholders do. If rates are inadequate, those shortfalls need to be paid out of policyholder reserves. DFR has mandated that our policyholder reserves must remain within a specific level. Therefore, any shortfall that results from underfunding current rates needs to be replenished by charging higher rates in the future. So, in that way, rates that, that are lower for current policyholders must be made up for by future policyholders.
Q. So is affordability served if rates are set at inadequate levels?
A. No. All this does is to shift costs from current policyholders to future policyholders.
Q. Can, can rate reductions be justified on the grounds of affordability?
A. Yes. If we're in a circumstance where filed rates are excessive, then reducing those rates does not actually deplete reserves, and, if we don't deplete reserves, then future policyholders do not need to pay more in order to replenish those reserves to the level mandated by DFR.
Q. And has that type of rate cut occurred since 2014

when the board began regulating these rates?
A. It has. If we look at the results in 2014, we can see that the filed CTR was reduced from 1 percent to negative .1 percent, but actual results came in at the 1 percent that was originally filed. So in 2014 rates were reduced, but it created no shortfall in reserves, because actual results came in at that 1 percent level that had been originally filed.
Q. Now, how have the board's rate decisions since 2016 impacted Blue Cross's RBC?
A. In every instance where rates were cut below actuarially sound levels, it's led to rate inadequacy and reductions in RBC.
Q. And can you explain what the, the impact on policyholder reserves over that period of time is?
A. Yes, I can. So we can calculate that impact by comparing the filed contribution to reserve to the greater of the next two columns, the approved contribution to reserve or the actual contribution to reserve, and I say "the greater of" for a couple of reasons. One is that, if actual contribution to reserve performs better than expectations, then there is no reduction in surplus that we need to, to take into account here.
For example, in 2014, as I just described, even

though rates were reduced below levels that appeared to be actuarially sound, actual results came in better than that, so RBC was not reduced.

Similar, but on the flipside of that, by using the maximum of those two columns, we are not ascribing to rate cuts any downturns in performance that Blue Cross might have experienced, in other words, performance that was worse than expectation. So, if we look at 2018, for example, the actual CTR of minus 1.6 was worse than our expectation of minus 1. That difference of 0.6 was not due to the rate cuts. That was due to a downturn in performance.

So, focusing only on the value of any reductions in rates below actuarially sound levels, we can calculate that, over all of these years, RBC has been reduced by about $24 million or 112 basis points of RBC due to cuts below actuarially adequate levels.

Q. And what would those results be for the time period 2018 to the present?

A. We can use the same approach to calculate this for the last two years, and we can see that RBC has been reduced by about $15 million or 71 percentage points.

Q. And so where would Blue Cross's RBC be but for those 2018 and '19 results you just referred to?

A. It would be 71 percentage points higher, which, at

the end of 2019, would have put us within our mandated RBC range.

Q. And, when you say "mandated RBC range", can you just briefly describe what that means?

A. Yes. DFR has mandated that our RBC should be within a range of 590 percent to 745 percent, and, if we are below or above that range, we need to submit action plans to them to describe how we intend to return to the mandated range.

Q. Does setting Blue Cross's rates below actuarially justified levels provide Blue Cross a competitive advantage?

A. No, it does not. We are, of course, very concerned about the ongoing membership losses, and we are concerned about our rate differential between us and MVP, but, while we are taking every step that we can to try to address those issues, such as our good work with the lab benefit manager, we need to be in a financially sound position in order to invest in that new programming.

When rates are cut below adequate levels, it compromises our, it compromises our RBC and our surplus and reduces or eliminates the capital that we need to invest in innovative solutions. So, when we can't invest in those innovative solutions that will actually

bend the cost curve by improving health care delivery and outcomes, we are unable to make health care more affordable for Vermonters, and it's those same steps that would reduce our premiums and improve our competitive position as well.

Q. But wouldn't premiums be lower if you could have retained more members?

A. Well, our administrative costs would have been lower if we had retained all of our membership in 2020. In this particular filing, premiums would be lower by about 0.2 percent because of the, of administrative costs being somewhat lower due to higher membership. However, we can see that the membership loss had no overall impact on our rates.

The reason we know that is, not only through our actuarial analysis, but because we can see that we filed for a lower rate increase than MVP did. If membership losses were driving rates upward or downward between the two carriers, then the issuer who is losing membership would necessarily file a higher rate increase than the issuer that's gaining membership. That's not the case here. Our rates are increasing no more quickly than are MVP's. So we can conclude from that that the membership losses do not have a material impact on 2021 rates.

Q. I'd like to turn your attention now to Exhibit 1, Page 18 of the red numbers on the lower left-hand corner of the page, and, when you get there, I think you'll see that that's Section 1.8 of the actuarial memorandum that accompanied the filing.
A. I'm there.
Q. And do you see at the top of Section 1.8 where it lays out the statutory criteria that the board applies in this proceeding?
A. I see that.
Q. Would you just read that passage into the record, please?
A. Sure. "When reviewing a proposed rate, the Green Mountain Care Board must consider whether a rate is affordable; promotes quality care; promotes access to health care; protects insurer solvency; and is not unjust, unfair, inequitable, misleading, or contrary to the laws of the state."
Q. In your professional opinion, are the proposed rates as modified according to L&E's recommendations inadequate?
A. No, they are not.
Q. Excessive?
A. No, they aren't.
Q. Unfairly discriminatory?

A. No.
Q. Reasonable in relation to the benefits provided?
A. Yes.
Q. Unjust, unfair, inequitable, misleading, or contrary to law?
A. No.
Q. Are they affordable while promoting quality care and access to care?
A. Yes. These right, rates strike the best available balance among those three interdependent variables that are intentioned with each other.
Q. And do they protect Blue Cross's solvency?
A. Yes.
Q. Have you reviewed the public comments that the board has been receiving over the, the pendency of this proceeding?
A. Yes.
Q. And those comments show that Vermonters, many Vermonters, are struggling right now to pay for their health insurance, right?
A. Yes.
Q. In that context, why, how are you, are you able to conclude that these rates strike the appropriate balance, or I think you said the best balance available, among affordability, promoting quality, and

promoting access to care?
A. Well, in a couple of ways. First of all, these rates, as with any health rates in Vermont, need to be assessed on the basis of the total population or community that purchases these plans. We can't divide, derive these rates based upon individual circumstances. In fact, we are prevented from doing so by Vermont law.

So, by way of example, I cannot construct a rate for a 30-year-old who might have somewhat lower income and few health conditions that's different from a rate for a 60-year-old who might have higher income and a whole host of medical needs. Vermont community rating laws do not allow me to develop rates that are different for those two individuals. The rate must be the same for the entire community. So because of that we have to consider affordability on a community level rather than thinking about it from an individual very specific level.

The second thing that I can think about is how our cost of insurance compares to that of the rest of the industry. These rates consist of really three main parts. First are taxes and fees. Those are set by the government. Issuers have no control over those amounts. Second, and this is the majority of the rate, are claims. Claims, at their essence, are amounts that

providers are paid.

So, while Blue Cross does everything that we can to try to bend the cost curve, whether that's participating in Vermont's various initiatives or developing programming of our own, at its core that portion of premium is really a financial transaction wherein we are receiving premium payments from Vermonters and we are redistributing those payments to providers to pay them for the care that the policyholders are collectively consuming.

So that leaves us with the cost of insurance, which I'll define as the sum of administrative costs, CTR, and profit margin. Now, this is one place where we can exercise significant discretion, because we have a lot of control over our administrative costs, our CTR, and our profit margin. And, you know, L&E has looked at and analyzed where we stand relative to other carriers for those elements.

What they've found is that, in terms of administrative costs, our administrative costs as a percentage of premium are lower than 90 percent of the plans that they, that they assessed alongside of us. In terms of CTR, our filed CTR of, in 2020 of 1.5 percent, which is our same filed CTR this year, was lower than 80 percent of all individual and small group

filings nationally. And, of course, as we all know, there is no profit margin in these rates. So our cost of insurance is among the very lowest in the entire industry.

Q. Mr. Schultz, would you please turn to Exhibit 23?

(Exhibit 23 was shown to the Witness.)

A. Yes.

Q. And, when you get there, please explain what this is.

A. It's a lot of pages to flip over.

Q. Yes.

A. Okay. So this graph is a comparison of Blue Cross Blue Shield's MLR over time as compared to the average MLR across the entire industry from the years 2011 through 2019. The blue line shows Blue Cross's actual MLR results, and this is derived from the underwriting results that I described earlier in terms of how we assess performance by line of business. The red line is taken from a Kaiser Family Foundation study that we cite in the second footnote.

Q. Mr. Schultz, just, I'm looking at a black-and-white copy. Just in case anybody else is, would you please describe sort of visually which line is the Blue Cross line and which line is the national average line?

A. Yes. The Blue Cross line is the flatter line. It, it starts and ends above the other line. The national line is the one that, that kind of has a big spike up followed by a big spike down. That's the, that's the national line that I referred to as the red line for those of you with a color copy.
Q. And so the, the national average line, you said, is derived from a Kaiser Foundation study. Can you just say a little bit more about, about what that study was and how you found it?
A. Yes. I, I found it online. Kaiser Family Foundation does an awful lot of very interesting reporting relative to this line of business, and I, I try to stay abreast of that reporting. So, in reading a study that they did about how issuer MLR has changed over time and as that may relate to ACA rebates, I, you know, I found and read this study, I found the graph and thought that it would be useful to compare to Blue Cross's results over the same time period.
Q. So the, the national average line that appears on Exhibit 23 is taken from a figure and from data contained in that Kaiser study?
A. Yes. It's taken from the publicly available Kaiser study. That's correct.
Q. And did you oversee the preparation of this

document, Exhibit 23?
A. Yes, I did.
MR. DONOFRIO: Mr. Barber, I move Exhibit 23's admission, noting again for the record that the HCA has agreed to its admission.
MR. BARBER: Yeah, I'll admit it into the record.
MR. DONOFRIO: Thank you.
(Blue Cross Exhibit 23 was admitted into the record.)
BY MR. DONOFRIO:
Q. A couple of questions, and then we will be done with your direct testimony, Mr. Schultz. Can you just describe what MLR is?
A. Yes. MLR, which stands for medical loss ratio, in its simple form is simply the portion of premium that is consumed by claim costs. If we ignore taxes and fees, then MLR is the inverse of the cost of insurance that I talked about earlier. So an 80 percent MLR would equate to a 20 percent cost of insurance.
MLR is defined by the ACA as a little bit more complex than that. The ACA allows issuers to make adjustments for taxes and fees and also to make adjustments for quality improvement initiatives. Generally speaking, the ACA MLR will be somewhat higher than a simple comparison of claim costs to premiums.

If an issuer in the individual and small group line of business has an ACA MLR that's below 80 percent, they have to refund the entirety of that excess cost of insurance back to ratepayers.

Q. What does this document show us regarding the industry's cost of insurance over time?

A. So it, it shows us some interesting patterns, and I think it's easiest to think about this in three three-year segments. So, first, from 2011 through 2013, which is before the ACA went into effect, we can see that issuers were really consistently producing MLRs in the low 80s. This indicates that they were able to price very accurately based upon the laws and regulations that were in place in their jurisdictions prior to the ACA coming into play.

Now, when we move to 2014 through 2016, we see a very significant spike upward in MLR. We know that, in the early years of the ACA, issuers lost billions of dollars. We can remember the significant market exits that took place. We can remember the many co-ops that went out of business. So these MLRs that are very high is not what these issuers were targeting. This was a pricing issue. When the ACA changed all the rules, many issuers nationally had a lot of trouble trying to price this business, and we can see that, in the next

three years, they really corrected for that.

So, from 2017 through 2019, I would, I would refer to that as a market correction. So, nationally, we saw a few years of very, very high premium increases, and we can see that by 2018 I would argue that issuers nationally overcorrected for the money that they had lost in the preceding period from 2014 to 2016. That 70 percent average MLR nationally stands in dramatic contrast to the 93 percent MLR that Blue Cross experienced at that same time.

Finally, in 2019 we can see that the national issuers are finally kind of starting to revert to that area in the low 80s that they were targeting pre-ACA.

Q. What does the graph suggest about ACA MLR rebates?

A. Sure. So the, the graph suggests a couple things. First, we know this isn't on the graph, but we know that issuers paid more in ACA MLR rebates in 2019 than they had in any previous year, and what the graph shows is that, because those ACA rebates are based on a three-year average, we would expect that issuers are going to pay quite a bit more in 2020 than they, even than they paid in 2019, which had been a record.

Furthermore, because of the deferred care that's taking place in 2020 and the three-year averaging, it's likely that MLR rebates in 2021 will be even more

enormous than MLR rebates in 2020. We can compare that to the experience of Blue Cross. Blue Cross has never had to pay an ACA MLR rebate for those lines of business. We don't expect to pay a rebate in 2020, and we don't expect to pay a rebate in 2021, because we don't overcharge ratepayers.

Q. And what does the, what does the chart show about Blue Cross's cost of insurance over time?

A. So a couple things here too. First, it shows that our MLR and our cost, well, and our cost of insurance have been very stable. That indicates to me that we've done a good job pricing in this line of business, kind of in contrast to what we've seen nationally where other carriers have really struggled to price ACA business.

The second thing that it shows me is that we are well above the minimum threshold within the ACA. So that's that at 80 percent -- we have a dotted line on the chart -- that's the ACA minimum threshold. We have historically and consistently been well above that. Most issuers are targeting an MLR that's just above that 80 percent line. Our cost of insurance is less than half of that.

Q. Do the conclusions that you're able to draw from this chart relate back to affordability? And, if so,

please explain.
A. They do. So, again, what this, what this chart shows about our cost of insurance is that we have been able to limit that cost of insurance, and, again, that's the portion of premium over which we exert some firm control. We've limited that to industry-leading levels in order to provide the most affordable rates possible while still providing access to the high-quality care that Vermonters demand and that Vermont hospitals and doctors provide.
MR. DONOFRIO: Thank you, Mr. Schultz. I have no further questions at this time. I reserve right to ask questions on rebuttal. Thank you.
MR. BARBER: Thank you. Mr. Angoff, do you have questions for Mr. Schultz?
MR. ANGOFF: Yes, I do.
CROSS-EXAMINATION BY MR. ANGOFF
Q. Good morning, Mr. Schultz.
A. Good morning, Mr. Angoff.
Q. I'm, am I correct in assuming that you had nothing to do with the decision to make the investment that, that resulted in a $40 million loss to Blue Cross?
A. You are correct, yes.
Q. Okay. Do, am I correct in assuming that you had nothing to do with developing the investment guidelines

Blue Cross follows governing the assets that it will invest in?

A. Also correct.

Q. Okay. Do you know what the investment was that Blue Cross made that resulted in the $40 million loss?

A. No, I don't.

Q. You've never had -- you've never been involved in any discussion at Blue Cross about what that investment was?

A. No, I have not.

Q. Okay. And that $40 million investment is equal to approximately 180 points of RBC; is that correct?

A. Yes, it is.

Q. Okay. Could you explain how, how the $40 million -- does that mean that for each, each million dollars is equivalent to, whatever it is, four-plus points of RBC ratio? Is that how it works?

MR. DONOFRIO: Objection, objection, not relevant and asked and answered. And I apologize. I was on mute. I would have objected from the beginning of this line of questioning. I apologize.

MR. BARBER: So I need a repeat of the question.

MR. ANGOFF: I'm sorry, Mr. Hearing Examiner. I didn't hear you.

MR. BARBER: I need you to repeat the question, please.
BY MR. ANGOFF:
Q. Yeah. Is it correct that the, that, in order to arrive at our, the number of RBC points that a, a loss equals, you've got to multiply the, the amount of the dollar loss by a certain factor?
MR. DONOFRIO: Objection to the form of the question, and I'd like to add another basis for my objection, which is, in our June 26th letter from Don George, Blue Cross requested that the board and parties, if they had questions about the pension loss, provide those questions in advance in writing. There's nothing about these questions that couldn't have been developed ahead of time. So those are all of my grounds for objecting to this line of questioning, Mr. Hearing Officer.
MR. ANGOFF: Mr. Hearing Officer, nothing could be more relevant to the board's decision on Blue Cross's proposed increase than the fact that Blue Cross has lost 180 points in RBC ratio through no fault of the Vermonters, through only its own fault. The reason it is so relevant is that the, as Mr. Schultz was just explaining, the reason it is so relevant is that the lower the RBC ratio, the more Blue Cross needs to

charge, needs to charge its ratepayers.

Now, the board's counsel asked Blue Cross some very, very reasonable questions about this investment, about what it was, how it came to be, very, whether it, whether it complies with the law, whether Blue Cross notified the commission, very reasonable questions, and what Blue Cross told the board was to go jump in the lake. They said, we're not answering your questions.

I think that it's essential. It's essential for the board, and it's essential for the board on behalf of Vermonters to insist on answers to those questions, because that money that they threw away is, I'm afraid, going to result in higher rates to Vermonters, unless Mr. Schultz can guarantee right here that it never will do that.

MR. BARBER: So the question that -- sorry. I'm getting some echo here. The question, as I understood it, was about the, how many RBC points does a million-dollar loss equate to. That, that seems to be relevant. So, to the extent I understood the question correctly, Mr. Schultz, could you please answer the question?

MR. SCHULTZ: Yes, happy to. A million-dollar loss equates to about 4.5 points of RBC.

BY MR. ANGOFF:
Q. And, Mr. Schultz, could you give the board some idea of how much $40 million is? For example, what percentage of Blue Cross's total surplus before that loss does that $40 million represent?
A. I, I think Ruth Greene is going to be in a better, better position to answer that question. I can try to find the number of our surplus and do a little bit of quick math, but we're probably better served by asking our CFO the answers to those questions.
Q. Well, I suppose that's fair. Dr. McIntosh said you'll answer the questions. Now you're throwing Ms. Greene under the bus. Fine, I'm happy to --
MR. DONOFRIO: Objection, objection.
MR. BARBER: Sustained.
BY MR. ANGOFF:
Q. I'm happy to ask Ms. Greene. Can you tell me -- you're responsible, obviously, for the rate filing, correct?
A. Yes, that's right.
Q. Can you tell me how this $40 million that Blue Cross lost in this investment compares to the contribution to surplus or, as you guys call it, contribution to reserves that Blue Cross has filed for and been granted from the board in its history, that

is, since the new ACA system started up?

MR. DONOFRIO: Object to the form. Answer if you understand the question.

MR. SCHULTZ: I'm going to need a little bit of clarity on that question if you don't mind.

BY MR. ANGOFF:

Q. Sure. What is the total that, in, in dollars approximately that Blue Cross has received from the board in, that is, that the board has approved, in contributions to the reserves or contributions to surplus since the, since the beginning of this system with the board regulating rates?

A. So I'm referring again to Page 163 of Exhibit 1, which I think doesn't quite have all the information I would need to do that calculation, but I can, I can see that the approved contribution to reserve over time has been about 0.3 percent of premium. That is probably in the neighborhood of about $6 million.

Q. Okay. And, and the system's been going for six or seven years?

A. That's six years of experience, yes.

Q. Okay. So that, so that's six times, I'm sorry, six, about six times $6 million?

A. No. I'm sorry. So, you know, each year the board might approve a different CTR. Our expectation after

the 2019 decision, for example, is that our CTR would be zero. So in 2019 we can compare that $40 million to zero. In 2018 we expected that our actual CTR would be negative. So now we're comparing to a negative number.

Q. Okay. Mr. Schultz, can you guarantee that Blue Cross policyholders will never pay, directly or indirectly, for the $40 million that Blue Cross has lost in this investment?

MR. DONOFRIO: Objection.

MR. ANGOFF: I --

MR. BARBER: Hold on. Objection on what grounds?

MR. DONOFRIO: It's, it's asking the Witness to do the impossible, essentially, guarantee the outcome of future events.

MR. BARBER: Well, he can answer for himself. Mr. Angoff, could you please repeat the question?

BY MR. ANGOFF:

Q. Yes. Mr. Schultz, can you guarantee that Blue Cross policyholders will never pay, directly or indirectly, for the $40 million that Blue Cross has lost through the investment that it made this year?

MR. DONOFRIO: Object to the form. You can answer.

MR. SCHULTZ: What I can say is that we're

here today to talk about the 2021 rate filing and that not a single penny of that $40 million has been included in the 2021 rate filing.

BY MR. ANGOFF:

Q. That was not my question, though, Mr. Schultz. I'll repeat my question. Can you guarantee that Blue Cross policyholders will never pay, directly or indirectly, for the $40 million that Blue Cross lost in connection with its investment this year?

MR. DONOFRIO: Objection. To the extent Mr. Angoff is asking a question that projects beyond the rates before the board, the question is seeking testimony that's irrelevant.

MR. ANGOFF: I don't think it -- it couldn't be more relevant. This board regulates the rates, decides whether to approve or disapprove the rates that Blue Cross filed.

MR. DONOFRIO: Correct. The board has jurisdiction over the filed rates before it, which are the 2021 rates, and that question's been asked and answered.

MR. ANGOFF: It's been asked. It hasn't been answered.

MR. BARBER: What is your response to the objection, Mr. Angoff, that the rates before the board

are for 2021 and do not extend beyond, I mean, to the extent that he's answered the question as it relates to the rates for next year?

MR. ANGOFF: My response is the board has the authority over rates, not just this year, but for next year, and, in addition, my response is that the answer to Mr. Schultz's question, if he does answer it, I think would have an effect on the board's decision as to what to do with respect to the rate increase this year.

So, for example, if Mr. Schultz were to say, Yes, I can guarantee that no way, one way or the other, will Blue Cross charge its policyholders for the $40 million bucks that Blue Cross lost, that might have a different effect on what the board's decision would be than if Mr. Schultz were to say, I can't guarantee that. Because 180 points of RBC ratio is a lot, and, if it turns out that, because of this 180-point loss, the RBC ratio falls to a low level, say, below 500, unfortunately, regrettably, we're going to have to raise policyholders' rates to pay for it.

MR. BARBER: So, clearly, Blue Cross Blue Shield's solvency is an issue before the board, and the impact of the rate on solvency. Clearly, the pension loss has an impact on solvency. I think it's relevant

over what time period that impact will be felt. I'm going to allow this line of questioning, but we, but -- yeah, so proceed. You can proceed with your question, Mr. Angoff.

MR. ANGOFF: Can the reporter -- well, Mr. Hearing Examiner, should I ask it again, or should I have the reporter read back the question? How would you like to proceed?

MR. BARBER: Would you please restate the question for the Witness?

BY MR. ANGOFF:

Q. Yes. Mr. Schultz, can you commit to the board that Blue Cross policyholders will never pay, directly or indirectly, for the $40 million that Blue Cross lost this year through its investments?

A. Quite frankly, that decision is above my pay grade. So, no, I personally cannot make that guarantee one way or the other.

Q. I will move on. Thank you, Mr. Schultz. Mr. Schultz, to what do you attribute the great success that Vermont and Vermonters have had in containing the coronavirus pandemic?

A. Dr. McIntosh is the expert in this area. So I would refer to, to her testimony. She's already testified about this. She's asked and answered. I

rely on her expertise in these sorts of matters. They really aren't an actuarial matter. What Dr. McIntosh testified, to the best of my recollection, is that she gave lot of credit to the governor. She gave some credit to good fortune as well.

Q. I appreciate that. Do you have anything to add to what Dr. McIntosh testified to?

A. I have nothing to add.

Q. Very good. You remember, don't you, that, when I asked Dr. McIntosh what she assumed in the modeling that you and she and your teams had done as to how much Blue Cross would pay out this year due to the coronavirus, she said she didn't know and I should ask you. So consider that question asked. How much -- well, I'll ask a series of questions.

Number one, Dr. McIntosh testified that today the number of cases per day varies between 17 and 2, the range is between 2 and 17. Do you remember that?

A. I do remember that.

Q. Okay. What did you assume as to the number of new cases that Vermont would experience per day in coming up with your projections that you set forth in the, in the addendum, which I believe is Exhibit 17?

A. Yes. In that modeling we assumed that Vermont would see seven to eight additional cases per day,

which matches the average from June forward.
Q. You assumed that Vermont would, would see seven to eight cases a day for the rest of the year?
A. Yes.
Q. Okay. And then what did you assume as to what would happen in 2021?
A. So we assumed, so we assumed a couple of things. I should clarify my, my original response. So we did assume that, through August, Vermont would continue to see seven to eight cases per day. From September through December with the return, with the potential return of students to schools and to universities, we allowed the modeling to vary from between that seven to eight level to something as much as, I believe, 10 percent higher than that.

And then for 2021 we allowed the model to take a random variable, again, choose a random variable anywhere between the 7 to 8 cases a day and a maximum of about 15 to 16 cases a day.
Q. Okay. I was just going to say. I'm not going -- I wouldn't quibble with you about 10 percent one way or the other, but the difference between 7 to 8 and 15 to 16 is pretty significant, isn't it? How did you -- how did you come up with that 15 to 16?
A. Yeah, again, that's based on an expectation over

time that, as we continue to loosen social restrictions, Dr. McIntosh testified about in the fall and winter, especially when everybody is within enclosed spaces, it's likely that the virus is going to spread more rapidly than it has thus far.

So we, we included that full range of where we are today to a level that's about twice that high and allowed the model to randomly select a value within that range. So some of our simulations say that the infection rate in Vermont will never be higher than what it's been in June and July. Other of our simulations take a look at what happens if that infection rate is about twice as high. Based on everything Dr. Kate testified about, it seems pretty unlikely that the infection rate is going to, to decrease from here.

Q. Can you show me where that data which you've justified described is in your modeling addendum, Exhibit 17?

A. I can certainly try. So it, it should be addressed in the treatment cost section, and I will direct you to Page 4 of Exhibit 17. At the bottom of Page 4, we talk about how we dampened the incidence rate, and so we dampened it by about 50 percent. That's because that 7 to 8 new case average that we've

seen in July and in June is about half of what we saw over a time period that was studied by the Society of Actuaries from March 22nd through May 17th.

The Society of Actuaries studied these infection rates by medical service area for the entire nation, and what they found for the Burlington medical service area, and this also tied very closely to statistics reported by the Vermont Department of Health, is that, over that time period, infection rates were about at twice that level of 7 to 8 that we've experienced in June and July. So, when we talk about the 50 percent dampening, that's another way of saying we're assuming 7 to 8 new cases a day for July and August.

Q. So you mean in, earlier in the year in March and April, there was a greater incidence of cases, about twice the incidence of cases that there is currently?

A. That's right. In March, well, late March and very early April, in fact, the incidence was many multiples higher than what it is currently, and then that dampened by the end of April to a level of about four cases a day, and that's what we experienced for much of the month of May. So, when we look at that Society of Actuaries timeframe, that includes both the very large spike we saw in March and April, and it also includes a very kind of a long portion of the very low incidence

we saw in May before some of the social distancing restrictions were loosened.
Q. So, if I understand you then, the, the trend in -- obviously, everything's starting from the very low base, but the trend in coronavirus cases in Vermont has been down since March, but you're projecting a higher incidence later in the year. Why is that?
A. No. I'm sorry. Let me explain again. I think you're misunderstanding what I'm saying. So we're projecting that, for July and August, it will be about 50 percent of that time, of the level of that time period from March through May. That includes some much higher incidence and includes some very low incidence. That 50 percent assumption matches the 7 to 8 cases per day that we've seen in June and thus far in July. So for July so far, it's been a very accurate assumption.
Q. Okay. If I'm interested and if the board is interested in, in hard numbers, pure, the pure number of cases, number of infections, number of hospitalizations, numbers of deaths, is that in here? Is there any place where we can find something to the effect of we assumed 8 cases or 16 cases, or we assumed 60 deaths or 90 deaths? Is there anything like that in this, in this addendum, Exhibit 17?
A. No, we did not summarize our modeling in that way.

Q. Okay. You remember also Dr. McIntosh testified that, even though there was just one hospitalization as of June 30th, today there are four and that they fluctuate between one and four; do you remember that?
A. I do remember that, yes.
Q. Okay. What did you assume as to the number of hospitalizations from here on out during the rest of 2020 and then for 2021?
A. So, again, we didn't summarize our modeling in that way. I'd be happy to follow up with that answer. That answer is going to be very low. We are assuming 7 to 8 new cases per day across all of Vermont. Blue Cross Blue Shield insured business accounts for well under 10 percent of the, the total Vermont population. So, just in terms of new infections, we're expecting within our insured lines well less than one person per day.

Now, hospitalization, we, we took, again, from, we used some national statistics for that, some published data for that, and we compared it to Vermont data on Vermont hospitalizations during the peak period to understand how many positive cases tend to result in a hospitalization. So I'm going to avoid doing math on the fly, but the hospitalizations per case was obviously well less than 100 percent, way less than 50

percent. So the number of hospitalizations of Blue Cross insured members that we're assuming is going to be very, very low.

Q. Okay. Well, then let me ask you this: Can you turn to, on Exhibit 17, Page 22?

A. Sure. Okay. I'm there.

Q. Okay. And you see the first number under 2020 is $339 million; you see that?

A. Yes, I do.

Q. Okay. Of that projected paid claims of $339 million, how much of that is paid coronavirus-related claims as of whatever the date is that Blue Cross has those, those numbers available?

A. Well, zero. Those are baseline claims in the absence of coronavirus.

Q. Okay. Then where are your, where in this addendum is your estimate of coronavirus claims costs in 2020?

A. Sure. So you can see that in the direct costs row. So we have these, as I, as I testified earlier, we have these various scenarios as to what a second wave might look like. So let's, for the sake of simplicity, stick to there is no second wave. The direct costs that we're paying for coronavirus treatment are projected at $4.3 million. That is just over 1 percent of the total claims projection for the

year.
Q. Okay. Leaving approximately $335 million in noncoronavirus-related claims, correct?
A. Again, the $339 million is a baseline number. So the $4.2 million would increase that 339 up to 342, I'm sorry, 344.
Q. Okay. Of that $339 million in projected paid claims, how much has Blue Cross paid to date?
A. So the, the question, as I understand it, is what, what is the total amount of paid claims that Blue Cross has paid through June, and I don't have that number at my fingertips.
Q. Okay. Could you please submit that number to the board and to the Health Care Advocate so we can use it in our post-hearing memorandum?
A. Yes, I can.
Q. Okay. The reason I ask that, if you could go, Mr. Schultz, to Page 2 of Exhibit 17 and read the first line of Paragraph 3.
A. "On July 7th Blue Cross's actuarial team completed the monthly incurred claims estimates that incorporated claims paid through June 30th 2020."
Q. Okay. So that's the, the -- you can understand why I would be asking that question, can't you? Because this statement says, We incorporated the claims

paid through June 30th 2020. So it, it is -- maybe I'm -- it is -- are paid claims paid through June 30th 2020 in this addendum at all?

A. Yes. Well, the, the amount is not in the addendum.

Q. Well --

A. So claims payments to date are in the modeling.

Q. Okay. That's what I'm asking for. I'm asking for the amount of paid claims. How much has Blue Cross paid out so far in 2020? I thought from this statement that it would be in the addendum. You've just told me it's not, correct?

A. That's right.

MR. DONOFRIO: Object to the form of the question. There was some testimony in there from counsel.

Mr. BARBER: Sustained.

BY MR. ANGOFF:

Q. Why is it not in the addendum?

A. Because it's not particularly relevant. That specific number is not particularly relevant to the modeling. Other numbers like the amount of deferred care are very relevant to the modeling, and those numbers are reported within the addendum.

Q. You don't think the board should be able to decide

whether the amount of paid claims that Blue Cross has made in 2020 is relevant or not?

MR. DONOFRIO: Object to the form of the question. You can answer if you can.

MR. SCHULTZ: So, Mr. Angoff, I would say that I did not include every possible number within this addendum. Within the limited amount of time I had to put it together, I included what I thought was the most relevant information for the users of the addendum. If, if the HCA or the board would like to see some additional information, I would be more than happy to provide it.

BY MR. ANGOFF:

Q. Thank you. I will accept that offer. Yes, we would like to see the paid claims data, and I assume -- I won't speak for the board, but the HCA would certainly like to see the paid claims data, to the extent that it is available, for 2020.

Could you turn, please, Mr. Schultz, to Page 3? And I just want to ask you a question or two about certain terms. Of Exhibit 17. Are you there?

A. I am.

Q. Okay. The first full paragraph, the second line, the second sentence talks about completion factors and margin. Could you just explain to me and to the board

what a completion factor is and what margin is?
A. Sure. So a completion factor is an estimate of given paid claims through a certain date, what will the total incurred claims for a given period be? So, and what I mean by best estimates before margin is that, for purposes of financial reporting, we are required to use estimates that include an element of conservatism. We removed that element of conservatism when performing the, the incurred claim projections for this modeling.
Q. Okay. And, and what, if anything, is the difference between margin and profit?
A. There's a huge difference between the two. We're a not-for-profit. There is no profit anywhere in anything that Blue Cross Blue Shield of Vermont does. What margin means in this context is that, again, we are required for statutory accounting purposes to include some element of conservatism within the projections that we're doing. That's a requirement, because statutory accounting requires that we consider moderately adverse conditions when we're putting that accounting together. That's not a decision Blue Cross makes. That's, that's a required element of that accounting.
So, when we're using margin in this context, it has absolutely nothing to do with profit. It doesn't

even have anything to do with policyholder reserves or CTR. What it means is it's an explicit margin that we include in our completion factors for purposes of producing financial statements as required by statutory accounting principles.

Q. Could you turn, please, to page, to Exhibit 6, Page 59, and there are a lot of numbers on that exhibit, and I would like you to go through them with me so that I understand what they are and the board understands what they are.

A. Okay.

Q. Are you there?

A. I am.

Q. So across the top you've got five columns, Vermont capital region, no second wave, Boston suburban southeastern New York. You see that?

A. I do.

Q. Okay. What is -- why do you no second wave presumed, I think I understand what that means. No second wave means you're assuming there will be no second coronavirus wave, correct?

A. Yes.

Q. Okay. Then, under the other four columns where there are no numbers, what, what do those, what do the headings for those columns denominate?

A. Sure. So these have to do with our various scenarios as to the severity of a second wave. So, as you correctly pointed out, we did model what happens if there is never a second wave. In the, in the left-most column we modeled what would happen if Vermont experienced a second wave but it was exactly the same as the first wave. That is to say that the best experience in the country in terms of preventing infection and preventing hospitalization and death.

So, in order to provide a variety of scenarios, we thought it would be instructive to look at what's happened in other nearby regions and see what the impact to Vermont would be if our experience within a second wave matched something that was more like some of these other areas. So I'm not trying to make any predictions that Vermont is going to suddenly look like suburban southeastern New York, but, for purposes of understanding what a scenario like that looks like, we did model it, and we did summarize those results within this, this page.

Q. Mr. Schultz, have you ever sold a house?

A. I have.

Q. Okay. And, when you try to figure out or when the real estate person tries to figure out how much to ask for your house, they look at comparables, right?

A. They do.
Q. Okay. Could you tell me why you thought, why you think, apparently, that Boston and what you call southeast, suburban southeast New York, which I assume is a euphemism for metropolitan New York, can you tell me why you use those as comparables rather than Maine or New Hampshire or Wyoming or some other sparsely populated state?
MR. DONOFRIO: I'm going to object to the form of the question. You embedded an assumption about what the Witness thinks or doesn't think, and it contains some argument, but, if you're able to follow the question, you can answer.
MR. SCHULTZ: Thanks, Mr. Donofrio. So, first, I'll just say suburban southeastern New York is not a euphemism for New York City. We, we used White Plains, as it happens. Infection rates were very similar in most areas in New Jersey as well. I don't think that's what's going to happen in Vermont.
To repeat my testimony, we modeled a number of different scenarios that range from the very best experience in the entire country to one of the worst experiences in the entire country. We did not model an experience that, that would be something that like Italy experienced or some scenario that is something

that hasn't been experienced by anybody anywhere. We looked to nearby areas for the purpose of informing us what happens if Vermont's experience in the first wave is not as good, I'm sorry, Vermont's experience in the second wave is not as good as it was in the first wave where we were, as many witnesses have stated, and some counsel as well, we had the best experience in the country in the first wave.

If you don't derive value from those Boston or suburban southeastern New York columns, then, by all means, feel free to ignore them. That's why we included the Vermont column. That's why we included the no second wave column.

BY MR. ANGOFF:

Q. Okay. Let's go, let's go through these numbers. I see the 567 RBC. I get what that is. That's the RBC, blue Cross's RBC ratio as of the end of year last, in 2019, correct?

A. Yes.

Q. Okay. And then impact of changes in insured volume of a plus 75 percent, what does that mean?

A. Simply put, our insured membership declined from 2019 to 2020. Because of that, the denominator of the RBC calculation will also decline, which means that, for a given level of surplus, we actually have a higher

RBC, not by virtue of having increased that surplus, but by virtue of the denominator being lower.
Q. Okay. So the fewer, all else equal, the fewer insureds you have, the lower RBC can be?
A. Correct. Well, I'm sorry. The fewer, the fewer insureds we have, the higher RBC will be for a given level of surplus.
Q. Okay. I'll accept it that way. Just very briefly, I know you talked about this a little bit, and I don't want to, you know, I don't want to prolong this, but why has Blue Cross lost so much business?
A. We attribute it to the pricing differential that exists between us and MVP. It's a pricing differential that's, that's existed for quite a long time. That differential won't get any worse based on this year's filing, but neither will it get better, and we, we've seen membership losses over time primarily for that reason.
Q. Did you ever think that maybe, if you asked for a little less of a rate increase, you'd have more members and that that would be better for the company overall?
A. Well, I, I testified to this earlier as well. The membership changes do not actually have that much of an impact on the 2021 rates. We can see that, because we're not asking for a bigger increase than MVP. We

can see that through our analysis as well.

I also testified that, inasmuch as rates are underfunded, and that's what I take your question to mean, if we were to intentionally ask for premiums that were below actuarially sound levels, what that would do is reduce our surplus and make it less possible for us to invest in new programming like the Civica RX initiative that can actually bend the cost curve and lower costs for Vermonters.

What we have to do here, in other words, is not present some sort of nominally lower rates that are going to deplete our surplus and compromise our ability to implement programming that will, in fact, bend the cost curve. What we need to do is to have the ability to invest in that programming so that we can bend the cost curve both through participating in Vermont state initiatives and through implementing our own programming.

Q. Okay. Then the next number is projected impact of 2020 operating results. You say that that reduces RBC by 17 percent?

A. Yes, that's right. It's important to take that in conjunction with the next number, which is a plus 16 percent for investment results. Our, as we talked about our historical financial performance, our

operating results in the absence of investment income have tended to be zero or negative over the last several years. We expect that to continue based upon rates that were approved versus rates that were requested, and we expect further that the investment income will offset the operating losses.

Q. Okay. So let me ask you about each of those individually, because neither of them seem to make sense to me. I may be missing something. But, when you say projected impact of 2020 operating results is a loss of 17 points, what that means, isn't it, is that you are losing money on your 2020 business, correct?

A. That means that we're not making, we're going to make less, we expect to make less than the 1.5 percent CTR that is required to maintain a constant level of RBC.

Q. Okay. And so is that negative 17 net of how much you all saved because of minimal coronavirus costs, or is that just based -- strike that. Let me ask it again.

Can you -- you agree, don't you, that Blue Cross is, will be paying out in 2020 less than Blue Cross projected in 2019 that it would be paying out in 2020?

A. Yes, I do.

Q. Okay. If that's the case, if you're paying out

less than you, for 2020 than you projected in 2019 that you would be paying out in 2020, how can the impact to operating results be negative rather than positive?
A. Because this is the impact for the baseline scenario before we consider Covid impacts. The Covid impact you're talking about can be found in a -- we don't have these labeled, but it's farther down the page --
Q. Okay. I get it.
A. -- just below the, the second subtotal.
Q. I get it. Thank you for that description. Then, conversely, when you say that the projected impact of 2020 results is a plus 16 percent, not to harp on this, but how can it possibly be a plus 16 percent where you guys lost 40 million bucks?
A. So two reasons for that. One is this, this is not the pension investment results. That flows through an entirely different accounting mechanism that I'm sure Ms. Greene will be more than happy to elaborate upon. This has to do with the investments we make relative to the premium dollars that we take in relative to the cash flow of that, those premiums and the, the claim payments out. So this is not pension investments but other investments that we make as we maintain a certain level of assets.

Q. Okay. But, but the pension money -- okay. So you include -- the pension money is on this; it just comes, it, we'll find out about it later on down in the, in this exhibit?
A. Yes.
Q. Okay. Then investment in Vermont Blue Advantage, that's a negative 20 percent. You see that?
A. Yes, I do.
Q. Okay. And what's Blue Advantage?
A. Vermont Blue Advantage is a, is a brand new company that's going to begin offering Medicare Advantage plans in Vermont in 2020 --
Q. Okay.
A. -- I'm sorry, in 2021. I misspoke.
Q. Okay. And Medicare Advantage plans are not for people in the individual and small group market, correct?
A. Correct.
Q. Okay. And so why should people in the individual and small group market be paying for Blue Cross to make an investment in a company that is not in the individual and small group market?
A. That's an interesting question. We, you know, Blue Cross is, looks to provide quality products to all Vermonters. There has been a lot of market demand for

us to get into this space, and it's important for us as a going concern to be able to invest in the types of new products that expand access to quality care for all Vermonters.

Q. Okay. And then the negative 6 percent on the next line, that's in a -- what is that for? What's the new company that that goes to?

A. That's, that's for Civica RX, which Dr. McIntosh testified to. Civica RX is an, an innovative solution that's going to bring lower cost generics to the state and make them available to our policyholders. So that's an investment. Again, it's a really good example of an up-front investment that we need to be able to make in order to bring greater affordability a few years down the road, in this case starting in 2022.

Q. Okay. And that's something that would benefit individual and small group policyholders, correct?

A. Yes, it will.

Q. Okay. So you, you net out all those, and you got a baseline RBC as of December 31st 2019 of 657, right?

A. Yes, that's right.

Q. Okay. Then there are more adjustments, right? The equity market losses of a negative 14 percent, again, that doesn't include the 40 million bucks. What is that?

A. So, again, that relates to those investment results that we talked about earlier. That's our, that's our typical cash flow separate from the pension funding.
Q. Okay. And is, is a 14 percent loss on, equity market loss typical for Blue Cross?
A. You'll have to ask Ruth Greene that. She's our treasurer. She'll know that answer.
Q. Very good. Then there's a plus 42 percent for the acceleration of the AMT credits, and I believe I understand that the AMT credits were supposed to be spread out between 2019 and 2022, but you guys are getting it all in 2020, correct?
A. That's my understanding.
Q. Okay. And is that, is that about 40 million bucks total? I'm sorry. That's a bad question.
Does the total, do the total AMT credits amount to about $40 million?
A. That sounds about right to me, yes.
Q. Okay. I see the 2 percent risk adjustment true-up. I won't harp on that. The 46 percent, that is for the, the risk corridor litigation based on the Supreme Court's decision a few months ago, correct?
A. Yes.
Q. Okay, all right. And then, and then you had this

negative one, 180 based on the $40 million, which I've said enough about, but that's what, that's what produces the 553, right?

A. Yes, that's right. It's part of the calculation.

Q. Sorry. The, the difference between the 657 and the 553 is because of the various adjustments between the 657 and the 553?

A. Correct.

Q. Okay. And then so, if you, if you disregarded the 180 percent hit to RBC because of the $40 million investment loss, then what would Blue Cross's RBC ratio be?

MR. DONOFRIO: I'm going to object just to a word choice. Mr. Angoff said "investment loss", and I just want to be clear I believe he's asking about the pension loss just to keep the record clear.

BY MR. ANGOFF:

Q. Yes, I stand corrected. That's what I mean. If you, if you disregard the $40 million in pension, in the -- if you disregard the $40 million investment with respect to the pension plan and thus disregard the 180 percent drop in RBC, what would Blue Cross's RBC ratio have been in 2020 before Covid impacts on operations?

A. Doing a little quick math, it looks like 733 percent.

Q. Okay. Then, with the, the numbers right below the 553 number, you've got there are different numbers, obviously, for the different, the different scenarios that you assumed. So that, so that means, if we just look at that, those five numbers, those five numbers are the estimate of the impact to RBC based on Covid-related claims and deferred care in 2020, correct?

A. Specific to 2020, yes, that's right.

Q. Okay. So there's a positive 60 percent impact for no second wave; is that right?

A. Yes.

Q. Okay. But only a positive 33 percent impact for suburban southeast New York?

A. Yes.

Q. And a 98 percent positive impact for Vermont?

A. Yes.

Q. Okay, all right. And thank you for your patience. I know this is grating, but I want to make sure I understand all this. The next set of adjustments are all Covid-related adjustments; is that correct, the, the adjustments before you get to the estimated RBC as of December 31st 2020?

A. Yes.

Q. Okay. And how did you -- what methodology did you

follow in determining those, those impacts?
A. So it, it kind of varies by item. In terms of uncollectable premiums, I can give you a very brief overview, but Ms. Greene is the person responsible for this estimate. So we know that we have extended grace periods quite significantly during the emergency. We expect that a lot of those premiums will, in fact, never be paid, and so we, we have a 21 point impact to RBC that's estimated here.

The canceled -- the next item is a 6 point impact due to the cancelled recruitment of Blueprint overpayments. That one kind of is what it says it is. We were going to recoup those overpayments from providers, but, in light of the crisis that's ongoing, we decided to forgive that recruitment.

Q. Yeah. If I can just try to shortcut this a little bit --
A. Sure.
Q. -- these, these are estimates for projections, right? There's not formula that you used to determine these numbers?
A. There's, there's no formula. These are, these are all our best estimates of what the impact is or is going to be.
Q. Based on actuarial judgment?

A. In, in many cases, based on actuarial judgment. In some cases, based on -- the Blueprint number, for example, is reality. That's an actual number. The pharmacy number as another example is a projection based upon the six months of pharmacy experience that we have to date. So we have some pretty good line of sight into how that pharmacy experience is emerging. So I would consider that and a number of these other items pretty solid projections.

Q. Okay. Can you just go down to the last line before the footnote under key assumptions? You see the two key assumptions?

A. Yes.

Q. Okay. And the second one is no significant loss of membership due to economic downturn. Do you think that's a reasonable assumption?

A. I do. We, we've seen some small membership losses to date, but we have not seen what I will term a significant loss of membership at this point.

Q. Okay. And my final question for this exhibit is you see just the, you see in the line right above key assumptions it says RBC as of May 31st 2020 and then 695? Do you see that?

A. I do.

Q. Okay. Does that 695 include the 180 drop because

of the $40 million loss or exclude it?
A. Again, I'll defer that question to Ms. Greene who will be able to and, I'm sure, has the answer to that. I didn't want to say the wrong thing. So we'll wait for her to give us the right answer.
Q. Very good. You, you're familiar with Oliver Wyman's conclusion that your projections here are somewhat conservative, right?
A. I am.
Q. Okay. And you know that they say that, based on their analysis, that the net effect of the, the impact of the coronavirus should be between 21 and 105 points positive, that is, RBC should increase by somewhere between 21 and 105 points, correct?
A. I have seen that, yes.
Q. Okay. And you disagree with that?
A. Completely.
MR. ANGOFF: I believe, Mr. Schultz and Mr. Chair and members of the board, you'll be pleased to hear that's all I have. Thank you, Mr. Schultz.
MR. SCHULTZ: Thank you, Mr. Angoff.
MR. BARBER: All right. So we're going to move on to board questions. Start with Member Lunge.
MS. LUNGE: Thank you. Okay. Hold on just one second. Hi, Paul. I hope you're doing well.

MR. SCHULTZ: Hi, Robin. I am, thank you. You too.

MS. LUNGE: So on the -- let me start with asking you about the Oliver Wyman estimate that we were just talking about. So you had testified earlier that the second version of, of the modeling in Exhibit 17 takes out the conservatism. Am I remembering that correctly?

MR. SCHULTZ: It takes out any element of conservatism that we could find, yes.

MS. LUNGE: Okay. So didn't Oliver Wyman indicate that part of the conservatism was related to the deferred care assumption?

MR. SCHULTZ: They did.

MS. LUNGE: And your testimony today is that the 56 percent chart that's in Exhibit 6 is the correct chart; is that right?

MR. SCHULTZ: So that chart is correct in terms of the returning care by line of service. The 51.7 percent that's included on the chart in, I believe it's Exhibit 17, that 51.7 percent is the new overall assumption.

MS. LUNGE: Okay. So you, you, the modification you made was to drop that from 56 to 51 percent? I'm rounding.

MR. SCHULTZ: It is. It's really a function of math rather than a modification. You know, as we included the June data, each of those 33 service categories had a different result in terms of the amount of deferred care. So we did the, when we did the math on the new data, we come up with 51.7 percent rather than 56.1 percent.

MS. LUNGE: Okay. Thank you. I think you heard my questions to Kate about the cost-containment programs. Is, are you the right person to ask about that, or should I direct those to Andrew?

MR. SCHULTZ: I hope I can answer some of them. So let's, let's give it a shot.

MS. LUNGE: Okay, great. So, in the actuarial memorandum which is Exhibit 1, Page 37, there is a discussion about cost-containment programs that were delayed due to Covid, which included programs that would reduce inpatient readmissions and reduce ED admissions. What I was hoping to understand was a little bit more in terms of the rationale for not resuming those programs at some point in 2020.

MR. SCHULTZ: It's a good question. I'm not in charge of those programs. So I'm not making those decisions. So, hopefully, Mr. Garland may be able to give us some insight there.

MS. LUNGE: Great, thank you. I'm going to ask him about the home infusion program, too, unless you can tell me the difference between the program that was discontinued and how that's substantively different than a reduction in prior auth.

MR. SCHULTZ: Yeah. So my understanding of the program that was discontinued is that this was some kind of positive outreach to try to encourage members to use more home infusion rather than traveling to the hospital. So it's really that outreach that's been suspended to try to move those, the site of that care from hospital to home. The prior authorization program is, is something that's completely separate from that.

MS. LUNGE: Right. But wouldn't you expect the same result that, if there's no prior authorization, more people would get it?

MR. SCHULTZ: Good question. Potentially. I've not studied that data myself. So I, I, you know, I'd want to do so before saying something conclusive about that.

MS. LUNGE: Okay, thank you. Sorry. I'm taking notes, which requires me to flip back and forth in my notebook. So give me --

MR. SCHULTZ: No problem.

MS. LUNGE: And do you have any utilization

statistics on the change in home infusion over the course of Covid?

MR. SCHULTZ: I don't, no.

MS. LUNGE: Okay. Is that something that you can get us, or do you think Andrew would have that?

MR. SCHULTZ: I doubt Andrew has that at his fingertips as well. So that's something that I can follow up with.

MS. LUNGE: Thank you. Okay. So you testified about that care was already returning to the hospital. Can you give us more specifics about what kind of utilization you're seeing?

MR. SCHULTZ: So, overall, we're seeing our estimate of June utilization is about 5 percent above what we would expect based on historical norms and that --

MS. LUNGE: For what?

MR. SCHULTZ: I don't have all the numbers at my fingertips by service category, but we definitely see some surgery service categories running at way over 100 percent. There are some surgical categories that have not returned yet to 100 percent. To my recollection, things like heart surgeries and lung surgeries are still pretty low. I, I'm not a practitioner, but I'm, I'm guessing that's because

hospitals may still be grappling with how to safely do those surgeries in a Covid environment, but, for a number of other service categories specifically related to surgery, we're way above 100 percent.

Mental health is also pretty escalated. I don't think any of us will be surprised by that, given everything that's going on, and I, while I've looked at kind of that full distribution by all 33 categories, those are kind of the ones that I'm remembering off the top of my head.

MS. LUNGE: Yeah. So you also talked about how the change in membership did not create a change in the 2021 rate. Is that your testimony for the 2020 rate?

MR. SCHULTZ: For the 2020 rates, we did, in fact, have a submit a higher increase than MVP. So, using the same comparison, you might be tempted to conclude that the membership losses were driving the increase. I, my conclusion is a little different from that. I know that MVP -- I'm not here to talk about MVP's filings. I'm not the expert in them, but I can say that MVP, in 2020, submitted a utilization trend of zero. I know that was ordered to be increased as part of the process last year.

So my professional actuarial opinion is that MVP

included a utilization trend in last year's filing that was much too low. I personally would not use a 1 percent utilization trend for this year either, which is what they filed for this year's filing. So, if, if I were MVP's actuary, which I'm not, I don't think a 1 percent trend is, is reasonable. So I think their rate may be too low this year as well.

MS. LUNGE: So but the membership has impacted the morbidity of your population, has it not?

MR. SCHULTZ: It has impacted the morbidity. Yes, that's true. And we have adjusted for that in doing our utilization trend projections.

MS. LUNGE: In this year or only in prior years?

MR. SCHULTZ: I'm sorry.

MS. LUNGE: In this year or only in prior years?

MR. SCHULTZ: In this year and in prior years we have consistently adjusted for morbidity changes in the population when developing our utilization trend.

MS. LUNGE: So in Exhibit 1, Page 163, which is the CTR chart --

MR. SCHULTZ: Yes.

MS. LUNGE: Myself here. Where it says approved contribution to reserve, these numbers don't

reflect what the board approved; isn't that right?

MR. SCHULTZ: That is correct.

MS. LUNGE: So these numbers you have adjusted based on other changes that the board made in its order assuming that those would fall to the CTR; do I understand that right?

MR. SCHULTZ: Yes, you did.

MS. LUNGE: Thank you. Okay. In terms of the investments in Blue Advantage, which other markets are contributing to the Blue Advantage program?

MR. SCHULTZ: That's a hard question to answer. I mean, all of the entirety of our book of business contributes toward our surplus and, therefore, toward our overall RBC.

MS. LUNGE: Including self-insured plans?

MR. SCHULTZ: Yes, that includes self-insured plans. So it's not, it is not as if we're, you know, we're not doing something as direct as saying, okay, we need to increase this rate by 5 percent or half a point or whatever to pay for Blue Advantage, right? It's, our surpluses are aggregated, the, the result of our aggregated operations over the entirety of the time that Blue Cross has been in business.

So, when we decide to spend that surplus, whether that's on a new, making a new product available so that

we can improve access and quality for a segment of Vermonters that we weren't able to serve before, or if that's for new programming that's going to make the cost of care more affordable for all Vermonters, that comes from that entire amalgamation of 40-plus years of business that we've done.

So, yes, it's all in there. If you want to think about who has contributed toward that, it's self-funded lines. It's these insured lines we're talking about today. It's large group insureds, our Medicare supplement business. It's our investment performance over time. It's kind of all of those things intermingled.

MS. LUNGE: Okay, thank you. In the administrative costs or cost of insurance estimates, did you include any assumptions related to the federal requirement to provide a separate bill for abortion services?

MR. SCHULTZ: We did not do anything explicit there, no.

MS. LUNGE: Okay. So there's no increase in your administrative costs relating to that requirement?

MR. SCHULTZ: That's correct. There is no increase.

MS. LUNGE: Thank you. That's good, because

it's not happening, so we wouldn't want to charge for it. Okay. So I have some questions related to unit costs and items that are in the confidential portions of the exhibit. It might, if it makes sense, Mike, to hold those until all, everybody else has gone, because I might not be the only one.

MR. DONOFRIO: Yes, that makes sense. Thank you.

MS. LUNGE: I meant our Mike.

MR. DONOFRIO: Oh, sorry.

MS. LUNGE: That's okay.

MR. BARBER: Which exhibit, Robin?

MS. LUNGE: Well, I have on page, Exhibit 131 there is a sentence that is confidential related to fee schedules.

MR. BARBER: Yeah, I think, Mike Donofrio, do you anticipate an executive session for Andrew Garland's testimony?

MR. DONOFRIO: I believe so. If, if Bridget can chime in, Bridget has been working most directly with Andrew. You'd get a better answer from Bridget on that.

MS. ASAY: Yes, we do anticipate an executive session for Mr. Garland.

MR. BARBER: Okay. Why don't we do all of it

at once?

MS. LUNGE: That makes sense. Because my questions may be for Andrew. I'm not sure. So that would be more efficient, I believe. Okay. Then I'm good. Thank you.

MR. SCHULTZ: Thank you, Robin.

MR. BARBER: Okay. Maureen?

MS. USIFER: Hi, Paul.

MR. SCHULTZ: Hi, Maureen.

MS. USIFER: A couple questions. In the opening arguments and something that you've also touched upon, which is that your rates submitted have been lower than the competitor's this year, so 6.2 versus 7.3.

MR. SCHULTZ: Yeah.

MS. USIFER: And one of the things I guess I want to look at, How do we think about the risk transfer adjustment? Because, prior to the risk transfer adjustment, the Blue Cross rate increase would be 7.7 percent, and the MVP rate increase would be 6.1. So, basically, you have a higher rate request, I think, on the underlying rate than does MVP, but, because there's an assumption that, based on the risk transfer, I guess, that you'll have unhealthier people and you'll have paid more, which is included in your rates, you

get money back.

Am I thinking about that wrong? I just want to make sure, because, you know, it's kind of a new approach for you guys to be looking at the competitor and what they're charging, and I tend to look at it prior to risk transfer as what the underlying rates are, and then the risk transfer is a separate adjustment. I just wanted to get your point of view on that.

MR. SCHULTZ: Yeah. I think that's an appropriate way to view it, but the, while the risk transfer is a separate adjustment, it's very closely related to kind of that underlying amount that you talked about as well. In other words, the reason that our increase without risk adjustment is higher than MVP's is because we have a, we have all the, the folks who have higher health care needs. So, really, the risk adjustment program is working exactly as intended. Inasmuch as, you know, one carrier has much more of the unhealthier risk and the other carrier has most of the healthy risk, the risk adjustment transfer is supposed to net that out.

So I, you know, I, I look at things myself as well before the risk adjustment transfer, and I often see that we're having losses because claims are higher than

I projected, but then the risk adjustment transfer comes in higher than expected as well and kind of washes that out. That's the way those two things are supposed to work, and it appears to be working that way in Vermont.

MS. USIFER: Just to that, how then should that relate to premiums charged? So if, if, in fact, a risk transfer is kind of helping to set the market straight, right, wouldn't, wouldn't, in theory in a perfect world, wouldn't then, you know, the risk transfer make the rates comparable on similar plans, so gold to gold, bronze to bronze, etc., you know, knowing there's a different mix of people? And I'm not trying -- I'm just saying, you know, to me, I thought that's part of what it's supposed to do, and so why doesn't that happen?

MR. SCHULTZ: Yeah, that's, that's a really good question, and I've been spending a lot of time over the past couple of years trying to answer that question for Blue Cross. So what, what we're seeing is that the morbidity differences between Blue Cross and MVP net of risk transfer are not really changing over time, because that, that net increase that we're asking for is, is very similar to what MVP is asking for, and as, as I respond to, to Robin Lunge, I think there are

some other reasons why MVP's rate requests have been a little bit lower than ours in past years specific to the utilization trend assumption.

So I think about risk adjustment. While the situation isn't really worsening, I do think there's an opportunity there and that, if we were able to optimize risk coding, in other words, if doctors in Vermont were coding for every condition that a member has but no conditions that a member doesn't have, so, if risk coding were perfect, I do believe there's a pretty significant opportunity to increase that risk adjustment by as much as $10 million in terms of the transfer, and, if we were able to make that happen, that would bring our rates very much more in line with MVP's.

So I, I am working with some of my teammates and others within the organization on just that, to try make that happen, because we believe the risk adjustment has not been really operating at 100 percent maximum efficiency and that there's some opportunity there.

MS. USIFER: Okay. Because, I mean, it would be obviously good if our Vermont-based insurer could be, you know, competitive with the, you know, other insurers to, to keep that viable.

When, when you talk about admin costs, and you actually quoted, you know, something that was in the reports, you know, 90 percent lower than, you know, in the L&E report, again, you know, kind of all well and good, but, when we look at in the state, right, and amongst the two filings that we have, you know, Blue Cross is, is over 12 percent higher on a PMPM basis than what MVP is for an admin rate, and, you know, again, so we're kind of comparing, you know, within our market, right, and there's different dynamics that go on there, and I know they're coming out of you New York, etc. But, you know, how should we look at that? Because it's pretty significant to have, you know, such a high increase on a PMPM, high comparable on a PMPM basis.

MR. SCHULTZ: So I, first, I'd say probably percent on a percent of premium basis is the more apt comparison to make. A lot of the administrative expenses are variable, and they are variable with respect to the number of claims. If a, if members are not using an awful lot of care, they're not calling the call center as much, we're not processing as many claims, etc., etc.

So there's a whole line of sort of variable expenses that do fluctuate based upon the amount of

care that's consumed. So, for that reason, I, I personally would steer clear of PMPM comparisons and look at it more in relative to percent of premium. Beyond that, I'm not sure that I can give you any, like, key insights into, into MVP's administrative structure or how or why it might be any different from Blue Cross's administrative structure.

MS. USIFER: Okay. I'm going look at two charts, one, the Exhibit 1, Page 163 that we've talked a lot about which had the 12.6 million actual operating losses in the past six years, and I think you were adjusting it slightly for what you now know may be a little bit different, and so I think you were increasing it by maybe, you know, 2.8 million. So is that about right? So you're going to be about 15 million, and, if I look at actually the last three years including that additional change, it's been a net change of about, I think, a negative $3 million.

MR. SCHULTZ: Yeah, I think that might be a little bit much. Again, I'm doing math on the fly, which I'm not supposed to be doing, but I think the risk adjustment transfer true-up was a little bit less than a million dollars, if I'm recalling correctly.

MS. USIFER: Okay.

MR. SCHULTZ: So that that 12.6 probably

becomes something in the range of 13.5, 13.6, somewhere around there. But, yeah, apart from that clarification, I think your understanding of what we show in the chart is accurate.

MS. USIFER: Okay. And then, if we go to Exhibit 6, Page 59, you know, looking at the RBC and what's gone on there, would it be fair to say -- or I guess I'll ask the question. You know, on average, you know, year over year on average, knowing there's ups and downs, but do you project investment gains?

MR. SCHULTZ: Yes.

MS. USIFER: Do you expect investment gains, on average?

MR. SCHULTZ: Yes.

MS. USIFER: Okay. And the reason I point that out is because, as we look at the number that you had for this last six years and even if we make it the last three years, but, for the last six years, I think it had a total of about a 70 point impact on RBC. Is that correct?

MR. SCHULTZ: In terms of the operating losses or --

MS. USIFER: Yeah. So $12 million in operating losses --

MR. SCHULTZ: Yeah.

MS. USIFER: -- has had about a, about a 60 percent, 60 points, and we would expect that we would have investment gains. So I just point that out, because we hear a lot about what the Green Mountain Care Board has done to the rates, and, you know, here we have a six-year trend, we have a $12 million loss -- maybe it's a $13 million loss -- over six years, and we did expect, as a company, you would expect there would be investment gains that would offset that. So, overall, I don't think that's, that's too bad. I mean, I know there's puts and takes, but --

MR. SCHULTZ: Well, I do want to point out I think it's important to recognize that the 1.5 percent CTR that we file assumes that we will have investment gains. So, if we did not have investment gains, our required long-term CTR would not be 1.5 percent but something quite a bit higher than that. I can't sit here and do the math right now, but, for sake of argument or sake of illustration, I'll just say that might be 3 percent, but, because of investment gains, we're able to bring that back down to 1.5 percent.

So I do think what we were showing in the earlier exhibit is a fair comparison, because it shows what's happened from operations. We do expect some investment gains, but those investment gains are what allow us to

file a CTR that's as low as 1.5 percent instead of filing something much higher than that.

MS. USIFER: And I know last year we talked a lot about the, you know, AMT tax and what was going to happen and whether it was admitted or not admitted, and all this went back and forth, but, you know, at this point, when we look as of May, reported 695 for an RBC. When you look to the end of the year prior to the pension change, it would be 733, and prior to any other Covid adjustments, which would put us near the top range of the 590 to 745.

And, you know, I'm not going to belabor the point at this point, but that, you know, the 180 basis point hit that's going to be expected for the pension, from what I've been reading, it doesn't occur until 12/31. So it's not in the May numbers. You know, that 180 first contrasted to what we just said was a six-year loss or a six-year change for this plan with the 60 basis points or 70 basis points.

So, just to kind of shift to the magnitude of what this 180 is going to potentially do to the, to the RBC is huge, and I think the, you know, prior questioning, you know, is very relevant. Whether we say it impacts or not, it impacts. It's, when this hits at the end of the year, if it's still 180, it will be 180 basis

points reduction, which will bring us now to the lower end of the range, versus being quite healthy in the upper end of the range.

So, you know, I'm sure there will be some other questioning on this. You know, I know it wasn't what was expected to happen with this pension and there's going to be lawsuits and everything else going from this, but, you know, it's a significant burden, and it's three times the size of six years of, of impact for what, what has been for the, you know, for this book of business.

So I don't know the answer to it. I don't know what we do, but it certainly, you know, it certainly plays into what's happening, and I'm sure it was a big surprise to everybody, and I'll, I'll just leave it at that for now, but I do think it's pretty critical.

As we talk about the, and I believe this is nonconfidential, but, you know, the hospital rates and what's, what has been approved and then what rolled through this filing, specifically to Exhibit 21, which was rates that had been submitted potentially by UVM, I just want to get an understanding on what's included in the rates right now. Have we included just the prior hospital rate increases, or have we overlaid? I believe we have overlaid. I believe you've overlaid

this increase in there, and can you talk to that?

MR. SCHULTZ: We have not included this increase. This is something that, you know, the letter that's included in the exhibit came to our attention well after the filing date. So what we included in the filing was simply an assumption that the commercial rate increases that were approved in 2020, were approved in 2019 -- it's hard for actuaries to keep our years straight sometimes. Sorry about that -- that the commercial rate increases approved in 2019 would match the commercial rate increases that you're about to approve in 2020.

MS. USIFER: Okay. And we talk a lot about the rate increases and comparing, so when we're going to get the new numbers in and the rates, you know, inevitably won't be the exact same, and we, we, you know, look to, you know, you always look to adjust that and put that into your plans. How do you look at utilization and what the hospitals put in their budgets for utilization? Which, I think, is, is equally as important for all their utilization assumptions, and I just want to get a handle on, you know, how do you guys look at that as well, or can you? I mean, obviously, their utilization is of all types, and, you know, but still there are major assumptions that you have and

major assumptions that they have.

MR. SCHULTZ: Yes. So I do think hospitals' utilization assumptions are extremely important in terms of assessing their commercial rate asks. You know, especially given that we have already seen a huge deferral of care and we expect a lot of that care to return, I don't think it would be appropriate to include a zero percent utilization in a hospital budget.

Beyond that, and you kind of started touching on it, Maureen, I believe that our utilization trend is the most accurate utilization trend specific to our business. Hospitals have to consider Medicaid. They have to consider Medicare. They have a whole host of patients that are well beyond just our insured patients. They have to consider, you know, state employees, Vermont teachers that are part of self-funded programs.

So, you know, it is, it is not exactly an apples-to-apples comparison. So I do think it's an important assumption, and I'm glad that the board will be looking at that for hospital budgets as well, but I also think that our assumption is the best assumption that we can use specific to the Blue Cross utilization for Blue Cross members in these lines of business.

MS. USIFER: Okay. And one last question on cost savings and cost containment. You know, there have been things in prior filings, there are things in this filing, and there will be things, obviously, in future filings. I just really want to push on, How much can we get from the cost savings or cost containment? I know, I believe it was last year, I think, in some of the testimony, you know, when we put in 1 percent for affordability, it was like, well, we, you know, we, if you told me in advance that I needed that, I could get it, but you can't tell me in the current year. Something like that was stated, right?

So how do we get? You know, maybe there's already some in for '21. There is, but how do we get that bigger in the future filings? How can we say now, I want that to be 2 or 3 percent, you know, next year? I mean, what are we working on and what can we get, and how can we push that harder?

MR. SCHULTZ: Yeah, I think having that guidance early from the Green Mountain Care Board as to what your expectation is will, will help us as we strive to implement that, some of that programming. It, it's not always an easy thing to implement some of those savings programs, because we are often making tradeoffs.

While we're enhancing affordability, we might do that by restricting in some way access to care, whether that's directing -- you know, if we think about some of the cost differentials and so forth that exist within the hospitals, one thing we could do, potentially, is direct members who need a colonoscopy, for example, to one facility over another. That could generate some savings, some enhanced affordability, but at the cost of access. You can no longer drive down the street and go to your local hospital and have this service. You might have to drive 45 minutes down the road, an hour down the road, something like that.

Other programming that we're implementing has an impact on providers, and we often get an awful lot of push-back from providers when it comes to implementing that kind of programming. So, yeah, there are some things we can do. In this year's rates, we've included, as I testified, about $5 million worth of savings through Blue Cross programs. That $5 million is, is going to be something like maybe 1.7 percent or so of total premiums. So that's a pretty good number. We've already included that. And, if you tell us now that, We expect you to include some number, 1 percent that's been your affordability cut in the past, 2 percent, whatever that number may be, I think that

would be helpful for us as we try to take strides to actually achieve those savings and incorporate them into the premiums.

What we can't do is, as you alluded to, we can't react immediately. So, if you tell us now, We need you to achieve an extra 1 percent in savings through this programming by next year, there's just not enough time to develop and implement a program by the start of 2021 to achieve that savings in 2021. If you told us right now, We expect you to achieve an additional point of savings in 2022, then that gives us enough runway to actually figure out how to do it, if you will.

MS. USIFER: And you could exceed your savings, as you have this year. I think you had exceeded in one, some of the commentary, you exceeded how much you thought you would get. So, I guess, are you conservative in what you roll in there for these estimates?

MR. SCHULTZ: It's a good question. We try not to be. Sometimes it's, it's difficult to, to project exactly how much savings we're going to see. Some of the programming that we had in in the last few filings isn't going to, isn't going to lead to the type of savings we had estimated, for large part because we've had to suspend a lot of those activities due to

the pandemic.

So sometimes things come to fruition. Sometimes they exceed what we thought they were. The lab benefit manager is a good, is a good example of one that's actually worth more than what we thought. So, while we had something in our rates last year for it, we actually achieved something greater, and that delta flows into this year's rates. So that, you know, the savings that we're including as part of that $5 million in this year's rates are on top of the savings that we already assumed that we were going to achieve in last year's rates. It's all cumulative as we go along.

MS. USIFER: Okay. That's all for my questions. I'm sure I have some others, but I'm sure the other board members will address those as well. So thank you.

MR. SCHULTZ: Thank you.

MR. BARBER: Okay. Next, we'll go to Board Member Pelham.

MR. PELHAM: Hi, Paul. How are you?

MR. SCHULTZ: Morning, Tom. I'm quite well. How are you?

MR. PELHAM: Are you holding up okay?

MR. SCHULTZ: I am holding up okay, yes. Thank you.

MR. PELHAM: So I want to start with just a little bit of housekeeping just to be sure. I want to go back to Exhibit 23.

MR. SCHULTZ: Okay.

MR. PELHAM: And that was the Kaiser chart.

MR. SCHULTZ: Yes.

MR. PELHAM: And just, so, at the top of your version of it, you, where you've added Blue Cross Blue Shield's profile, it says individual, slash, merged market medical loss ratios, and then, when you click on the link, it says average individual market medical loss ratios. So I'm just wondering. Is this an apples-to-apples comparison? Did you put in, insert the merged market to make it clear that in Vermont it's a merged market, but are these numbers nationally just for the individual market?

MR. SCHULTZ: They are just for the individual market, and I, I do think that's the best basis of comparison relative to our merged market. When CMS issues various reporting about how the markets are performing, whether that's related to MLR rebates or anything else, the Vermont merged market is included with all the individual market reporting.

So I do -- you know, it's, as you point out, it's not a precise comparison, but I think it's the best

comparison we can make.

MR. PELHAM: Right. I mean, especially, it's hard to find national data. I mean --

MR. SCHULTZ: It is.

MR. PELHAM: Jess found that chart and sent it around to us, you know, months ago, and, you know, and I kind of have had it in the back of my mind. Hang on a minute. Did I lose you?

MR. SCHULTZ: I'm still here.

MR. PELHAM: Okay. So I just want to start again by just, you know, for me kind of finding a path between kind of the look-back trending actuarial approach and the kind of the look-forward all-payer model approach, because there's there is a tension there. And, you know, I've kind of aligned myself just in terms of my board work with the 3.5 percent target, because I know where that comes from. That comes from, you know, Jeff Carr and Tom Kavet's analysis of the gross state product from 2001 to 2016, and that's where that 3.5 percent came from. So it's grounded in the Vermont economy, and, obviously, things change. The economy has, you know, taken a bit of a wear and tear in the last few months, but it's, it's a number.

And so the first year in, in the, that we have the APM total cost of care for 2018, we're at 4.1 percent.

So we're still within those guardrails around the 3.5 percent, but I worry that '19 to '20, '21, especially reading letters like Todd Keating's, you know, that we are, you know, we are not going to get where we want to go.

So, so, but I, I do want to say that, in terms of the Wyman data, you know, that, those numbers tie out precisely in terms of the, the net gains to what's in your audited financial statements and what's in the supplemental health care exhibit. So, so I feel comfortable in that, and they do say, and I -- they do, if you kind of add them up from the 2015 to 2019 period -- pick whatever venue you want -- you end up with a total gain of $16.8 million over those five years with, with losses, let's see, net income accruing in three years and losses in two years.

So I raise that just because I run into people and say, Hey, this is insurance companies. They've got all the money. Just whack, you know, and it's just popular out on the street there. You know, and I kind of want to agree with them in some ways just, you know, emotionally but that's, it's not there, I don't think, but I do think that you can find savings.

No budget is perfect. Maureen says that all the time. It's a, it's, it changes from the minute it's

been approved, and, you know, I've found that in my experience. There's always 2 or 3 percent you can find if you push a little bit, and there's some screaming, but it's, it's there.

So, so I want to go to the, the quote, and I think it's in -- I'm not going to go search my binder. I just hope my notes are good here. It's in Exhibit 1, Page 31 where you say, "Observations of recent contracting and provider budgetary changes are the main source of unit cost trend", and, further, you say, "53 percent of the total medical claims occurred in Vermont facilities and providers impacted by the hospital budget review process of the Green Mountain Care Board".

And, you know, I, I can look at data that we have in terms of hospital budgets and stuff and kind of get, and even commercial insurance, you know, you know, what, what that is in terms of revenues to hospitals, but I'm just wondering if you -- and, if you're not the right person, that's fine -- if you can you dig a little deeper on that, on that 53 percent and kind of how the entities that comprise that 50 percent, how their input to it is weighted relative to one another.

I mean, is there a weighting system that goes on when you're kind of looking at the trends of those

entities?

MR. SCHULTZ: Yes. And then the weights that we use are the, the claims that our members incur at those entities. So, as you might imagine, University of Vermont Health Network is the strong majority, you know, by far the biggest entity within there. I, I don't know that they're a majority of the 53 percent, but I could get that data and share that with you and your fellow board members so that you --

MR. PELHAM: I can tell you, in terms of NPR and in terms of overall commercial revenue, they are more than a majority. We have those numbers here. The, you know, the number for 2019 was, total commercial revenue of hospitals was $1.395 billion, and the network was 54 percent of it. So, you know, it's, it's, but it's just something to, to ponder.

So my next question is that, that the trends that you look back on are trends that Blue Cross Blue Shield has had a hand in negotiating. I mean, earlier you said, you know, that we look back into our database, and you obviously have a database about claims, and that's part of your trend, but it's, it's not that it's entirely -- the, the trends that you look at are not entirely kind of a free market independent process. You, you are part of the process of negotiating those

trends. That's a yes-or-no answer, I guess.

MR. SCHULTZ: Yes. And I think Andrew Garland will testify at length about that process.

MR. PELHAM: Okay. Well, I'll just ask the question now, but I'll ask it to him later is, is just, you know, there's another quote, and I'll, I'll say it from last year, where they basically say that, you know, that, with some providers, you kind of run up against a brick wall, and it's either give them what the Green Mountain Care Board approved, or they won't, they might withdraw from your network. That was the testimony, you know, last year.

And so I'm just wondering, you know, you know, about that process and trying to kind of get more toward the all-payer model result. Is that -- and I'll ask Andrew this, but it seems to me that kind of the message is, Green Mountain Care Board, you do the heavy lifting here, you set the constraint and, and, you know, constraint so anything over that constraint is, is going to be a kind of a negotiating item between the insurer and the provider.

MR. DONOFRIO: If I may, Board Member Pelham, I apologize. I just want to remind Mr. Schultz that the question veers towards confidential areas of testimony about provider negotiations, and I would just

caution Mr. Schultz, since we're in open session, not to reveal any such information. There will likely be an executive session where we can go into that in more depth later. Thank you.

MR. PELHAM: I appreciate that. That's why I referenced data that, you know, comes out of our system, you know, in terms of the, you know, commercial payments in 2019. So, and this might not be a question for you, but it, in the 2019 supplemental health care exhibit, it indicates a $1.63 million expenditure for cost containment. What, do you know what that is, what that goes to directly?

MR. SCHULTZ: I do not. Ms. Greene will most likely be able to answer that question for us.

MR. PELHAM: Okay. Provider negotiations, essential benefits we covered. Cost shift, thank you, I was going to ask that question, and your attorney beat me to it, but I wasn't going to ask the question that you did answer on the difference between the QHP operating loss and the, the supplemental health care underwriting. I wasn't going to ask that one, but I got the answer anyhow.

Administrative charges, provider network. Just one question on the loss ratio. I mean, you can go back through history and look at loss ratios, I think,

for some of your portfolio near the beginning. It's on a sticky here somewhere. But you were down in the, you know, for, for -- it might have been individual claims, or it might have been small group -- in, like, the high 80s going back four or five years.

And I'm just wondering if, if there were a, a more aggressive approach toward provider budget increases and, and, therefore, claims cost would be driven down a little bit, you know, that could fall to the benefit of ratepayers. It's because, you know, and staying kind of at the same ratio, that could fall to the benefit of ratepayers.

MR. SCHULTZ: Yes, I agree. Inasmuch as hospital reimbursements are lower, that definitely benefits ratepayers, and the same is true, you alluded a little bit earlier to, you know, if we were able to trim budgets by 2 or 3 percent. With respect to the premium rate, we need to understand that 2 to 3 percent is, means we're paying providers 2 to 3 percent less, right?

MR. PELHAM: Right.

MR. SCHULTZ: That's, Blue Cross's admin portion of the premium is very small, so we can't find 2 to 3 percent of total premium there. We're talking about paying providers less.

MR. PELHAM: Right. That's right. I mean, that's why I raised the Wyman data, because I think there might be something there in admin, things of that sort, but it's not where you're going to find the money to really substantially impact premium rates. It's, it's in the, it's, as the money comes out of the ratepayer's pocket, goes through you guys and out into the real world, you know, that's where this option is.

And so I, I just was trying in my simplistic way to get a sense of what we're talking about here, and so this is my simple math, and you can correct me if I'm wrong, is that, if you look at what was filed for 2021, it was a $311 million increase or a $311 million premium amount, which is $18.5 million above the $292 million number projected in those small group and individual for, for, you know, for this year. So it's an $18 million delta, and, if you divide that by the original 6.34 percent increase, that's 2.93, 2 million, $2.93 million per point, and so you're now at 5.5 percent.

If, if the target, my target, were 3.5 percent, you could say to me, Go find it, Mr. Pelham, but that would be 2 million, I mean, 2 times the 2.93 million or $5.8 million. So that's what, that, to get down to a 3.5 percent level, we're talking about $5.8 million in

the system that, that might be impacted on providers out there in the world, you know, mostly the hospitals. Is that a rational logic?

MR. SCHULTZ: So it is. A couple --

MR. PELHAM: Okay. You can stop there.

MR. SCHULTZ: There are a couple key differences between the all-payer model and what we're putting in our rates. Most notably is that the all-payer model target doesn't include pharmacy. So our, our rates, you know, as I testified, 3.7 percent of that increase is due to specialty pharmacy.

MR. PELHAM: Yeah.

MR. SCHULTZ: So, if, if we -- you know, some of specialty pharmacy, granted, takes place as part of the medical benefit, so that would be part of the 3.5 percent target. It especially is about 50/50 in terms of retail pharmacy versus medical benefit. So, if we take out half of that 3.7, we're talking about a little under 2 percent that's specifically due to specialty pharmacy. Retail pharmacy is also escalating. Well, retail pharmacy is mostly escalating because of specialty pharmacy. So I'll just leave it at that.

Kind of the other key difference is that that 3.5 percent includes all payers, as the title suggests, right? So it's Medicare, it's Medicaid, and it's

commercial payers, and now, as we've seen year after year after year in the hospital budget submissions, there is inevitably a cost shift from Medicare and Medicaid to commercial payers. So I, even if we, as a state, achieved 3.5 percent, I, I would be astonished in a really good way if that 3.5 percent came from 3.5 percent from Medicaid, 3.5 percent from Medicare, 3.5 percent from commercial.

What's been the experience in Vermont and what I would expect to happen is something that's more like a very low number, zero to something very small for Medicaid, again, a very low number for Medicare, and then the commercial increase becomes the balancing item. So we might be at zero, one, and six, by way of example, just using some really rough, rough illustrative estimates.

So I, you know, I'm not sure that there's a scenario where we actually get there. Because of the, because we include prescription drugs and because of the, you know, the prevalence in cost escalation of the specialty pharmaceuticals but also because of the cost shift, it's hard to foresee a situation where, where a commercial rate increase would be as low as 3.5, because the Medicare and Medicaid increases are unlikely to be as high as 3.5.

MR. PELHAM: Yeah. Well, I mean, those are very good points, and, when it comes to the pharmacy specialty, I have no good ideas. I mean, it just seems a world beyond our borders, you know, that, that can't be, you know, adjusted or manipulated. But I think, in terms of -- and I agree with you on the all-payer model 3.5 percent to some extent, but keep in mind that increases in Medicaid don't count, during this period, don't count to the total cost of care, because the agreement exempts them, basically. So what drives the 3.5 percent is the, is the commercial and, and the Medicare.

So, you know, so when I, when I kind of -- I had another point to make there, but hopefully it will come back. But, when I kind of look at, kind of follow the money over the last five years, and it, and I see that the UVM Medical Center, not the network, but the UVM Medical Center itself, over the last five years up through 2019, accrued $295.8 million of the operating margin of $329.2 million, and we have other hospitals that are hanging on by their fingernails, something seems possibly awry to me in, as the money comes out of ratepayers' pockets, goes through the insurance system, negotiations happen with these providers, and, and the flow of the money is heavily weighted. I mean, 89

percent, you can do the math on that February 26th notation that was in my letter to you folks. That seems to me a place where the board might be helpful giving, well, the board might be helpful in, in setting some boundaries that aren't up in the 6, 7, 8, 9 percent world. So it was one more thought I had.

And, oh, in terms of the cost shift, and, again, this is, this is outside your domain, but, you know, in terms of looking at it, you know, where might we find more Medicaid money, or where could we have found more Medicaid money to maybe balance the scales a little bit? Because, if Medicaid does contribute more, then the cost shift might be nullified on you guys a little bit, certainly not the 16 percent or whatever it is.

And so, as you, as you follow the big items in DVHA's Medicaid budget through the third quarter of the state fiscal year 2020, they had only spent, and it was adjusted downward in the legislature's budget adjustment, they had only spent 63 percent of their appropriation, but we are three-quarters of the way through the year.

There are tens of millions -- and this has been going on year after year after year as the economy rose, and, when I was finance commissioner, I saw the reverse of that. You know, it gets pretty scary when

it's going the other way. But, you know, there's opportunity there, I think.

You have Doug Hoffer's audit of Dr. Dynasaur where he found that people were not paying their premiums but still getting Medicaid benefits, and just the small sample he used was $2.3 million. That's, you know, and, you know, you have the fact that Dr. Dynasaur premiums are lower today than they were in 2004. Think about that. And that's because they were taken out of the legislative domain and put into the, the agreement with the feds, the waiver, 1115 waiver agreement.

So there are options out here if we think beyond this process, and but, within this process, you know, I think it's an important venue for us to set expectations, you know, that it's, it's not just the insurers have an obligation and the board has an obligation, but other players have an obligation, or we're not going to be successful, you know, with the agreement that we've, the journey that we're on.

So that's more my rant than my questions, but I, I just think it's important that we can be here and worried about all these kind of, you know, in the weeds about all these technical issues, and I'm certainly glad to go there, but I'm just not quite sure what it will get you go in the long run, in the big picture.

MR. BARBER: Okay. Board Member Holmes.

MS. HOLMES: Okay, thank you. I guess we all are asking you the same question, Paul. How are you doing, right?

MR. SCHULTZ: I'll be happy for that next break.

MS. HOLMES: Yeah. And I was thinking about that. I think this happened to me last year, but I've always said I don't teach classes before or after lunchtime because, before lunchtime everybody is starving and they just want to get out, and after lunchtime they have a food coma. 12:41, so bear with me. I know I'm the only thing between and you and lunch, or, actually, Chair Mullin has to go, too, but thank you for bearing with all of our questions.

As a quick thought in reference to Maureen's, you made a comment to Maureen, if you can give us a longer runway to achieve some cost savings, and so tell us by 2022. So here's your runway. By 2022 we've got to get these premium growth rates to, you know, at the wage growth in the state of Vermont. So, if you need that runway, here I am giving it to you. But, anyway, that's an aside. Can you just turn to Exhibit 1, Page 33, if you would?

MR. SCHULTZ: I'm there.

MS. HOLMES: Okay, perfect. It's the bottom chart, and you're talking about the, you know, since 2014, implementing new programs to combat fraud, waste and abuse. It, you know, those programs increased rapidly over that time period. You were able to recover more claims, and in 2018 you recovered, you know, 1.42 percent claims. The migration to a new platform slowed it down in 2019, and then you talk about, due to COVID-19, you've stopped those programs, and it's unclear when they will start again.

So my question is around that. Why? And I understand that you may not be the answer, you may not be able to answer the "why" question, but, if you could answer the "why" question, I'd really appreciate it, because it does seem to have an impact on, you know, on rates and on affordability having those, you know, those programs in place. So how has Covid 19 stopped the FWA programs?

MR. SCHULTZ: Yeah. So I'm, I'm not particularly closely involved with that decision, but my understanding is that, because providers have so much on their plates right now responding to the pandemic, that we're trying to ease the burden on them in other ways. We've suspended some prior auths, and we've also made the decision to suspend fraud, waste

and abuse activities, just to ease that burden on providers during this difficult time.

MS. HOLMES: Okay. So let me follow up a little bit with that. So now we know that, for example, you know, utilization is, has increased above capacity. So, to the degree that we'd want to really be vigilant about fraud, waste and abuse, now would be the time perhaps even more so, recognizing that, should there be a second surge or something like that, we may want to cut back even, you know, providers are dealing with a pandemic, but, given the levels of infections that we have now and the increased utilization that we're seeing, it seems like now would be the time to, to think about reinstating those programs.

And I just, if you can turn to Exhibit 6, Page 59, I want to be able to understand this. It looks like to me on -- this is where we're looking at RBC. It looked like to me the impact of suspension of those audit activities has a RBC reduction of 19 percent, which is actually greater than the projected impact of 2020 operating results of 17 percent, right? So, I mean, the magnitude is not insignificant. It's, in the notes it talks about claims will be about $4 million above projections because of the suspension.

So I guess what I would ask is, Actuarially, if

you returned to the 2018 levels for 2021, what would the impact be on the premium rate change?

MR. SCHULTZ: Oh, that's an interesting question. That makes me, makes me think about my actuarial work a little bit. So we, we did not assume in this rate filing that FWA would go away. We assumed that, that it would maintain at the pre-Covid levels. So we did make some adjustments in coming up with our utilization trend to adjust for the fact that it's kind of varied over time, but we did not assume in this filing that those FWA activities would go away and would continue to be gone for 2021.

My understanding is that we've, we've agreed to suspend those activities as long as the emergency order is, is in place. Beyond that, I can't really speak to the timing of when we think that those activities will come back, but we do expect to resume them at, at the -- well, my expectation is that they will have resumed by 2021, I guess, would be my best way of putting that.

MS. HOLMES: Well, if you turn to Page 34, which is the next page, it says you assume that the percentage of claims recovered through these programs will remain at approximately three-quarters of a percent of total points, right? So you're assuming the same level in 2021 as in 2019, which is below the 2018

level.

MR. SCHULTZ: Right.

MS. HOLMES: So I guess what I'm asking is, if you went back to the 2018 level, what would be -- and maybe you can answer later if that's helpful, or --

MR. SCHULTZ: No, that's okay. So, you know, we're talking about, you know, the delta from 2019 to 2018 looks like about .65 percent of claims. Premium, as we know, is not exactly equal to claims. So there's, you know, we do have some other items that are in there as well, and that will be on medical claims only. So I'm trying to kind of talk through the answer rather than giving you a precise answer, but we're, we're probably talking about something that's less than a half a point on premiums.

MS. HOLMES: Okay, thank you. And I know my colleague Robin asked you about the why cost-containment programs were suspended. I'm not going to ask you the why. I know she'll ask Mr. Garland later. But I guess I did want to ask -- I did want to say, again, on Exhibit 1, Page 14, it talks about the claims experience for 2019. This is in the first paragraph under 1.5. Claims experience for 2019 was very slightly favorable relative to the expectation embedded within the 2020 filing driven by a 1 percent

improvement due to, you know, Blue Cross Blue Shield's cost-containment programming that exceeded expectations.

So we know that the programming has an impact on claims and on, you know, cost containment. It seems to be working, at least according to that. So I guess my question to you would be, actuarially -- trying to keep the actuarial questions for you -- if cost-containment programming was the same as it had been prior to the platform being introduced and prior to COVID-19, what would the reduction be there in premium growth rate?

MR. SCHULTZ: So there wouldn't actually be one here. The 1.3 percent that we're referring to in this paragraph has to do with the lab benefit manager that Dr. McIntosh discussed, and those savings are, well, the savings that took place are included in the filing, and we're assuming that those savings will continue into the future as well. In fact, we're assuming that the lab benefit manager will be able to hold lab utilization to zero, to no increase at all as we move forward in time. So that, those particular savings are most definitely already in here.

MS. HOLMES: Okay. So do you know -- I'm not asking you why, but, of the programs that were suspended, if they were resumed, what would be the

impact? Do you have any sense of that?

MR. SCHULTZ: I, I don't think there would be an impact. Those, that programming will have already manifested itself in the experience, like in the claims experience we used to develop this filing. So, by resuming them and allowing them to continue, we, we would, we would assume that that would, you know, we would assume that the impact that they had in the claims experience will continue to be the impact that they have in the future. And so, again, I would not make an adjustment for that, assuming we turn them back on before 2021.

MS. HOLMES: Okay. I had similar questions to Maureen about the admin costs in terms of per member per month. You know, it is a stark difference per member per month, and I recognize that you would prefer to look at it as a percent of premium, but, you know, whenever we can, it's nice to see an apples-to-apples comparison, right? And, when we look at two competitors in the same market within the same state with roughly the same size member population, that seems like the best apples-to-apples comparison one could possibly make, and there is a significant difference in the per member per month administrative charge.

And so I, I know you've already tried to answer that. I'm not going to, you know, ask it again, but I, I would just point out that, you know, on a per member per month basis, it's very difficult to see that huge difference and not think, What is underlying that? So I don't -- I'll give you the opportunity to just comment, but, if you just want to say it's better to look at percent of premium, I will --

MR. SCHULTZ: I do think, because of the variable costs that are involved, it makes more sense to look at the percent of premium.

MS. HOLMES: Okay. A second, another question is, you know, we've talked a lot about the COVID-19 impact and a lot of modeling, and I appreciate all the modeling that's been done. I know how very difficult that is. So many different assumptions, so many different ways which you could tackle that. Obviously, the impact can be positive, negative depending upon whether there's a second wave, what we think about with deferred procedures, the cost of vaccines, the cost of treatments, all of that.

But one of the things that seems to me to be more predictable is the fact that telemedicine is probably here to stay, right, and not going away, and we know that there are studies that are showing there's

significant cost savings associated with, as we have more telemedicine, ED visits go down. You know, urgent care visits go down, which are very costly, and your own modeling talks about a 14 point reduction in utilization related to that telemedicine in those ways.

So I'm wondering. Why not carry that forward? Because that doesn't necessarily depend on how many cases we have, whether there's a surge, what the treatment costs of Covid are. That's a change in demand that's happening because provider and consumer behavior is changed. So why not factor that into your assessment of costs and utilization?

MR. SCHULTZ: We did. We have a, a section in, in the, in the memo, and I, I believe we repeated it in the addendum. We are assuming that ER and urgent care utilization will never return to pre-Covid levels. That assumption is kind of belied by emerging June experience. We'll see how that continues to develop. It looks like, based on what we know today about June, that that ER and urgent care utilization did return to pre-Covid levels. That's a surprising result to me.

But we ignored that for purposes of the modeling, and we did include an ongoing reduction of about 14 percent in ER and urgent care utilization in recognition of the increased use of telemedicine and so

forth.

MS. HOLMES: Perfect. I thought you had modeled it, but I didn't realize you had included it. So that is a great answer to my question. I'm looking at all of my notes as well. So is there -- and this might be a question for Ruth, but I'll ask you anyway, and you can tell me if it's more of a question for Ruth.

Are there legal limitations on how CTR might be used? So, you know, CTR is largely meant to cover medical costs, unexpected medical losses, things like that, but, to the extent that, you know, if Blue Cross Blue Shield, let's just say, wanted to build a new building, new office building or wanted to do something, would it come out of CTR? Are there any limitations? Are there any minimum that has to be kept in CTR to cover medical costs?

MR. SCHULTZ: So that's a good question. It's a complex answer, and Ruth would probably be able to elaborate it, but DFR, as our solvency regulator, keeps close tabs of how we're spending our surplus, what we're doing with it. For example, for Vermont Blue Advantage, which we've touched on a little bit, that all had to be approved by DFR before we spent that money and took that step. So I, I think I'll kind of

leave my answer there.

MS. HOLMES: That's fine.

MR. SCHULTZ: That's probably just a starting point, and Ruth will probably be able to elaborate on that.

MS. HOLMES: Okay, great. My last question is, actually, this is more of curiosity, but I just recently read that there are a bunch of new reports that premature births have plummeted as a result of COVID-19, and they can't figure out why, but it's happening in different countries, and it's a very, very significant drop in premature births, and they're trying to unpack it and figure out why. So I'm, this is a curiosity question, but, obviously, premature births are extremely expensive, and I'm wondering if we're seeing that, if you're seeing that even as a topic of conversation at Blue Cross.

MR. SCHULTZ: That is fascinating. I was unaware of that, and I'm interested to go back and look at our own data. Our birth rate in Vermont is not so high. We might have really good data on it. Because, you know, just one or two premature births will really throw that percentage around when we're talking about a small population like Vermont. But that's really interesting, and I look forward to looking at our own

data to see if we can find that here too.

MS. HOLMES: Yeah, okay. That was a curiosity. Thank you. I have some other questions that I think probably will, you know, go towards executive session. So thank you.

MR. SCHULTZ: You're welcome. Thank you.

MR. BARBER: Okay. I think I'm probably not the only who needs a bathroom break. So why don't we take five minutes prior to the Chair's questions, potential redirect? I would just say we're, again, despite the prefiled testimony, behind where I was hoping to be at this point in the hearing. So just be aware of that. We have two more --

CHAIRMAN MULLIN: Wouldn't it be more efficient if you combined your bathroom break with a lunch break?

MR. BARBER: It would save five minutes. Sure, we can do that. Do you want to go ahead and ask questions?

CHAIRMAN MULLIN: Oh, I was just saying that it would be nice just to have one break. I don't have to ask my questions now if people are crossing their legs, but I'll leave it to you, Mr. Hearing Officer.

MR. BARBER: Does anyone need a five-minute break? No? Everyone's good? All right, Mr. Chair.

CHAIRMAN MULLIN: Thank you. Good afternoon, Mr. Schultz.

MR. SCHULTZ: Good afternoon, Chair Mullin.

CHAIRMAN MULLIN: Earlier this morning you testified that retail pharmacy was cutting into margin and thus into reserves, but isn't it true that Blue Cross made several changes to make it better for Vermonters facing the pandemic by, I believe, in some cases allowing for 180-day fills and things like that?

MR. SCHULTZ: Yes, suspension of early refill, those sorts of things, yes, that's true.

CHAIRMAN MULLIN: So wouldn't you begin to see some savings from that, since they won't need to get those medications over the next few months?

MR. SCHULTZ: Yeah, for the most part, we're talking about 90-day fills, and those, those programs were implemented generally in the late March, early April timeframe. So, if we look at data through June, we will have seen sort of the full ebb and flow of that. As scripts were filled in early April for 90 days, they don't have to be filled again until July. So I do think that we were able to assess that fairly by looking at data all the way through June.

CHAIRMAN MULLIN: Okay, thanks. Last year you testified about some savings that could occur -- it

may have been the year before. Time runs by me now -- through the opening of the ASC. Have those estimated savings come to reality?

MR. SCHULTZ: I, I honestly haven't looked at those data. So that's something I'd be happy to follow up on.

CHAIRMAN MULLIN: Okay. Sometimes it's, as Yogi Berra would say, it's deja vu all over again, or maybe I feel like I'm in Groundhog Day, but you testified that really a lot of the orders that the Green Mountain Care Board has offered in the past were really just a reduction to reserves, and you also made the statement, and I know that one member followed up on that, that you said, If you want us to achieve savings, tell us to do it in 2022.

Why does the Green Mountain Care Board need to tell Blue Cross Blue Shield to try to be efficient?

MR. SCHULTZ: You don't. And I think we have lots of evidence for that in this filing and in previous filings. We've saved over $5 million for Vermont ratepayers through the actions that we took relevant to this filing. The number, I think, was quite a bit bigger than that last year. These are things we continue to work on, we work on all the time.

And so, when, you know, when we already include

those amounts, those savings in our filing, what becomes really difficult is when we're then told, Go find 1 percent more, and, by the way, go do it within the next four months. That, that's just not practical. That's the point that I was trying to make.

CHAIRMAN MULLIN: Do you believe that Blue Cross has a responsibility to Vermonters to operate efficiently?

MR. SCHULTZ: Yes, I do.

CHAIRMAN MULLIN: Okay. Do you believe that Blue Cross is doing everything that it possibly could to be as efficient as possible, offering prevention programs that would have an ROI in the future and things like that?

MR. SCHULTZ: That's, that's maybe not a question for an actuary. What I can tell you is that, you know, we don't have carte blanche to just do whatever we want. There is often pushback from providers. In some ways, some of those programs that improve affordability also restrict access, and so there's pushback from legislators, and there can be pushback from members.

So, you know, we can't just go out and implement everything we possibly want to in order to reduce the costs, because there are a lot of trade-offs and a lot

of interested parties that want to have a say in these matters.

CHAIRMAN MULLIN: But you'll admit that there could be some things that Blue Cross could do that could make it more efficient?

MR. SCHULTZ: I, I don't know that more efficient is the phrase that I would use. There are steps Blue Cross could take to make things more affordable. Whether Vermonters or whether the Green Mountain Care Board want us to take those steps and whether providers are willing to help us take those steps may be a different question altogether.

CHAIRMAN MULLIN: Okay. In the testimony by Dr. McIntosh, there was a lot of questioning, and I'm not sure. This may not be for you, and it may be for Ruth. But, again, we were trying to get to the percentage of the more expensive hospitalizations that are carried through the exchange product as opposed to Medicare. We know that there's a much older age demographic when it comes to hospitalizations and this decease. Medicaid and third-party administered plans, has any calculation been done as to what percentage of these more expensive hospitalizations relate specifically to the QHP?

MR. SCHULTZ: I don't have the specifics

related to hospitalizations. What I can say is that Blue Cross has spent $4.4 million on Covid-related costs so far this year.

CHAIRMAN MULLIN: Okay. I believe that you said earlier that you do not have any involvement in either investments as far as reserves or in pension; is that correct?

MR. SCHULTZ: That is correct.

CHAIRMAN MULLIN: Who are the people directly involved at Blue Cross Blue Shield who make those decisions?

MR. SCHULTZ: Ruth Greene is our CFO and treasurer, and she will have the most insight into that process.

CHAIRMAN MULLIN: Okay. I'll save those questions for Ruth then. Did you do any type of review or have any input into the letter that Mr. George sent to us in the latter part of June regarding the pension loss?

MR. SCHULTZ: No. I read the letter. That was the extent of my involvement.

CHAIRMAN MULLIN: No editing or no --

MR. SCHULTZ: Correct. I was not part of that process.

CHAIRMAN MULLIN: Okay. Likewise, back in

March when we certainly were not aware of it but you reported to DFR, according to press accounts, that this problem had occurred, did you have any involvement at that time in that reporting to Department of Financial Regulation?

MR. SCHULTZ: None.

CHAIRMAN MULLIN: Okay. Those are all my questions. Everybody can go to lunch.

MR. SCHULTZ: Thank you, Chair Mullin.

MR. BARBER: Not quite. We go with the opportunity for redirect for Mr. Donofrio.

MR. DONOFRIO: I have no questions. Thank you.

MR. BARBER: Okay. Now we can go to lunch. I was hoping that take an hour, but it seems like that may be too long, given that we have two more Blue Cross witnesses, the commissioner, which I imagine you guys will have some questions for, L&E, and then Mike Fisher. So, so I'm thinking half an hour lunch break, unfortunately. What do folks think about that?

CHAIRMAN MULLIN: Whatever you tell us.

MR. PELHAM: Better than five minutes.

MR. BARBER: All right. Why don't we reconvene at 1:40? Sound good?

CHAIRMAN MULLIN: Sounds great.

(A recess was taken from 1:04 p.m. to 1:40 p.m.)

MR. BARBER: So we're going to go back on record in the meeting, and, I believe there are two more Blue Cross Blue Shield witnesses. So, Ms. Asay or Mr. Donofrio, could you please call your next witness?

MS. ASAY: Yes, we're going to call Ruth Greene, and I'm just checking to see if she's in the meeting.

MS. GREENE: Yes, I believe I'm in the meeting.

CHAIRMAN MULLIN: She's listed as unknown user.

MS. GREENE: Oh, sorry. I am here. Can you hear me?

MS. ASAY: Yes, I can. Thank you. Blue Cross calls Ruth Greene as its next witness.

MR. BARBER: Okay. Give folks just a minute to find Ruth and pin her if that's what you're doing. Okay. Ms. Greene, could you please raise your right hand?

R U T H G R E E N E,

duly sworn to tell the truth, testifies as follows:

DIRECT EXAMINATION BY MS. ASAY

Q. Would you please state your full name for the record?

A. Ruth Greene.

Q. Ms. Greene, what is your position with Blue Cross Blue Shield of Vermont?

A. I hold the position of Treasurer and Chief Financial Officer.

Q. Would you please take a look at Exhibit 12 in your binder?

(Exhibit 12 was shown to the Witness.)

A. Yes.

Q. Is Exhibit 12 your prefiled testimony in this matter?

A. Yes, it is.

Q. Do you affirm that it is true and correct to the best of your knowledge?

A. I do.

Q. Does your prefiled testimony discuss matters related to Blue Cross Blue Shield of Vermont's reserves, its proposed contribution to reserves, and the appropriateness of the proposed rates?

A. Yes, it does.

Q. And in your prefiled testimony did you explain why you directed Mr. Schultz to include a 1.5 contribution

to reserves in the filed rate?
A. Yes, I did.
Q. As of January 1, 2020, was Blue Cross Blue Shield of Vermont's reserve level below the range that is required by the Department of Financial Regulation?
A. Yes, it was.
Q. You discuss this point in more detail in your prefiled testimony, but could you please briefly summarize for the board why it is important for Blue Cross Blue Shield of Vermont to reach the point where its reserves are within the required range?
A. Yes. Blue Cross Blue Shield of Vermont requires, is required to maintain reserves and stay solvent so that we can pay the claims for our members, pay for their health care, and, as Commissioner Pieciak has told the board many times, that insurer solvency is the most important aspect of consumer protection.

We also need reserves, as Paul had indicated in his testimony, excuse me, to have the resources to be able to invest in programs and initiatives that bend the cost curve. Also, we need the flexibility to address the needs of Vermont markets, in particular, the, the senior market, and Paul outlined the investment in Vermont Blue Advantage in the Medicare Advantage market.

That's currently an underserved market in Vermont with only 16 percent of Vermonters buying Medicare Advantage, but we believe we can bring that up to closer to the national levels by having a Blue network and a Medicare Advantage plan. So reserves are required to allow us to serve all the markets that we serve.

We also have a, the study that was done to determine the appropriate range for our business is unique to Blue Cross Blue Shield of Vermont, and it's based on the risk profile of our business, and in that same study that was reviewed by Oliver Wyman and DFR and resulted in the ordered range, it was noted that the place in the range that we should aspire to be on a consistent basis is 690 percent reserves that would lead to an RBC of 690 percent so that, in any given year, it would reduce the chances that we'd fall outside the target range.

Q. And do reserves play a role with respect to losses in particular lines of business?

A. Yeah. So, as the testimony earlier from Paul around the purpose of reserves, reserves is the protection for all of the uncertainties and risks for our business, and that's for all of our lines of business. So, to the extent that the individual and

small group risk pool has sustained losses over the last several years, those have also come out of reserves.

Q. As other witnesses and the board have discussed today, the COVID-19 pandemic is an unprecedented event. Has the experience of the pandemic changed the way that you think about reserves?

A. Yes and no. I'll say "no" first. When we think about reserves, they're protection against uncertainties and risk, and, as we explained before to the board, the pandemics and natural disasters are a classic example of things that reserves are intended to protect against. So, in some ways, that's, that's exactly what the reserves are there for. We need to be there when our, our members need us the most, and, to the extent that those reserves are consistently maintained with a modest CTR of 1.5 percent, that is what sustains over time.

On the other hand, I do think we are thinking about reserves a little bit differently. The pandemic has really been a learning experience for everyone, and, as we partnered with the State of Vermont and providers and our loyal customers to deal with stay-at-home orders and the various things that had to be adapted to respond in the case of the pandemic, we

really did have to focus our resources where it was needed most, and reserves play an important role in being able to bring that flexibility to the health care system.

Q. In your prefiled testimony, you explained why the proposed rates satisfy the statutory criteria?

A. Yes.

Q. Is it your opinion that the board should approve an average rate increase of 5.5 percent?

A. Yes, it is my opinion that the rate increase of 5.5 percent should be approved.

Q. Why?

A. There's no debate that the rates are actuarially sound. Paul went through that and shared the L&E view. We are highly confident that the rate reflects the expected cost of care in 2021, with the exception, as Paul noted, for the Covid claims, and there is no padding in these rates. There's a very modest CTR, and the administrative cost ratio is very efficient, and there's no profit margin included in these rates. So the, the rate of, rate increase of 5.5 percent is what I would say needs to be approved.

Q. And what has been Blue Cross Blue Shield of Vermont's overall experience with this line of business?

A. The, Paul went through several areas of testimony that outlined how the, this line of business has lost money over the last several years, and in the exhibits that were submitted as part of the prefiled testimony, we show that that was about $12.5 million. Even if you include the litigation recoveries, this line of business has significantly lost money since its inception.

Q. This is a slight change of track, but, as we're talking about the rates, there was some testimony earlier I think you heard with Mr. Schultz and board members regarding fraud, waste and abuse. Do you recall that testimony?

A. I do.

Q. Is there anything you'd like to add to Mr. Schultz's explanation?

A. Sure. I thought it would be helpful for the board and the Health Care Advocate that, when we talk about and as Paul indicated in his actuarial memorandum, that the cost-containment programs were suspended or came to a halt, in my department that was due to removing the burden on providers.

MR. BARBER: It seems like someone may have forgotten to put themselves on mute.

MS. GREENE: Can you still hear me?

MR. BARBER: I can, but it sounds like someone's driving. Could everyone who's on the line please check their computers and their phones to make sure they're muted?

MR. BARBER: Good.

MS. GREENE: Okay?

MR. BARBER: Okay.

MS. GREENE: So I think I was just following up on the testimony about the fraud, waste and abuse programs that had come to a halt. The Department of Financial Regulation issued an insurance order that required us -- and I made a note. On March 16th it was the DFR Insurance Bulletin 211 that required us to sort of get out of the way, if you will, of providers in terms of spending time with them on those programs. So we will get those back into play as soon as we're allowed to.

BY MS. ASAY:

Q. Ms. Greene, if you could take a look at the Lewis & Ellis report, which is Exhibit 9 in your binder.

(Exhibit 9 was shown to the Witness.)

A. Yeah, I'm there.

Q. You had mentioned earlier that administrative costs for Blue Cross Blue Shield of Vermont are low compared to other plans. Are you familiar with L&E's

analysis of the administrative costs reflected in the proposed rate?

A. Yes. Their analysis, I believe, is on Pages 19 and 20.

Q. And do you have any response to their analysis?

A. Yes. I concur with their conclusion that the revised expense assumptions are reasonable and appropriate, and I noted that, as Paul had indicated, L&E had done a survey of other Blue plans that operate in the individual and small group markets, and so on Page 20 it does talk about the, on a percentage of premium basis, we had lower expenses than 90 percent of other, of the Blue plans who were in their survey. But I also wanted point out that the administrative costs on a PMPM basis are lower than 82 percent of the plans that they surveyed.

What this tells me is what I already know about how we operate our, our company. We are very focused on operating efficiency. It's a key portion of everyone's daily work. We are constantly looking at programs and processes to make sure that we're doing them as efficiently as possible. In fact, we have one employee-based program called Blue Ideas that has produced about $5 million in savings over five years. That program is actually evolving to be more

proactively looking at processes and taking manual work out of those processes and making things more efficient.

But, as an enterprise in total, we manage our costs across all of our books of business, and we've been consistently able to serve all of our customers with operating expenses at 7 percent, less than 7 percent of premium on a consistent basis. When we do our own benchmarking externally, that compares to other commercial insurers of about 10.7 percent. So that's a median of some of those external surveys.

The other thing is, when we are doing the programs like the ones that Dr. McIntosh and Paul testified about, we are constantly allocating our staff towards the higher priority items and away from lower priority items or programs that have been, you know, analyzed and understood to be of less value.

So, as Paul testified, the rate increase for 2021 would have been 1.7 percent higher if it weren't for some of the programs that we've implemented for 2021, and that really does take the resources and the, the active allocation of our staff to go towards bending the cost curve.

Q. You indicated in your prefiled testimony that Blue Cross Blue Shield of Vermont had not made a final

decision about pay increases for 2021. Is there anything you can add to that?

A. Yes. One thing I just wanted to point out, which we've shared with the board in the past, is that the impact of the average salary increases at Blue Cross Blue Shield of Vermont is, in fact, very, very small impact on any given year's rate increase. If we eliminated the average salary increase in 2021, it would have an effect of reducing the premium increase by three-twentieths of 1 percent.

Nonetheless, we do recognize the extreme financial stresses that everyone is under in Vermont, and with the pandemic and the stay-at-home orders and the economic slowdown and everyone working as hard as they can to adapt, we do recognize we have to put a new lens on our plans for 2021, as everyone is, and we're still working on ideas, but the executives at Blue Cross Blue Shield of Vermont have already come to the conclusion that they will commit to not having salary increases in 2021 for the executive team, and we're looking at other options. So we remain committed to a strong, motivated workforce.

Q. You also indicated earlier, I believe, that L&E had found the 1.5 percent CTR assumption in the rate to be reasonable. Are you familiar with L&E's analysis of

the proposed CTR contribution in the rate?
A. Yes, I am. It's, it starts on Page 20 and goes into 21 and 22.
Q. Do you have any response to L&E's comparison of proposed CTR to other plans?
A. Yes, I was struck by the information that they pulled together. They looked at the filings. I'm on the middle of Page 21. They looked at the 783 Qualified Health Plan filings and compared, looked at the average submitted CTRs. The median CTR that was submitted was 3.24, and the average was 3.45, and they, based on their analysis our modest CTR, contribution to reserve, of 1.5 percent is lower than 80 percent of those filings.
Q. Did L&E consider Blue Cross Blue Shield of Vermont's reserve levels as part of its analysis?
A. Yes. They went on on that same section to look at reserves. They looked at them from several different points of view. They actually compared to other companies on several metrics, four metrics in particular, and all of those assessments concluded that our reserves are low, which is consistent with what my understanding is.
Q. In fact -- sorry. Go ahead.
A. At the bottom of Page 21, I wanted to point out

one in particular point that they shared was that over half of the Blue plans had actual RBCs higher than Blue Cross Blue Shield of Vermont's targeted maximum, and, said another way, that, that means that, even if we were at the top of our range, we would be lower than half the other Blue plans where they currently sit today.

Q. Did L&E address the Blue Cross Blue Shield of Vermont's historical CTR for this line of business?

A. Yes, they did. At the top of that same page, this is a table, actual to expected contribution to reserve. This is a table that's not unlike the table that Paul testified about earlier today. Sorry. Just making sure that wasn't me. The actual to expected table does indicate that we lost money on this book of business, and I did, as Paul had mentioned earlier, but I'd like to draw out L&E's comment that L&E believes -- this is right above the table -- that the results demonstrate that Blue Cross Blue Shield of Vermont has successfully projected future results based on the information available at the time final rates are approved by the board.

So what's important here is that, when we're estimating the rates for 2021, it's important to recognize that we've been consistent in our ability to

project those costs. And the other thing that this table shows is that, when the board cuts the rates below the actuarially sound levels, it does result in losses to the company, or least in, it does not achieve CTR, and in many years, four out of the six, it resulted in losses.

Q. If the board cuts the proposed rate this year, will it reduce the cost of health care that Blue Cross Blue Shield of Vermont is required to cover?

A. No, it won't.

Q. Ms. Greene, I'd like to direct you to Exhibit 10. Could you identify Exhibit 10, please?

(Exhibit 10 was shown to the Witness.)

A. Exhibit 10 is the solvency opinion from DFR, and it includes by reference the letter from Oliver Wyman in support of that solvency opinion.

Q. Have you reviewed the Oliver Wyman report?

A. I have.

Q. That begins on Page 7 of Exhibit 10?

A. It does.

Q. Has Oliver Wyman changed its position regarding an appropriate target range for Blue Cross Blue Shield of Vermont's reserves?

A. No, they haven't. On the bottom of Page 7, they do outline that this report was an update on the

previous work that they had done in support of the proposed surplus range at the time of 590 to 745.

Q. Does Oliver Wyman agree that Blue Cross Blue Shield of Vermont's reserves are below the required range as of December 31st 2019?

A. Yes, they do. On Page 9 of Exhibit 10, they note that, as of December 31st 2019, Blue Cross Blue Shield Vermont's RBC ratio of 567 was 23 points below the low end of the approved range.

Q. And do you have any response to Oliver Wyman's analysis of this point?

A. It was important, and I think it's important for the board to understand that the, the increase in RBC during 2019 was primarily due to the receipt of the alternative minimum tax rebate, and/or refund, and Oliver Wyman made a point that the nearly all of the increase was due to that one time item. So that is important from my perspective because it doesn't change the fundamentals of having a adequately priced book of business.

Q. Does Oliver Wyman also compare Blue Cross Blue Shield of Vermont's reserve levels to other comparable companies?

A. They do. On the next page they updated the comparative analysis that they had included in their

previous report, and they confirm at the bottom of Page 10 that Blue Cross Blue Shield of Vermont's RBC ratio in 2019 is the lowest of all the comparative companies. They also pointed out that, during the period of 2016 to 2018, on that page, the average of the companies excluding Blue Cross Blue Shield Vermont had increased pretty significantly over that timeframe, whereas our RBC had decreased. That's important to note.

Q. What does Oliver Wyman conclude about the outlook for Blue Cross Blue Shield of Vermont's RBC?

A. Oliver Wyman's conclusion is on Page 16, but they did conclude that there is a strong likelihood that Blue Cross Blue Shield of Vermont will remain under the 590 low end of the target surplus range at the end of 2021 if the overall impact of the COVID-19 claims utilization is relatively modest, which is what Blue Cross Blue Shield of Vermont has modeled. Paul had testified earlier about the taking on the feedback from Oliver Wyman and updating the modeling and seeing that it, it still had a pretty significant impact.

They go on to say importantly that any negative adjustment to the proposed premium levels will increase the likelihood that the 2021 RBC ratio will fall out, fall below the target RBC range.

Q. Blue Cross Blue Shield of Vermont has experienced

a reduction in claims so far this year because of the pandemic. Why didn't Blue Cross Blue Shield of Vermont reduce or eliminate its rate increase for 2021 to reflect those lower claims costs so far in 2020?

A. As I outlined in my prefiled testimony, to take a step like that at this point would be premature. There is a -- we're only a few months into the pandemic, and no one knows how that's going to unfold. If, for some reason, as the future comes to pass and there's the end result of the 2020 and 2021 claims activity due to the Covid pandemic results in moneys in surplus that could be refunded, we'd cross that bridge when we come to it, but, at this point, it's just simply premature to take that step.

Certainly, with all the uncertainties that are in our current future surrounding our surplus and solvency, it would be imprudent to take that step now.

Q. Did you include in your prefiled testimony an outlook for Blue Cross Blue Shield of Vermont's risk-based capital at the end of 2021?

A. I did. And, in fact, it's the same RBC outlook that Paul and the board were looking at in the earlier testimony this morning.

Q. And in Exhibit 12 that's Page 37?

A. Yes. That's the same exhibit that we were looking

at earlier. So this, I wanted to further elaborate on this RBC outlook. There are many, many uncertainties, and, as you can see from scanning down through this analysis on Page 37, that there are a lot of uncertainties, and there are a lot of big inflows and outflows that have to do with our future RBC level.

So we put this together with the express purpose to help people understand what the, the 12- to 24-month view might look like and how we're seeing it, and, in the interest of transparency, we just wanted to make sure that everyone had the benefit of what we see, and what I see here is a lot of, a lot of things that have yet to come to fruition and a lot of things that none of us know how to predict at this point in terms of how the pandemic will unfold.

So the end result that was really to be focused on on this exhibit was the estimated RBC at the end of December 31st of 2021, and this also incorporates, obviously, the scenarios that Paul modeled on the pandemic, which was, as Paul indicated and I can reiterate, was an illustration of what could happen, not that we know which, which scenario will pan out, but just to give some sense of what the order of magnitude could look like.

So, for the five different Covid modeling

scenarios and incorporating the other variables, the range at the end of 2021 is from 545 going down to 419 at the bottom.

Q. You might have heard earlier, with respect to one item that's on this RBC outlook, you may have heard in Mr. Angoff's opening a discussion of the potential recoveries in risk corridor and cost-sharing litigation. Would you describe those potential recoveries, should Blue Cross receive them, as a windfall?

A. Absolutely not. I don't view those as a windfall at all. Those are payments that were part of the original ACA design when the Qualified Health Plans were rolled out, and the federal government didn't come through on those payments. So that is, in part, a contributor to the losses that we've experienced. So these are recoupments, if you will, of the payments that we would have expected.

And when, in my prefiled testimony when I showed the loss on this book of business being a little over $12 million, I assumed that these payments came back to us. So, even with these payments, the Qualified Health Plans have lost $12 million, and that has come out of surplus. So it's not a windfall at all. It's, it's recouping something that was really a part of our

business strategy for participating in this market.
Q. Also on the subject of reserves, in your prefiled testimony you stated that Blue Cross Blue Shield of Vermont has committed to paying pandemic costs for 2021 out of reserves. Does that commitment include additional temporary hospital commercial rate increases if the board approves such increases later this year?
A. At the time we said that, it did not include the, the eventuality, if it happens, for special allowances for the hospital budgets. We, as I sit here today, I would not recommend those special increases, and the reason is, if it's important for us to take a, a 12- to 24-month view on the impact of the pandemic on Blue Cross Blue Shield of Vermont's solvency, I think it's reasonable to take a longer view on where the hospitals will end up.

If, if the increase in claims that Paul mentioned and we've seen in our June and July results, or July payments, if that continues, I do think that we need to to take up a longer view with respect to what's appropriate. If, if there were some special allowances approved, I'd have to say it would have to go into the rates, because that is not incorporated anywhere in our, our thinking yet.
Q. Is the impact of the loss of value of in pension

assets including in the RBC outlook?
A. Yes, it is, as we talked about earlier today.
Q. If not for the pension asset losses, could or would Blue Cross Blue Shield of Vermont have reduced its contribution to reserves in this rate?
A. No, we would not have. Again, I'd like to emphasize that this RBC outlook was to give people a sense of the level of uncertainty that's out there in the next 12 to 24 months. It's not an expectation of what -- it's not a point projection of what we think the RBC will be, but, if you do take, as, as we began this morning, if you take the pension loss out of the numbers that I mentioned a moment ago at the bottom of that page, the RBC range would be 599 to 725, and that is very much still within the, the target range, and it wouldn't be until we're consistently and predictably expected to be, you know, at the top or, or above the range that we would consider reducing the, the 1.5 percent CTR.

The 1.5 percent CTR, which I say in the rate filing for Paul's benefit and then also in my prefiled testimony, that 1.5 percent is a long-term consistent maintenance of reserves so that we ensure that the book of business is, is supporting itself, and then, to the extent that we have other things coming and going in

the reserves, we don't want to be swinging our rates around as a result of that. So the 1.5 percent is really where I would have landed even without the pension loss.

Q. Mr. Angoff stated in his opening that Blue Cross Blue Shield of Vermont is benefiting from the pandemic. Do you agree with that opinion?

A. I take issue with the words that we're benefiting from a pandemic. I don't think anybody's benefiting from a pandemic. Our employees are working from home and trying to home-school their children and, you know, take care of their, their family while they're also serving our customers. I don't think Blue Cross Blue Shield Vermont has benefited from the pandemic.

If, by way of benefiting, Mr. Angoff is referring to the low-down in claims as a result of the shutdown and stay-at-home order, as the analysis has shown and how, as Paul described, we believe that, in the fullness of 2020 and 2021, all of those, many of those services need to be paid for, and so we're here, we'll be here when those payments need to be made.

It's not benefiting Blue Cross Blue Shield of Vermont. It's benefiting our customers. I'd like to also just point out briefly that not everyone understands that, when the providers had the slowdown

in mid-March, April, May and into June and actually coming back online in June, the only moneys that go into our reserves for future payments are for the insured business. We have a large book of self-funded business, and so the claims slowdown that comes out of the hospital revenues related to the self-funded business actually goes back and, and remains with those self-funded employers. So, just to be clear about where, where the claim slowdown flows through in terms of the current economy.

MS. ASAY: I have no further questions for Ms. Greene at this time.

MR. BARBER: Okay, thank you. Mr. Angoff, do you have questions for Ms. Greene?

MR. ANGOFF: Yes, I do.

CROSS-EXAMINATION BY MR. ANGOFF

Q. Good afternoon, Ms. Greene.

A. Hello.

Q. I want to emphasize -- I'm going to ask you several questions. I want to emphasize, and I hope you understand, none of this is personal. It's just business. None of it's personal. Second, and please take this seriously, I'm not interested in communications between you and your attorneys. If I ask a question and something that you've said to your

attorney or your attorney has said to you is relevant, please do not tell me about those. Any other communication is, is what I want to hear about. Do you understand that?

A. Sure.

Q. Okay. In your capacity as Treasurer and CFO as Blue Cross, of Blue Cross Blue Shield of Vermont, are you responsible for Blue Cross's investment policy?

A. The finance committee of our board is responsible for the investment policy, but as Treasurer and Chief Financial Officer, I am charged with implementing that, yeah.

Q. Okay. And who is on that committee?

A. It's a subcommittee of the Blue Cross Blue Shield of Vermont board.

Q. And, and who is on it?

A. So we have Scott Giles.

Q. What's his position?

A. He is CEO of the VSAC organization. We have Jo Bradley, who is former Vermont Economic Development Organization. Sorry. Not Economic Development. I'll have to get you her title. We have -- shoot. I'm sorry. There's five members, and I can get the names for you.

Q. Okay. Will you please submit those to the board?

A. Yeah.
Q. Great. And so are you one of those five members?
A. I'm not a member of the board, no.
Q. Okay. But --
A. I'm management, and I, you know, report to the board.
Q. Okay. So who, so who makes the decision as to what Blue Cross's investment policy should be?
MS. ASAY: I'm just going to object on the grounds of relevance, that Blue Cross's investment policies for its, its assets are not relevant to this proceeding, and I believe it's been noted that we have some time issues here.
MR. BARBER: Mr. Angoff, what is the relevancy of this line of questioning?
MR. ANGOFF: Well, we want to, I think we want to find out who is responsible. We don't want -- anyway, I won't speak for the board, but if, if Ms. Greene is responsible, then I'm, I'm happy to hear from Ms. Greene, if, and we should hear from Ms. Greene. On the other hand, if there's a committee that's responsible and Ms. Greene is not responsible, then the question should be, Why are the responsible parties not here testifying before this board?
MS. ASAY: May I respond to that?

MR. BARBER: Of course.

MS. ASAY: So I'm not exactly sure what Mr. Angoff is talking about responsibility for. I don't believe there's an issue here with regard to the investment policies that Blue Cross uses for its, its own investments. If this is referring to the pension matter, that is a different matter, and I would make -- I would object on several grounds, and the first is we have taken the position consistently here, and I refer back to Don George's letter that went to the board members and to the, that the HCA received where we asked that, if the board or the HCA had questions about the pension asset loss matter, that we be given an opportunity to respond to them in writing, and we reiterated that in the written filing. The HCA has never objected to that or given us any written questions or proffered those to the board. That would have been open to them. They did not follow that.

And, second, I would reiterate that those questions as well are both irrelevant to this proceeding beyond the amount of the loss, which has been disclosed, and to the, and we begin to move into areas that fall within attorney-client privilege and work product. Thanks.

MR. ANGOFF: Mr. Hearing Officer, I'll move

on after just saying this. The reason that the HCA didn't ask any questions is because the general counsel to the board asked questions, and it asked exactly the right questions, exactly the right questions, and the answer that the board got, as I said in my opening, maybe not too artfully, was, Go jump in the lake. So I'm going to ask Ms. Greene and see if I get any better answers.

MR. BARBER: Well, I think there's an objection on the table that I need to deal with at the moment, so --

MR. ANGOFF: I withdraw the question.

MR. BARBER: Okay.

BY MR. ANGOFF:

Q. Ms. Greene, how did you guys lose $40 million?

MS. ASAY: Objection for the same reasons I gave earlier. If you'd like me to restate them, I will but --

MR. BARBER: So okay. So let's deal with these one at a time. The grounds that the HCA did not file questions in writing or object to your request to do so, I don't think, has any relevance. They are not obligated to do that. They have the opportunity to ask questions here at the hearing.

As to relevancy, I am struggling to find the

relevancy with who specifically is responsible for the pension losses. I don't think that is the board's role. The board certainly has a legitimate interest in that. I think, I think all policyholders have an interest in that. But it's not something that the board is going to be deciding in its, in this rate case. So I, I realize I sent those questions out on behalf of the board, but, you know, the board, just like you guys, can ask any questions they want, but we have a properly put objection here, and I, I think that line of questioning is not relevant.

MR. ANGOFF: And, Mr. Hearing Officer, I withdrew that question. The question pending --

MR. BARBER: This line of, this line of questioning is, is going to draw further objections, I believe. So you can keep asking questions, but I suspect they'll keep drawing objections.

MR. ANGOFF: Okay. And I will explain why those objections are unfounded, and, and the Chair can rule. The question pending is, seems to me a very reasonable question: "How do you lose 40 million bucks?"

MS. ASAY: So just to, my understanding is that I objected to that and it was ruled on by Mr., by the hearing officer. Maybe I didn't follow that.

MR. BARBER: Sustained.
BY MR. ANGOFF:
Q. Okay. Ms. Greene, what was the investment on which Blue Cross lost $40 million?
MS. ASAY: Objection, relevance.
MR. BARBER: Is that not in the record?
MS. GREENE: I think it is in the record in the response that we filed in Exhibit 22, which was a response to the questions. We, we responded to what we could respond to and feel as though the information was helpful, I hope, to the board to the extent that we could make those responses.
In that letter we do talk about, at the bottom of Page 4, "The trust experienced a substantial decline in value in February and March 2020 due to the poor performance of the assets invested in a series of funds managed by Allianz Global Investors. A substantial portion of the $40.6 million loss suffered by Blue Cross Blue Shield Vermont as of June 2nd reflects this investment loss. The losses are distinct from general market losses that resulted from the COVID-19 pandemic", and then we go on to show the table. So that is the extent of information that I've been told I can share at this point.

BY MR. ANGOFF:
Q. Okay. Ms. Greene, don't insurance companies, including Blue Cross, have an obligation to invest in prudent investments?
A. Yes.
Q. Okay. Could you please explain then how the investment that lost $40 million was a prudent investment?
MS. ASAY: I'm going to object on the same grounds of relevance and to the extent it's seeking information beyond what's provided in the written response.
MR. ANGOFF: May I respond, Mr. Hearing Officer?
MR. BARBER: You may.
MR. ANGOFF: The reason all these questions are so relevant is that the board's decision, I believe, regarding this increase should depend in part on the extent to which this was just a unique, aberrational circumstance that Blue Cross could not have known about and, therefore, it was nobody's fault or whether it was a reckless, negligent investment that involved sophisticated hedge fund analysis, volatility funds, it, it, things that I don't understand about various investment vehicles, but, if it's a very

speculative, reckless investment, that, I think, is very relevant, should be relevant to what the board decides to do regarding this proposed rate increase.

I would also, I would also suggest, I mean, the, the board, the board asked questions, very reasonable questions, that got no response. I don't know when the board found out about this investment, but it would seem to me that it was Blue Cross's obligation, if they're seeking a rate increase from the board, to let the board know as soon as possible, as soon as possible what's happening, what happened to their, their surplus, which could affect the rate increase. So I think this whole line of questioning is extremely relevant.

MR. BARBER: Ms. Asay, do you have any response to that?

MS. ASAY: Yes, I have several responses. First, I'd like to read what we said in the filing on Page 6:

"The National Employee Benefits Committee is investigating the loss and has retained counsel to advise on the possibility of legal action to recoup all or a portion of the loss. That investigation is ongoing, and, as a result, much of the information Blue Cross Blue Shield of Vermont receives as a result of

the investigation reflects attorney-client communications and work product."

So this line of questioning goes into a very delicate and privileged area that, in addition to not being relevant, that poses serious problems for pursuing it in this forum.

We also advised the board in our written response that the Department of Financial Regulation, who is the solvency and market regulator, is conducting an examination directed at the pension asset loss. So it is within their authority. It is the subject of that proceeding, and, again, this is not a forum in which the questions that Mr. Angoff wants to ask have any relevance. There is not a penny in this rate request that is based on the pension loose.

MR. BARBER: Well, the, I mean, the pension loss is relevant and its impact on Blue Cross's solvency and how it impacts solvency, regardless of whether there is a specific, you know, specific ask in the rate to recoup, you know, because of the loss. Because the board could decide that it would want to reduce the rate more and it wouldn't threaten Blue Cross's solvency but for the pension loss.

So, I mean, I think questions regarding the loss, questions about how the, how the, how it impacts

solvency, how it impacts RBC over what time period, I think, are certainly relevant.

I think the nature of the investment sounds like it more is in the realm of DFR's authority and not the board's. Mr. Angoff, you spoke about when the board knew. I suspect you have questions about that or when, sorry, when Blue Cross knew, but I guess there's not a question on the, at the moment about that. So I'm not going to get there. But the -- so I don't, I don't think the questions about the, the fund are relevant.

MR. ANGOFF: I'm sorry. I want to make sure I understand the Chair's objection. You don't think the questions about the fund are relevant, meaning I can't ask what this investment was?

MR. BARBER: No. I think that question was asked and answered. Did I misunderstand that?

MR. ANGOFF: No. Well, I'll ask this, and you can rule on this. I mean, I understand what, what stocks are and investment in stocks is. I understand what bonds are and what investment in bonds is. I don't understand. I believe that this investment is neither. I believe it's a very arcane and, from what I've read, reckless type of investment to invest in, and I would like Ms. Greene to, to explain what it is.

I would think that we would all have interest and

you all particularly would have an interest in finding out what -- if you lose 40 million bucks, I would think you'd want to know what it is that was responsible for that loss.

MS. ASAY: So that is the line of questioning to which we object.

MR. BARBER: So I'm going to -- board members, would you like to go into executive session to receive legal advice on this, or do you -- that is an option, but my ruling is that it's not relevant to the rate decision otherwise.

CHAIRMAN MULLIN: Would that mean that we could not even ask those questions under an executive session?

MR. BARBER: That's correct.

MS. LUNGE: I think it might be helpful, Mike, if we go, if the board meets with you separately for just a couple minutes to, so that there's clarity among board members about the line, but I would defer to Kevin, since he's the Chair.

MR. BARBER: This is a little awkward, because I am also the counsel, and I'm also the hearing officer, so --

CHAIRMAN MULLIN: Sure, and I don't think you should be put in the middle of this.

MS. LUNGE: We could meet with Amerin, maybe.
MR. BARBER: Yeah, you could meet with Amerin.
CHAIRMAN MULLIN: I do not need to, but, if Robin requests it, then I think we should, because the board members have to feel comfortable.
MS. COMBS: Mr. Hearing Officer, Lynn Combs is also on the line and happy to discuss with the board if that would be helpful.
CHAIRMAN MULLIN: Robin, do you see great value in having this discussion?
MS. LUNGE: I think it will only take us five minutes, and I think it will speed things up later on. Because, otherwise, I think board members will be asking questions which will draw an objection and then Mike will then have to rule on. So I think it would be better if board members were clear in their mind about which areas of the pension question were allowable and not, and that might speed us along in the long run.
CHAIRMAN MULLIN: I'm not going to be limited to what I can or can't ask by a consultation with a staff attorney. I'm still going to ask whatever questions I desire to ask, and, if the hearing officer rules me out of order, then I will realize that I can't ask those questions, but I still plan on pursuing a

line of questions on this.

MR. BARBER: Then it sounds like maybe it's not going to help.

MS. LUNGE: Yes. Let's keep moving then.

MR. BARBER: Okay.

BY MR. ANGOFF:

Q. Okay? Ms. Greene, what was the process that Blue Cross followed in deciding to make the investment in whatever investment it was that lost this 40 million bucks?

MS. ASAY: I'm going object on the same grounds to the extent it's requesting information beyond what's provided in the written statement.

MR. BARBER: Well, that's not grounds for an objection. So is the objection for relevancy or --

MS. ASAY: Yes, the objection is based on relevancy and attorney-client privilege and work product.

MR. BARBER: Mr. Angoff?

MR. ANGOFF: I, I began my questioning emphasizing that I'm not interested in communications between Ms. Greene or her lawyer, lawyers.

MR. BARBER: Yes, it does not appear to call for attorney-client privileged communication. I do think it is not relevant for the reasons I've already

stated. So I'm going to sustain the objection.
BY MR. ANGOFF:
Q. When did you make -- when did Blue Cross make the investment that resulted in a $40 million loss?
MS. ASAY: I will again object on grounds of relevance here.
MR. BARBER: Mr. Angoff, what is the relevance of when the investment was made?
MR. ANGOFF: I just think it's, I think the board has a right to know as much as possible about this investment, because how this investment occurred and what this investment was is something that I believe is, should be relevant to the board's decision on this rate increase.
MS. GREENE: Bridget, would it be helpful to just bring to the board's attention the response on Page 4 that is part of the binder that describes, starting at the top of Page 4, that we participate in the National Retirement Trust and that's how investments are made? It's, I just don't know if everyone on the board had an opportunity to spend a lot of time with that response. I don't know if that's helpful.
MS. ASAY: Thank you. Thank you, Ms. Greene. And, you know, maybe that is helpful to -- I don't want

to, though, interfere with Mr. Angoff's examination. I do think the written response explains that this program is a national program that Blue Cross participates in as one of many participating plans, and we did provide ample documentation to the board through the Forms 5500 that provide quite a bit of detail about the National Retirement Trust and its investment over time.

I, if that helps with, with forestalling this line of questioning, I think that it should, given that it does, it provides that background, and that background is even more explained in the Form 5500s.

MR. ANGOFF: Mr. Hearing Officer, I'll move on if the Chair is going to continue to move against me. I want to just say this. Aren't you all curious as to what this investment was? It's not every day that you lose 40 million bucks, that the value of a fund goes down 58.6 percent. I would like to know how that happened.

MR. BARBER: So the board members will have an opportunity to ask their own questions, but do you want to ask another question?

BY MR. ANGOFF:

Q. Yes, yes. Ms. Greene, after Blue Cross made this investment, did anyone at Blue Cross monitor it?

MS. ASAY: I'm going to object the form of the question. It assumes facts not in evidence.

MR. BARBER: Could you restate the question?

BY MR. ANGOFF:

Q. Yes. After Blue Cross made this investment, did anyone at Blue Cross monitor the investment?

MR. BARBER: I don't think that calls for --

MS. GREENE: So, Bridget, I'll again come back to our response in Exhibit 22, which talks about that the investments are made through our participation in the National Retirement Trust, and we do receive monthly reports on those assets and the returns on the assets as they're allocated to our portion of that trust.

BY MR. ANGOFF:

Q. And did anyone at Blue Cross know the details of the investment which resulted in a $40 million loss?

MS. ASAY: I'm going to object on grounds of relevance and to the extent the question is seeking information protected by the work product doctrine and attorney-client privilege.

MR. BARBER: So the question was what again, Mr. Angoff?

MR. ANGOFF: Sorry, Mr. Chair. I was, I was ready for you to uphold the objection, and so I was

looking for my next question.

MR. BARBER: That's probably where I'm going, but I would just ask you to restate the question.

MR. ANGOFF: After you made -- after Blue Cross made the investment, did anyone monitor the investment?

MR. BARBER: I'll sustain the objection.

BY MR. ANGOFF:

Q. Okay. Ms. Greene, are you familiar with the Vermont statute and regs specifying the types of investments insurers can make?

A. Yes, I'm familiar with that.

Q. Okay. And do you believe that this investment that lost $40 million complied with those statutes and regs?

MS. ASAY: Object to the extent it calls for a legal conclusion by the Witness.

MS. GREENE: I just wanted to point out that the pension assets are invested as part of a trust that's under the ERISA laws. It's not under the insurance laws. Our Blue Cross Blue Shield of Vermont assets are invested in accordance with the regs, the state regs on investing, but the pension assets are, are invested in accordance with federal law.

BY MR. ANGOFF:

Q. Okay. And do you know -- you may not -- but do you know whether the insurance regs also apply to the pension investments?

MS. ASAY: Objection to the extent it calls for a legal conclusion from the Witness. Appears she can't answer, but --

MR. BARBER: So I'm sorry. Did you say it appears she can answer?

MS. ASAY: I saw her shake her head, so if she's --

MS. GREENE: No.

MR. BARBER: I was going to sustain it.

BY MR. ANGOFF:

Q. Ms. Greene, how did you, how did you find out -- well, let me ask it this way first:

Did there come a time when you found out that the asset, the investment that lost $40 million was losing money?

A. We were notified by the National Employee Benefits Committee that one of the assets in the National Retirement Trust had lost money and all the plans in the fund that had, that were participating in that trust had also lost money.

Q. Okay. And, when you were so notified, what, if any, action did you take?

MS. ASAY: So I'm going to object on grounds of relevance and, again, to the extent this is seeking information protected by the attorney-client privilege or revealing attorney-client communications.

MR. ANGOFF: I'm not seeking any information protected by the attorney-client privilege or any communications between Ms. Greene and her lawyers.

MS. ASAY: I would note it's a very broad question. So I might add vagueness to the question, but I, it's also, would also add the relevance objection as well.

MR. ANGOFF: It's not in the least bit vague. It's directly relevant. The question is, When she found out that the, that the investment was losing money, what action did she take?

MS. ASAY: I'm just going to let Mr. Barber rule.

MR. BARBER: Yeah. Again, does this go to your -- the relevancy of this, in your mind, Mr. Angoff, is that fault is something the board should be considering in deciding whether or not to account for this drop in RBC or -- because all of these questions seem to go to fault, which I already explained was not relevant.

MR. ANGOFF: Fault, but also the likelihood

that it could happen again, which is why the process questions are so important and so relevant. If Blue Cross has processes set up and this was just a, you know, just some crazy thing that happened, then the board should have one reaction. If Blue Cross's processes that are set up are, are defective and it's reasonably likely that something like this could happen again, then, obviously, I would think that Blue Cross, that the board would have a different reaction.

MR. BARBER: Mr. Angoff, what about that, that argument?

MS. ASAY: I would just add or just reiterate that the points that Mr. Angoff are making about process would be exactly the types of topics that the Department of Financial Regulation might consider and that the Department of Financial Regulation has already issued an examination order on this issue. So they are not relevant to the board's proceeding here, which is about, which is directed at the adequacy of the rates. To the extent they're relevant to one of the state regulators, they fall squarely within the authority of DFR, which they are exercising.

MR. BARBER: The board also has authority to issue supplemental orders to ensure benefits and services are being provided under economical and

efficient management. Does this not implicate that authority?

MS. ASAY: Respectfully, we would say "no" and would -- again, this is not a proceeding, I think, in which that area could really be explored, and it is within the authority of Blue Cross -- it is within the authority of DFR's examination order to look at the, at the pension assets, and that is happening, and I think here the question before the board has to do with, Is this rate actuarially supported and otherwise satisfy the parameters for rate review?

MR. BARBER: So I'm going to sustain the objection. I, there is a DFR investigation or examination ongoing. This seems to be directly related to their authority. So please move on, Mr. Angoff.

BY MR. ANGOFF:

Q. Ms. Greene, does the Blue Cross Association get to keep a percentage of the, of the assets that Blue Cross member companies invest with it?

A. So the National Retirement Trust has a number of fees that are charged by the people that are charged with managing the assets. So, to the extent that those fees, some of them might go to the association, it's possible. I don't know the amount.

Q. Okay. What percentage of Blue Cross's surplus

went into the investment that lost $40 million?
A. The accounting for pension funding has to do with the pension valuation, that happens once a year. So, over the many, many years of the pension being in existence, each year end the fair value of the assets is compared to the projected benefit obligation, and that surplus or negative amount is included in Blue Cross Blue Shield of Vermont's surplus, and that's accumulated since the inception of the pension plan.
Q. Okay. So, at the time that Blue Cross made the investment that lost $40 million, what percentage of Blue Cross's surplus at that time did it account for?
MS. ASAY: I'm going to object to the form of the question, because it's assuming a fact not in evidence, and object on relevance grounds.
BY MR. ANGOFF:
Q. Okay. Let me break it up then. Ms. Greene, at the time that Blue Cross made the investment that resulted in the $40 million loss, approximately what was Blue Cross's surplus?
A. So the, Blue Cross contributes its required contributions to the pension fund each year, and so, to the extent that the assets that had the loss at the end, during March of this year, I would not know when the actual inception of that investment was without

looking into it.

MR. BARBER: I'm going to have to, sorry, interrupt your flow there. We have a board member who appears to have dropped off the call. So we're going to take a pause until we can get Board Member Pelham back on the line.

MR. PELHAM: I'm back. I don't know how I got cut off, but, all of a sudden, you guys were gone. If Kevin needs five minutes, that's fine.

CHAIRMAN MULLIN: No, no, I'm good. I didn't realize you were already back.

MR. BARBER: Tom's back. Go ahead, Mr. Angoff.

BY MR. ANGOFF:

Q. Yeah. I believe there's a question pending, which is, What percentage of Blue Cross's assets at the time this investment was made did the investment account for?

MS. ASAY: I believe Ms. Greene answered that question.

MR. ANGOFF: I don't believe I heard an answer.

MS. GREENE: What I responded, Mr. Angoff, is the Blue Cross Blue Shield of Vermont makes contributions to the pension fund over time, and I

would not know what timeframe that investment began. I don't know what the inception of that investment was.
BY MR. ANGOFF:
Q. Okay. Ms. Greene, could you give us a range?
A. No.
Q. You couldn't give us a reasonable range? So it might be a tenth of Blue Cross's surplus?
MS. ASAY: Objection. I don't understand the question. It's vague, ambiguous, as well as relevance.
MR. ANGOFF: It's completely relevant. If it's a huge percentage of their surplus, that's a very big deal. If it's a tiny percentage of their surplus, it's not so important.
MR. BARBER: Well, I think the Witness stated she does not know, but, Ms. Greene, could you restate your answer?
MS. GREENE: Yes. My, my answer is that Blue Cross Blue Shield of Vermont makes contributions to the pension trust each year based on minimum funding requirements, and that's the extent of what we do in terms of funding the pension. In terms of knowing what the date was that the investment was made or what the inception of that investment date is, I, I don't have knowledge of.
BY MR. ANGOFF:

Q. Okay. At the time that the, the investment lost $40 million, at that time, what percentage of Blue Cross's surplus was that $40 million?
A. It's huge. It's a third.
Q. A third?
A. Yes.
Q. Okay.
A. That's not something that we've -- we've communicated that, and that is, we've been talking about that since this morning.
Q. Is Blue Cross taking any action to ensure that no loss like this occurs again?
MS. ASAY: So I'm going to object to the extent that this question is calling for any attorney-client privileged communications or work product, and I'm also going to object on relevance grounds.
MR. BARBER: So help me understand how it calls for attorney-client or work product, because it doesn't appear to on its face.
MS. ASAY: Because this is in, as we indicated in the written response, this is potentially a prelitigation matter, I think the work product doctrine sweeps quite a bit broadly, more broadly than it would in other contexts, and so I'm just cautioning

the Witness that, to the extent anything that this question treads on falls within the work product doctrine, that she should not reveal those privileged matters. I also object on the grounds of relevance, which is a separate point.

MR. BARBER: So, to relevance, Mr. Angoff, I assume this is going to your issue before is how does, how does, how do we know this isn't going to impact solvency in the future?

MR. ANGOFF: Exactly right.

MR. BARBER: I'll allow the question. Ms. Greene, please answer. But I, we're at 3:00 o'clock. I really do not think we're hitting on the issues that needs to be hit on before. We were scheduled to depart at 4:00. I don't think we're going to get through all the witnesses. I think this is taking up a lot of time dealing with objections, and I really wish we could move on to the rest of the, the hearing. So, Ms. Greene, could you please answer the question?

MS. GREENE: I'd like to just point out that the, the reason why these objections are important is that we are doing everything possible to protect the interests of our policyholders in terms of a possible recovery of any losses, and that's what was outlined in our response that the National Employee Benefits

Committee is investigating the loss, and that's, that's the source of a lot of the inability to share the details, not because we don't want to share them or even that we know some of them, but we're trying to protect the eventuality of recouping something.

In terms of happening again going forward, like with any of our processes, we always review them and, and make sure that the appropriate reviews are there. The National Employee Benefit Committee has communicated to us what their review process is and what they'll be doing going forward. They have, as an example, are looking at the investment advisors that they've been using and looking at possibly changing those out, and so that is the area that we're in.

I will do everything in my power to make sure this doesn't happen again, but, again, I didn't think this was going to happen either. So that's as much as I can say.

BY MR. ANGOFF:

Q. Mr. Hearing Officer, I will take your advice and wrap this up. Ms. Greene, can you assure your policyholders that they will never pay, directly or indirectly, for the $40 million loss that we've been discussing?

A. I think we talked about that or others talked

about that this morning, and I, I'm not in a position to guarantee anything about the future at this point. I, as we, I just mentioned a moment ago, we're doing everything in our power to make sure that we can see if we can recoup some of the losses, but I can't make any guarantees about the future.

Q. Okay. Ms. Greene, would you like take this opportunity to apologize to your policyholders?

MS. ASAY: Objection, form of the question, argumentative.

MR. BARBER: Sustained. Do you have any other questions for this witness?

MR. ANGOFF: No more questions, Mr. Chair.

MR. BARBER: Okay. Then I'll move to board members. Board Member Usifer?

MS. USIFER: Okay. Hello. How are you doing over there? Doing okay?

MS. GREENE: I'm okay.

MS. USIFER: Okay. I do have a few questions that also relate to the pension, but I think I'm taking it at a little bit of a different angle, which is I know the past policy or the policy has always been to take whatever the losses or gains are and put that through to your surplus account.

And just a couple questions on -- you know,

obviously, this was unexpected, massive thing. We could go back and forth about why that happened, but I understand where you're coming from, you know, as far as some of the things that have happened. But I guess a couple questions would be, you know, How is the policy, how is the program funded as far as being underfunded or overfunded?

You know, I know last year, just looking at the numbers, I think you had a $15 million gain on this, so it went from, like, 54 to 69. Obviously, this year there will be a huge reversal going the other way. But I just wonder if you're also going to look at any other way to maybe put this through to the RBC, whether that's looking at how much funding needs to be there, whether this all needs to be taken in one year. I don't know if you've thought about that at all.

MS. GREENE: Yeah, if I can clarify, the, the accounting regulations require that the valuation at the end of the year will get reflected in the surplus. So there's, there's no options around that. In terms of looking at the future liability, that pension benefit liability, we are doing a complete review of that in light of the circumstances, and that, that work is just beginning, and so we are looking at opportunities around the total pension liability for

the next valuation, but, once the valuation happens, the accounting regulations require us to put that in the financial statements, and that would reflect any changes that we, we arrive at through our review.

MS. USIFER: Okay. So, if there were any changes to the valuation because of how much needed to be funded, etc., you wouldn't do that until, you wouldn't make those adjustments into the RBC until that changed?

MS. GREENE: Yeah. So, if I can distinguish between funding, so cash funding to meet the federal target attainment percentages, it's called FTAP, those calculations are under way and are independent from the valuation that goes into the surplus accounting. So the, the surplus accounting at the end of the year will be a function of the fair value of the assets at the end of the year and the fair value of the liabilities at the end of the year, and then the level of funding is a cash flow consideration that's required in order to maintain the benefit features of the pension.

So we could choose to fund it at 80 percent or choose to fund it at 100 percent. The amount that goes into surplus will be the same regardless.

MS. USIFER: Okay. And did the, do you know, do the other Blues that are participating in this plan,

are they reflecting similar losses?

MS. GREENE: Yes, they had losses along the same degree as what we experienced percentage-wise.

MS. USIFER: And can you ball park what 100 RBC points is equal to in a rate?

MS. GREENE: 100 RBC points in a rate? I'd have to pull in my chief actuary. 100 RBC basis points is 21 million, and, if we take that on the premium that Mr. Pelham mentioned earlier today, if I have that handy, it was 300 million. I'll just use that. It's about 7 percentage points.

MS. USIFER: Okay. And, just to be, you know, transparent, I mean, the reason I bring that up is I do understand that in this rate filing right now this hasn't rolled through and that, at this time, your RBC is still below your range, but should this 180 go through as projected, and I know there could be lawsuits, there will be lawsuits, and, and, you know, there will be adjustments to this, but, come next year, it could be depressing the RBC by 180 basis points where there would have been a possibility that we would have been, we should have been at the top end of the range or exceeding that range.

At that point, we'll know more about Covid. A lot of things will have played out. You know, one thing

when I look at all these, I say it does catch up. We will know what happens with Covid. We'll know what's going to happen to these things at some point in time. So we can debate about a lot about what we think, but in a year or so, we'll know.

And, you know, that is where it's very concerning, because, had we gotten up into a higher range over 700 for a period of time, it would have gone back to ratepayers. And so I'm just going to put that out there, because, you know, it, it clearly is a direct impact at some point. Right now, we're not there. Right now, I agree, it's not in this particular filing, because, even if it were in there, you still would only be at the top of the range. But, you know, it's very unfortunate, but I do think it is relevant to the ratepayers and at, and at over what timeframe should they be paying for this and things like that, because, because it will impact.

But just, just touching on a little bit about the, you talked a little bit about the salary increases and looking at 2021 and looking at the executive group, but can you give a perspective on what percentage the executive group's compensation, their 3 percent increase, would make out of the total change?

MS. GREENE: I don't have that off the top of

my head, but it would be a reasonable percentage. In total, we have about 420 folks at the company, and I can certainly follow up with that detail for you.

MS. USIFER: And what prevents anything from happening on those things in 2020, I mean, we're, for 2021. We're only in July. Most companies we're seeing in the economy are struggling with everything that's happened with Covid. We see hospitals furloughing people, cutting back on salaries. We see educational institutions cutting back on salaries. You know, not, not, you know, not giving an increase. We're talking cuts. We're talking everybody across the board taking cuts, and I know of a lot that have been announced in Vermont.

And, you know, we're not seeing that sense of urgency from Blue Cross, you know, and we're all going to be in -- every company is going to have issues with recruiting people and everything else, but, you know, I think it's almost a tone deaf to have the executives and everybody else in '21 continuing to get increases when this is going on, and I want to find out what would prevent you from incorporating that now, even if it was in this rate filing as something different.

MS. GREENE: Well, there's nothing to prevent us from considering those options. As I said in my

earlier testimony, is that we are looking at all the options. We haven't concluded on anything beyond just the executive salary increase, which will be zero next year, but we certainly are taking it very seriously, and we can share further details.

MS. USIFER: Is it zero for 2022 or 2021?

MS. GREENE: 2021.

MS. USIFER: Okay. So they're going to have it for 2021? And just because, obviously, if you've read all the public comments, too, I mean, most of the people that are purchasing these insurance are paying higher premiums and making less money. You know, so it's just a little bit of a disconnect when they're seeing, you know, everybody over at Blue Cross getting an increase or a large percentage of people.

You're paid a little bit differently, so you have that flexibility to take those increases and put them into rate, or you have that flexibility to not take those increases, and, even if it's a small amount in rate, even if it's .2 or .3 percent in total, it sends a message, and I --

MS. GREENE: Well, we also, just, I'd like to point out that we do have a large contingent of folks at Blue Cross Blue Shield of Vermont that are hourly and do make, you know, much less than some of the

higher paid folks. So we're, we're working through what's appropriate to make sure that we're finding the right balance there. So there's certainly some, some folks in the Central Vermont area that we want to make sure we're, we're doing right by.

MS. USIFER: Okay. And then, when we look at, when we look at the premium and we look at the components of the premium, medical, inpatient, outpatient, things like that, what percent of the premium, not premium increase, the total premium, is related to the Vermont hospitals?

MS. GREENE: What percentage? That's a question I'll have to follow up on. I don't have that off the top of my head. Talk about a certain amount of medical cost with the, the Green Mountain Care Board, sorry, the Vermont hospitals, but I don't know what that would be as a percentage of total premium.

MS. USIFER: And the reason I'm asking that question is, you know, how do we correlate the massive shortfalls that we're seeing out of the hospitals, knowing it's across all three payers, but we're seeing their revenue down significantly across every payer because of utilization, knowing some of that might come back next year, but, you know, how can we correlate that and what you're receiving now and what you receive

next year? I don't know if you have any thoughts on that.

MS. GREENE: Well, I do. I made a note. I'll take the follow-up question for the percent of premium that is related to the Vermont hospitals. I would like to just clarify what I said earlier, that when, when the hospitals, and I think Paul mentioned this as well on his question and answers, that, when the hospitals absolutely are experiencing a drop in revenue, but that's across all of the Medicare, Medicaid, and commercial, and then, to the extent that a large portion of our book of business is self-funded, the hospitals are, are experiencing that decline as well, but that is not part of our rates.

So it's important to understand the broad categories of the revenue shortage with where, where that slowdown in claims is residing at the moment. So several of the large self-funded entities in Vermont are, in part, feeling the benefit of that slowdown in claims in the short time, sorry, short term.

So that, that is, when you add up the revenue shortage at the hospitals and look at, you know, where is that coming from, that self-funded group, which is a good thing in the sense that those large employer entities are not having to pay their health claims,

because they're, they're going to be deferred until later. So that helps them from a timing point of view. So I think that's a good thing to kind of keep in the mix of that view.

MS. USIFER: Yeah, I guess, in the self-funded world, they get it back now, and they have to pay it later. But in the QHP world you guys are holding onto that.

MS. GREENE: So that we can pay it later, yeah.

MS. USIFER: Yeah, but, you know, we don't know. You know, it's, they get to make that option. But, just looking at your prefiled testimony on Page 7 and 8, on 7 where the statement, under the statement, "What are the most significant factors related to the pandemic that could affect, potentially affect the reserves", and then, when you go to Page 8 of that Exhibit 12, it says, "Claim costs could increase due to Covid allowances given to hospitals in the form of commercial increases as temporary adjustments to compensate for fiscal year 2020 utilization that was not realized due to the pandemic".

And that statement seems to contradict what you said in your opening, that you think those should be included in the rates. And so I'm not, you know, we're

not saying how we're going to effect for that yet, but we're looking at that as a Covid adjustment. You know, we are looking at that as saying we definitely can see that the hospitals didn't get it. We're going to have them adjust for all of their funding they receive and then, looking at commercial only, what would make them whole over a two-year period. So, in theory, the math should be the same, in theory.

MS. GREENE: Yeah.

MS. USIFER: So I would then support that that increase shouldn't be added to any, the Covid-only increase shouldn't be added to a Blue Cross rate, because it should come out of reserves because it's related to Covid, and this statement, to me, supported that. That's good. But in your opening statement you specifically said something different than what I'm interpreting here.

MS. GREENE: Yeah, this list was highlighting, at the time we submitted this, this list was highlighting the risks to our reserves. What I testified earlier this afternoon was that I really think, based on the analysis that the actuarial team has done, that we really should take a long view. Because, if it is kind of a wash through 2020, 2021 and early 2022, we wouldn't want to, you know, increase the

cost of the health care system only to, you know, have to figure out how to get that money back out of the system later on. So it was included in my prefiled testimony as one of the risks to surplus, and it is.

MS. USIFER: Okay. And, I guess, to, to counter, I guess, in a perfect world, I can see what you're saying. If you'd look deeply at the hospitals, the 14 hospitals that we have, and the number that are losing money and several of which almost ran out of money during this period prior to getting some relief, it may not be, and the ones that are now hitting into bank covenants, you know, they're missing bank covenants and things like that, it's probably not realistic to say that they can suffer all these losses, additional losses, this year and just wait until it comes back if, in fact, it comes back.

That's, that's part of the problem with the mismatch, right, is the hospitals lost all their services. It doesn't mean they're going to come back to all those hospitals and those that didn't get Covid. So it's, so we're looking at their -- but their losing, a lot of, many of them are losing a lot of money.

MS. GREENE: If I may, I'll just comment that I think someone mentioned this early in the testimony that we have advanced payments to hospitals who

expressed some concern in those April and May timeframe where they were really suffering from the lack of payments from the commercial book, and so we have $10 million, we've advanced $10 million to facilities and independent providers to help them through the worst of those times. So I just add that to the perspective. It's a difficult situation to figure out, but we have been trying to help out as we can.

MS. USIFER: Okay. I think I'll leave the other questions to other board members. So thank you.

MS. GREENE: Thanks.

MR. BARBER: Okay. Board Member Lunge?

MS. LUNGE: Sorry. I have one follow-up to what Maureen just asked. Can you give us a list of those payments by hospital?

MS. GREENE: We can. I don't have it here handy, but I can provide that.

MS. LUNGE: Great, thank you. I don't have any other questions.

MR. BARBER: Board Member Pelham.

MR. PELHAM: Hello.

MS. GREENE: Hi.

MR. PELHAM: I want to start -- I only have a couple questions, but the first one, looking at Exhibit 1, Page 55, you don't have to go there. I'll read what

it is that I think is significant.

You say, "Blue Cross Blue Shield of Vermont is committed to providing insurance coverage for our members at the most affordable rates possible. As a result, even though it is impractical to react to enrollment shifts by immediately right-sizing, we nonetheless remove from our projections the entirety of the variables associated with reduced enrollment."

So I read that, and then I go over to Page 163 of Exhibit 1, which shows your member month track record from 2014 to 2019, and I see from -- and I'm going to start at 2015. From 2015 down to 2019, that's going from 768-plus thousand to 520-plus thousand. That's a downsizing rate of 9.3 percent a year over a five-year period.

And so I'm just wondering, you know, in the context of that language that I read earlier, what right-sizing things have, has Blue Cross Blue Shield done, you know, since 2015? Because this decline in membership has been at a pretty rapid rate, more than 9 percent a year, since, since then.

MS. GREENE: A couple of things, if I may. The, the member months that you're looking at on Page 163 is just with respect to the Vermont individual and small group business. The right-sizing that we

referred to in the actuarial memorandum talks about, as we look at our total book of business and understand where membership might be increasing or membership might be decreasing, we right-size the staff with that full picture in mind.

And I did look back, and thank you for submitting your questions ahead of time in light of this question. I did look back at the enterprise level membership, and that's, it's also gone down, I admit, but it's only gone down at a 2 percent per year level, and we have been able to, you know, reduce staff through attrition over time.

When we formulated the 2020 budget, we suspected that we were losing membership again, and so we, we took several positions out of the budget to make sure that we were calibrating in total. So that gives you a sense of how we think about the right-sizing of staff.

MR. PELHAM: Okay. So, so let's just focus on individual and small group. You have submitted your supplemental health care exhibit for 2019. That's in the record here, but 2015 isn't, and so I went back and looked at that. And so what you have in terms of covered lives going from 62,853 in 2015 to 42,699 in 2019. So that, again, is a 9.32 percent average annual year drop.

But what caught my eye was, is that the combined premium, which would be Line 1.12 on the supplemental, the, you would think, with a decline like that, that you'd see some significant difference in the premium amounts, claims amount, and general administration amounts, but that's not so. That the, the premium amount went from 322.8 million to 319.2 million, which is a two-tenths of a percent year drop. The combined claims from 292 to, 292.063 to 292.984, which is an eight-tenths of 1 percent drop, and the general administration went from 24.8 million to 24.3 million.

So, on a premium per covered life basis, claims per covered life basis, and expenses per covered life basis, all of those, I mean, respectively, those are 9.8 percent, 10.2 percent, and 9.5 percent, and so it seems to me, you know, that, you know, that, obviously, you know, within this, this book of business, you know, covered lives, the member months, they are falling away, but the expenditure amounts have stayed pretty flat, and that just seems odd to me.

MS. GREENE: Well, I think, if the membership had stayed level, just hypothetically, we do know that, over the course of the years, there has been increases in claims, whether it's the pharmacy increases that Paul testified to earlier or other types of increases.

We also know that the, the shift in membership between the issuers is such that the cost per member for our book of business has grown over time. Paul indicated that it wasn't so much the case this year with the analysis, which is good. It means that those trends might be alleviated to a degree, but it is something that we take very seriously in terms of the sustainability of this book of business.

MR. PELHAM: Okay. Again, on the 2019 supplemental it shows $1.63 million in cost containment.

MS. GREENE: Yes.

MR. PELHAM: So what is, what do you do with that 1.6 million bucks?

MS. GREENE: Right, yeah. So the way the supplemental health care exhibit works is that, as Paul indicated earlier, it's a statutory form that we fill out, and its purpose is to begin the mechanism for the minimum loss ratio calculation. It's not actually the basis for that calculation, but it's the beginnings of that, and one of the things that the regulators like us to parse out of our administrative costs are the costs and what we spent them on, whether it's cost containment or quality and so on, because that makes a difference in how they calculate the MLR.

So that $1.6 million is, through our cost allocations, what we believe internally are involved in the cost-containment activities.

MR. PELHAM: Thank you for that. Now I want to focus a little bit on -- I'd refer you to the page, but the print's so small you can't read it. So there's no sense in going to it, unless you've got a blown-up screen. It's Exhibit 1, Page 225, which is your consumer adjusted premium rates.

MS. GREENE: Right.

MR. PELHAM: And I don't know if you saw it, but DVHA last year, for the last two years, they've done a very good presentation on the premium cliff at 400 percent of poverty level comparing 2020, the last one I saw was comparing 2020 over 2019 rates, and you can see that, with the Vermont premium assistance and the advanced premium tax credit, that things are actually pretty reasonable below 400 percent of poverty, but, but, when you get to above 400 percent of poverty, it's a different story.

And so I'm looking at, you know, from that exhibit on Page 225, I just took a look at the same plan that DVHA used in their analysis, which was the bronze deductible plan, which, and these are the numbers that you'll find on Exhibit 1, Page 225.

For a single person, it's $572.05. For a couple it's $1,044.10. For a family it's $1,607.46, and so, right at 400 percent of poverty, the percent of -- so you're just above, and you don't have any of the advantages of the subsidies. You're looking at a 13.7 percent rate for a single, a 20 percent rate for a couple, and an 18.7 percent rate for a family, and they don't, those, that plan doesn't begin to get affordable by the federal standard until, for a single person, it's little over 70,000. For a couple it's 141,000, and for a family it's 198,000. And so, so that is the context.

To me, there is a big problem there. At the lower end of that scale, just above 400 to 500 percent of poverty, those are middle class Vermonters, and it's so striking that somebody at, at 410 percent of poverty can look over the shoulder of someone at 390 percent of poverty, and there's this vast, vast difference.

So, I know that Blue Cross Blue Shield was involved in the crafting of the 2019 report on health insurance affordability immersion markets that went to the legislature. It was conducted by DVHA and DFR, and it cites Blue Cross Blue Shield as a consulted stakeholder. You were a stakeholder.

And one of the recommendations, and I'll read it,

of that report was there was an array of ways to address this premium plans, and some of them were pretty cheap. So I'm going to read the cheapest one here:

"For additional premium subsidies, $2.2 million would be needed to lower premiums for enrollees between 400 percent to 500 percent of FPL, while $9.3 million would be needed to lower premiums 10 percent for all unsubsidized above 400,000 FPL. The 10 percent reduction translates to around an $800 in savings per member per year on average".

And so my, so here we have a study. It was done by Wakely and sort of reasonably actuarially sound, and, you know, at the low end for $2.2 million, you, you could lower rates for those between 400 percent and 500 percent, you know, by 10 percent or 800 per member, and I, you know, I don't expect this to come out of the pocket of Blue Cross Blue Shield, but I would hope that Blue Cross Blue Shield, and you have some great people on the hill, you know, would be always looking for ways to advance, you know, the cause of rateholders and ratepayers and help ratepayers achieve, for example, these subsidies.

I mean, when it came around to silver loading, and that's when I first came on the board, there was

activity like a beehive in order to put that advanced premium, you know, tax angle in place. And so, you know, I, I follow the state budget. It's a bad habit, I guess. And I see in, in the Medicaid area, I mentioned them this morning, that in Medicaid they were running at 63 percent of the appropriation, and that's after a budget-adjusted appropriation, you know, last January. They were running 63 percent when they're three-quarters through the year. You have the audit of the state auditor that found more than $2 million in claims and unpaid premiums by a small sample of the Dr. Dynasaur, and Dr. Dynasaur, the premium rates are lower today than they were in 2004.

MR. BARBER: Tom, Tom, we're really pressed for time. So if you could --

MR. PELHAM: Right. So the question, the question is, you know, Has Blue Cross Blue Shield followed up with any of the recommendations in the report to lower premiums for moderate income Vermonters above 400 percent of poverty?

MS. GREENE: Yes. It's my understanding that we were advocating for the recommendations that came out of that report. You make a good point about the cliff between or after 400 percent federal poverty level, and we, we agree that, that that is a barrier to

many people out there trying to afford coverage. My understanding is that the, the barriers is, you know, Where will the money come from? To the extent that there's, you know, we have ideas, but we are very much an advocate of some of the recommendations that came out of that report.

MR. PELHAM: Well, good luck. That's it, Mike. I'm through.

MR. BARBER: Okay. Thank you. Member Holmes? You're on mute. Let me try and take you off mute. No questions.

CHAIRMAN MULLIN: No what?

MR. BARBER: No questions? Got it. Mr. Chair, do you have questions?

CHAIRMAN MULLIN: Unfortunately, I do. Good afternoon, Ms. Greene.

MS. GREENE: Good afternoon.

CHAIRMAN MULLIN: Earlier today I asked Dr. McIntosh, and she referred these questions to you, and the questions were -- well, first of all, thank you for not kicking any QHP member off for their inability to pay during such crazy times. So thank you to Blue Cross for that decision. But can you tell us how many members are in arrears and how that compares to pre-pandemic times, maybe this time period last year?

MS. GREENE: Sure. So, as you mention in your question, that, at any given point in time, we often have people in arrears. So one of the things that we did in preparation for questions -- we get this question from others as well, and so what we did is we looked at the number of customers who were so far into arrears that they normally would have been cancelled but then, because we didn't cancel them, how did they sort of work their way through that and get back current, or how many are still not able to get current?

So that's a slightly different way of answering your question than just statistics about who's overdue. Hopefully, you'll find it useful. So we had around 560, 559, to be precise, customers as of the end of June, this analysis was done, that needed some sort of flexibility of some sort across all of our book of business.

For the individual and small group customers, there was 300, just over 300, 311, and the, that breaks down about 191 for individual and 120 for small group. The number of customers within that 311 that were delinquent to the point where we normally would have cancelled them but we didn't and now they've actually been able to figure out how to get current through getting back to work or for whatever reason is 173.

So I look at that as a very specific example of how taking a situational approach to, you know, had we cancelled those folks, they needed their coverage, it would have created a whole bunch of stress, and they would have had to reenroll anyway. So, so I think that's a really good example of how sort of remaining flexible for our customers makes sense.

That said, though, we do have a hundred or, sorry, 69 customers as of the end of June who are still delinquent within the individual and small group book of business that were delinquent to the point where we normally would have to have cancelled them, but we have not. So they still remain covered and will remain covered until something changes in terms of the stay-at-home orders and the emergency order.

CHAIRMAN MULLIN: When the pandemic was really escalating back a few months ago and the federal government reacted with the $1,200 stimulus checks, did you see just the opposite effect, though, people being afraid about their health care so they paid more timely?

MS. GREENE: Well, it's interesting you should say that. I think, in the very early stages, we were kind of bracing for the worst, but we did, and I don't know why, but we did see that people were able to

stay current in that very, very early stage.

We do have a number of folks in our call center who talk with people on a day-to-day basis. Some of our communications have said, Call us. If you have issues, we can work with you. They are, they did find a number of folks that were sort of waiting for that stimulus check, or they were waiting for the unemployment to come through, or there was something that they were, the timing just wasn't working out for them. So we were saying, Okay, well, just call us when you have an update, and we'll stick with you.

CHAIRMAN MULLIN: Did Blue Cross Blue Shield pursue paychecks protection funding?

MS. GREENE: That's a good question. We seriously thought about it. We even ginned up the paperwork to get going on it, and about the time that we were getting going on it, we realized that probably -- well, first of all, the funds were short the first round, and, second of all, we felt like the small businesses and, you know, the Main Street businesses were probably better served to have those folks get that money. So we, we made a strategic decision to not try to get into the second round when it came around.

CHAIRMAN MULLIN: Okay. Is Blue Cross seeing significant savings like other organizations around the

world as far as reduction in costs for travel, sending people to conferences, fewer office supplies, less occupancy costs like HVAC and electric, etc?

MS. GREENE: Yeah, we, I believe we answered a question-and-answer around that. I think it added up to around 275,000 as of the date that we sent that in, maybe through the end of June. The, you know, we have a very modest travel and conference budget to begin with. So, yes, it is a savings, but it's small in comparison to some of the other costs and, and stresses that the organization or others that the providers and the customers are experiencing.

CHAIRMAN MULLIN: How long is Blue Cross Blue Shield going to continue the policy of allowing people to work from home? Are you going to wait until a vaccine, or what is your, your plan?

MS. GREENE: I would really have to defer to Dr. McIntosh on that. She's in charge of kind of figuring that out. But, based on the company updates that we get regularly on this, there, with the back-to-school planning that's going on for many families, we're kind of plugged into trying to be as flexible for folks while also being safe about it and recognizing the numbers of people in close proximity within the building, etc. So we call it the pandemic

planning team. That team is working through those plans.

CHAIRMAN MULLIN: Okay. You used the term executives will not receive pay increases this year. Where do you draw the line? Is middle management included in that, or are you just taking C-suite?

MS. GREENE: It's the vice president level at the moment. That's what the decision has been made. As I mentioned in response from a question early for, for Board Member Usifer, that we're looking at all, all different options at this point, but, right now, that is the vice president level, C-suite, if you will.

CHAIRMAN MULLIN: Will the pay freeze eliminate any incentive pays, bonuses, etc.

MS. GREENE: We don't know yet, but that's part of the analysis.

CHAIRMAN MULLIN: Okay. How much do board members get paid for their role as a board member?

MS. GREENE: Board members get paid a stipend. I don't know the current per meeting stipend level, but I think it is disclosed. We can certainly get that to you. They get paid per meeting, and, if they serve on a subcommittee, they get a payment per meeting for that as well.

CHAIRMAN MULLIN: Okay. How often does the

finance committee meet, the finance committee that you referenced when it came to investment and pension decisions?

MS. GREENE: The finance committee meets on a standing agenda three times a year, once in January, once in March, and once in October. But, as you can imagine with all of the financial topics that are at issue, we have been meeting much more regularly, at least monthly and sometimes more depending on the topics.

CHAIRMAN MULLIN: Okay. And so I, I have interpreted it correctly that this one finance committee makes both the investment decisions and the pension decisions?

MS. GREENE: They make the investment decisions for the Blue Cross Blue Shield of Vermont investments. They review the asset allocation for the pension, but not, they're not overseeing the, the asset management, manager selection for the pension. So we're -- they oversee the, the total portfolio and look at the returns, and we determine the asset allocation and review that once a year.

CHAIRMAN MULLIN: So you talked about being in compliance with state regulations as far as your reserve investments, and you talked about ERISA being

the federal governing law that oversees the pension, and ERISA specifically refers to plan trustees, plan administrators, and members of a plan's investment committee. Help me to understand what Blue Cross Blue Shield believes is their investment committee. Is it this delegation to this national organization, or is it your finance committee?

MS. GREENE: So, if you keep the two things separate, the pension plan as part of the National Retirement Trust, the National Retirement Trust would have an investment subcommittee and investment advisors for that trust. That is not the Blue Cross Blue Shield of Vermont's finance committee. The Blue Cross Blue Shield of Vermont finance committee is the oversight of the reserve investments.

So, if I could just -- I don't know if this helps or not, but, in the response that's in Exhibit 22, we indicated that the Form 5500s, we shared with you for the National Retirement Trust, and some of those roles and responsibilities are outlined there for the National Retirement Trust.

CHAIRMAN MULLIN: Well, I don't pretend to be an attorney, but I can say that, in doing research for this meeting today, I could not find any ability to delegate to a national organization that would relieve

you of certain responsibilities to make sure that risk is mitigated on these funds, but I'll leave it at that.

You prepared the July 16th, or at least you're the one who signed the affidavit that your attorney submitted to board counsel answering questions. Were you also involved in conversations about the letter that was received by the board on June 26 from Don George?

MS. GREENE: Yes. Yeah.

CHAIRMAN MULLIN: And were you also involved in whatever took place in March where DFR was notified?

MS. GREENE: I, we were meeting with DFR weekly in March or after the pandemic began in March, and so, at one of the weekly updates, I did provide an update that we had had a loss in the pension fund and that we were looking into it, trying to find out more.

CHAIRMAN MULLIN: So it seems like you've been intricately involved in this, and I'm just curious why you chose to wait 90 days before you notified the Green Mountain Care Board.

MS. ASAY: I'm just going to interject and caution the Witness not to disclose attorney-client communications or work product in any response, and I do, I do feel like I should reiterate our relevance objection here. I think Ms. Greene well understands

the line between what we've been able to provide information on and what, with respect to protecting our stakeholders, has been a concern of ours. So I'm objecting. She can answer, but I'm sorry, Chair Mullin. I do want to caution the Witness on that point.

CHAIRMAN MULLIN: Well, I was going to say something snide, and I won't. So but I will say this, that perhaps, if Blue Cross had answered the questions that the board had put forth in their letter to Blue Cross instead of the perfunctory response that we received back -- I think Mr. Angoff was very kind when he called it telling us to go jump in the lake. My response was a little bit more severe than that. I'll leave it at that.

MR. BARBER: Well, hold on. I mean, there was a question. There was an objection to the form, or, sorry, there was a question, objection on relevance, and I do think that the amount of time it took to notify the board is relevant. There is a letter about CTR and impacts on solvency, and this was not among them. So I would like the Witness to answer the question, please.

MS. GREENE: Well, the time it took us to respond is purely a function of us getting a full

understanding of what we knew and what we didn't know and what the approach was going to be at the National Employee Benefit Committee level. And so the communication to the board was, you know, in the interest of transparency getting that over to you, but I think it was as quickly as we could have given the circumstances that we were looking into at the time.

CHAIRMAN MULLIN: At the very least, it's a lack of courtesy to one of your regulators, but I'll leave it at that. So, under the federal ERISA laws, there are rules for fiduciary conduct, and is it your belief that those rules for fiduciary conduct lie within this national association which you chose to put your investments into and not with your organization itself?

MS. GREENE: I'm sorry. You broke up at the beginning of that question. So could I ask you to repeat the question? Sorry.

CHAIRMAN MULLIN: Sure. There are rules that fiduciaries must follow under ERISA law, and I'm curious if you believe that any violations of those fiduciary responsibilities are to rest solely on the people at this national association which you chose to lay your trust in, or does anybody at Blue Cross Blue Shield want to take any personal responsibility for

this?

MS. ASAY: I apologize for interjecting, but I think I do have to interject here with an objection that it's asking the Witness to draw legal conclusions and delving into attorney-client and work product matters in this area.

MR. BARBER: Sustained.

CHAIRMAN MULLIN: How many years ago was it that Blue Cross made the decision to go with this national organization?

MS. GREENE: It's well over 20 years ago. It's when the pension, when the pension was offered originally, the mechanism for offering that pension was through the national employee benefits mechanism.

CHAIRMAN MULLIN: Do they have to notify you when they make changes to their investment strategies?

MS. ASAY: So I'm going to caution the Witness please not to --

MS. GREENE: They have to -- we sign up to be part of the plan. I don't think -- this is an area that I think is not something that we can go into.

CHAIRMAN MULLIN: Okay. I'll drop my line of questions. Thank you, Mr. Hearing Officer.

MR. BARBER: Okay. Do you have any redirect, Bridget?

MS. ASAY: I do not.

MR. BARBER: All right. I think we should talk about time, since we're 15 minutes from the scheduled end of the hearing and we have four witnesses remaining. What, what is folks' availability to go beyond 4:00? Do we need to reschedule or schedule a continued hearing in this matter, or do you think we can get through the next couple witnesses in a reasonable amount of time? I think L&E's testimony is going to be, I expect, fairly brief. Based on Mr. Fisher's testimony last year, I'm anticipating fairly brief testimony from him, but how long do you think Mr. Garland might take?

MS. ASAY: I think that, in terms of the direct, we can cover quite quickly with Mr. Garland and probably try to move very quickly to the executive session, and it's possible, if I had a couple minutes to confer with the team, we could come up with even, an even better strategy, but, certainly, I think, from our perspective, that testimony does not have to take very long.

It's even, I don't know if this would be time-saving, but we did put the basis for going into executive session in the prefiled testimony, and, if the board wanted to go directly there, perhaps we, it

is possible that we could start there and then see if there's any questions that we want to cover outside of the executive session afterwards.

CHAIRMAN MULLIN: Well, Mr. Hearing Officer, from my perspective I don't mind going as late as people possibly want to today, but I don't think we should go past 5:00, and one suggestion would be to get to as far as we can get to today and adjourn until 1:00 o'clock on Wednesday. Wednesdays are normally board meeting days. So I would hope that all the board members might be available on Wednesday afternoon and we could finish it at that time, but I don't know as to the parties of their availability.

MS. LUNGE: Well, I'll just say for myself staff has grabbed up my time in the 1:00 o'clock range. So I'm, I could try to reschedule meetings, but, that I have between 1:00 and 2:00, but I do have a health care appointment at 3:15.

MR. ANGOFF: Mr. Chair, I'm available at 1:00 on Wednesday, and, also, Mr. Hearing Officer, if it's any help, I have no questions for Mr. Garland.

MR. BARBER: All right.

MS. USIFER: Maybe we can look at is it possible to not look for a hard stop at 5:00 but see if we can wrap it up by 5:30, 6:00, I mean, at the

latest? It seems like there would be inefficiencies to regroup if we can get through the rest in two hours, which might be optimistic in how we've been going, but --

CHAIRMAN MULLIN: I'm willing to go all night, but I'm trying to be respectful.

MR. BARBER: Well, let me -- is the commissioner on the line?

MS. ASAY: Mike, Mr. Barber, I have one other suggestion if Mr. Donofrio agrees, which is, since Mr. Garland is kind of change in direction on the Blue Cross side, if it's more efficient to move through the other presentations first and then --

MR. BARBER: That's what I was thinking.

MS. ASAY: Okay.

MR. BARBER: Mr. Pieciak, are you on the line?

MR. PIECIAK: Yes. Can you hear me?

MR. BARBER: Yes. What is your availability to go beyond 4:00?

MR. PIECIAK: I had a meeting at 4:00 that I could let them know that I won't be able to participate in, and then, beyond that, I can go beyond 4:00 or other than that.

MR. BARBER: I propose we, we go to the

commissioner, because it's kind of a continuation of the solvency discussion that we've been having, and then move to Mr. Garland, and, to the extent you could cut down on the or eliminate the direct questions and we could go to the executive session, then do that and board questions. Like I said, I don't think L&E's testimony will take much time. I could be wrong. And then we can see if we can get through it as quickly as possible.

MS. ASAY: Okay.

MR. BARBER: Is there any objection to that?

MS. USIFER: No. Just, at some point, we might want to take a five-minute break.

MR. BARBER: Why don't we take five minutes now, come back, hear from Commissioner Pieciak, and then move on to Mr. Garland? So come back at 3:55.

(A recess was taken from 3:50 p.m. to 3:57 p.m.)

MR. BARBER: So, Commissioner Pieciak could you please raise your right hand?

M I C H A E L P I E C I A K,

duly sworn to tell the truth, testifies as follows:

MR. DONOFRIO: Thank you.

MR. PIECIAK: Thank you very much, Michael,

and thank you very much to the Green Mountain Care Board. I think I'm going to dispense with my opening remarks as I had them prepared and drafted due to the amount of time that I know or where the time is, and the amount of time that you probably would like to spend on this testimony is probably better served answering your questions.

But I will just point out the high levels of our solvency opinion. You know, this year is unlike others from my perspective. We are in the midst of a pandemic that we haven't seen the likes of in a hundred years. That uncertainty is on top of the normal uncertainty at that does exist in this process, regardless of that sort of external factor.

You know, from our vantage point, this process is really designed to forecast or, you know, predict what the total expenses will be of the insurance company for the next year, and there is just a great deal of uncertainty with that under normal circumstances, but now we really have quite extraordinary circumstances that we're dealing with at the moment and quite extraordinary uncertainty as well.

You know, I think, as we look upon and try to quantify that uncertainty, that there's no doubt that what's happening across the country from a Covid

perspective can and will likely impact the northeast to some degree in the near future. We have seen cases, you know, well above 50,000 per day in terms of new infections on a pretty regular basis across the country.

You know, we calculated in the last 9.5 days, last 10 or so days that we've had more Covid-positive infections reported than the entire state of Vermont, just to put some perspective on what's happening across the country. Last week we saw the northeast did see its case, week-over-week case growth increase by close to 10 percent. So we're not immune to this in the northeast. Although, from a Vermont-only perspective, we do remain quite steady in terms of new cases and in terms of hospital need and things of that nature.

But there is still great uncertainty on the longer term horizon when we look at how the virus will grow in Vermont and in the northeast as we move into the fall of 2020 and then, as it relates to this rate hearing, into the winter of 2021 when cooler weather forces us to spend much of our time indoors and potentially mitigation measures have to be reconsidered, and we'll see what happens, but I think that uncertainty is rather significant and will play, have a huge impact on what ultimately happens here in rate year, plan year

2021.

Talking about pre-pandemic financial position of Blue Cross Blue Shield, as we pointed out in our solvency opinion on Pages 2 and 3, prior to any Covid impact, Blue Cross did report a positive trend that its total surplus increased approximately $23 million in 2019 year end, and that's compared to the 2018 year end. Much of that surplus increase, it's important to note, did come from the receipt of their AMT tax credit, that total just under $19 million.

Similarly, it's also important to point out that they did sustain underwriting loss for the year, even though they did add to their surplus, and that includes an underwriting loss in the ACA marketplace as well. And, again, even though that is good news, we always like to see their reserves going up or at least staying stable. I do want to point out, as Oliver Wyman did in their analysis, that Vermont's Blue Cross Blue Shield is the lowest of its peer organizations across the country as, at the end of 2019 with an RBC of about 567. So, among the 18-or-so peer institutions across the country, Blue Cross Blue Shield of Vermont did stand at the lowest RBC level.

All that being said, there's, obviously, now that we're into 2020, there's obviously been a significant

impact from COVID-19. How these sort of major unknowns play out, in my opinion, will determine whether, whether the rates were sufficient for this current year, and then it will also determine what impact that will have on Blue Cross Blue Shield into 2021 and beyond.

No doubt that the biggest unknown in how this unknown is resolved will have the biggest impact, in my opinion, is the reduction and then also the potential return of medical claims, so medical procedures. Certainly, medical claims have been down pretty significantly from March, April, May, and we did see somewhat of a return to normal in June. So we will wait and see how that return to normal plays out.

Will that be something that's constant throughout the summer? Is that something that will roll back once the fall comes around and potentially increased cases of Covid are back on the rise in the northeast and potentially in Vermont as well? You know, there are a lot of unknowns in the trajectory of the virus, and, therefore, there's a lot of unknowns in the trajectory of the financial position of our health insurance.

We'd also point out, certainly, that Blue Cross Blue Shield will also have a direct cost of treating COVID-19 patients. We've leaned on them from a

department standpoint to implement policies that we think are good health policies. So, for example, zero cost share on testing, zero cost share on treatment for COVID-19, we think that was morally the right thing to do but also was the right thing to do as it relates to getting ahead of the health crisis that we're facing, making sure there were no barriers to people getting a diagnosis and for people getting treatment so that we can curb the spread of the virus, but those do come, obviously, with costs, and Blue Cross is bearing those costs directly.

Also, it has to be said, although not part of the 2020, the 2021 rates, that the extent of the pension valuation, that issue will certainly determine in the long run the solvency position of Blue Cross Blue Shield. We point that out in our solvency opinion. Just, just to proactively say a few things about that since I'm sure there will be some questions, you know, our stance is that the pension was well-funded coming into this particular event. That is certainly a positive thing.

Also, we'll just say that, you know, what was the remainder of the cash and assets were able to be reinvested at a low point in the market, and the market has returned quite steadily over the spring. So I

think that has to be taken into account as we look at the full year and not just the particular event that occurred. And then, of course, as has been alluded to during the hearing, the legal recourse, which I won't get into much detail on, but that's also something that will play out, and that legal recourse and its ultimate, you know, success or result will ultimately determine what the true impact is here. So there's a lot of uncertainty. There are a lot of factors that have to be borne out before we really know what impact that, that pension issue will have on the longer term impact of Blue Cross Blue Shield.

We also point out in our solvency opinion that there are a number of other smaller items that either will benefit or potentially be a detriment to Blue Cross in the shorter and longer term. There's some ongoing litigation relating to cost-sharing reductions referring to risk corridor payments that have a likelihood of success, and there are likely improvements of money there. I think the board is aware of this, but the ATM tax credit under the Cares Act will basically fast-forward it so that the total payments will be paid out on the current year. So that's money that we all were well aware of, but it is money that will be more quickly available to Blue Cross

Blue Shield.

And then, of course, there are some, some things that, again, will have an impact, the significance of which we'll wait and see, but there's certain things under the Cares Act that Blue Cross Blue Shield and other health insurers will be responsible for, like the payment, like the payment of vaccines, for example, when, when they are available, and I think, as already has been touched on, there are some other questions about the extent to which uncollected premiums from individuals or businesses that are having flexibility, to what extent those are able to be paid back in the short and long term and, potentially, the impact of any provider assistance that has been allowed by Blue Cross Blue Shield as well.

The extent to which those advances are or are not paid back is some degree of uncertainty also, but I think, without a doubt, the greatest uncertainty is the direct related Covid items that we, that I touched upon in testimony today but also in our solvency opinion as well. So, with that, I'll leave it there. I'm happy to take any questions that anyone might have.

MR. BARBER: Okay. Mr. Donofrio, are you doing questioning for the commissioner?

MR. DONOFRIO: No. Thank you, Mr. Barber.

Thank you for you testimony, Mr. Pieciak. No questions.

MR. BARBER: Okay. Mr. Angoff?

MR. ANGOFF: Yeah, just a few questions.

EXAMINATION BY MR. ANGOFF

Q. Good afternoon, Mr. Commissioner.

A. Hello, sir. Nice to see you. Sorry we can't be in person.

Q. I'm equally sorry. What, if any, authority does the department have over the types of investments an insurer or Blue Cross would make?

A. Generally?

Q. Yeah.

A. So, generally, obviously, we're very interested and concerned with the types of investments. Insurance companies, as you know, make their revenues either through underwriting or through investment returns, and both of them are equally important to the long-term sustainability of a company.

So, putting underwriting to the side, when we're talking about investments, we have obviously a great interest in that. We have statutes that talk about diversification and talk about the extent to which assets can be invested in certain asset classes as well, and then we have examinations that we do at the

department to determine whether investment policies that have been set by the company separate from that statutory regime that I mentioned are being adhered to as well.

But I will point out that what I just described applies to what are known as admitted assets. So those are assets to the company has at its disposal to liquidate and pay claims for for its members. What we don't have the same authority, statutorially or otherwise, over are nonadmitted assets that are the type of assets that would be in a pension trust. Those are governed by ERISA, which I think everyone knows is a federal regulatory regime and also a somewhat complicated regulatory regime.

But those would be considered nonadmitted assets that wouldn't be subject to our statutory requirements or necessarily to, you know, those types of investment policies that the reserve assets and the reserves that were invested would be subject to.

Q. Okay. So the, the investment that we've been discussing much of the afternoon is something that your department has no authority over?

A. Well, again, I think the, the assets are not subject to the statutes that we just referred to. Whether or not any decisions leading up to or whether

or not the assets themselves and how they were invested is a matter of our authority. I won't get into that. But it's not subject to the statutory regime that reserve requirements are subject to.

Q. Okay. So Blue Cross certainly didn't have to get your prior approval before making the investment that lost $40 million?

A. No.

Q. Okay. And did Blue Cross have any duty to disclose that investment to you at any time?

A. So, as a, as a primary regulator and certainly primary solvency regulator, certainly would anticipate an event of this magnitude being disclosed to us, and it was promptly disclosed to myself and to our team more broadly in late March.

Q. Okay. And, based on that disclosure, was there any action that you took?

A. Yeah. So, as I think it has been alluded to earlier, we have set up weekly standing financial calls with Blue Cross since the start of the pandemic. That is sort of, you know, our staff at the departments that are experts with the experts at Blue Cross Blue Shield talking to each other. So, not only did I, not only was I interested in learning more about the loss, but so were those experts, and they got information on an

ongoing basis from Blue Cross Blue Shield. It was certainly an evolving situation, I'll call it that, where information was learned over time, and we certainly wanted to be of assistance in any way that we could during that period, but, ultimately, we wanted to understand the full scope and extent of the loss and the decision making.

Ultimately, I think it's been alluded to in this hearing, we believe in sort of a posture of trust but verify, and, ultimately, at the end of the day, we decided to open up a targeted examination to look at this issue in greater depth. And I'll just point out that we had a regularly scheduled examination that was set to kick off at the end of the year in December 2020, January 2021. That's a five-year exam cycle, but we decided to move more quickly considering the scope of the issue.

Q. And, when you say exam, you mean a financial exam?

A. So it's a targeted exam looking specifically at the pension issue. It has a very broad range of questions and of interest, some of which are financial, some of which are more corporate governance related, but it is a, it is a broad exam that looks at the issue.

Q. Okay. And if the, as you said, the department

doesn't have, doesn't have authority to regulate those, the type of investment we're talking about, right? The investment that lost $40 million, the department does not -- that investment is not subject to the department's statutes?

A. That is correct. I mean, there's ERISA statutes, and there are a lot of case law, and there's a lot of ERISA policies that talk about investments and what type of investments are appropriate. I will say where we do have an interest in this, obviously, is to the extent to which, you know, a trust or a trust fund might have a negative impact on Blue Cross Blue Shield, because there are, there are requirements, financial requirements, that that trust has to make to pensioneers and to the extent to which Blue Cross Blue Shield has to contribute moneys to that pension.

So there is an interest for us and for all of us, but we don't have, you know, primary regulatory oversight over those, over how those investments are, you know, are invested and what the policies are around them.

Q. Does the department have any remedial authority in connection with the pension investment if it finds something in the course of its targeted examination that it's troubled by?

A. Yeah, I think we always have, you know, we have great authority both in the insurance arena, and, also, I'll just point out that we're also a securities regulator as well. So, if there is concern from that perspective, that's something that we have great interest in too.

Q. Okay. And so what would the department's remedial authority consist of?

A. You know, they have recommendations, directives, whether or not the current corporate governance structure is appropriate, whether it should be reconsidered, whether investment decisions should be made within the Blue Cross Blue Shield, you know, family or whether it is appropriate to continue to delegate those. I think those would be the types of issues and questions that we would be talking about here.

Where Blue Cross Blue Shield, as everybody knows, is not a for-profit company, it has no shareholders, it has no earnings, has no dividends, things of that nature, you know, there are certainly penalties, and things of that type are always available to any insurance company, but, in the case of, of one that is not a, is not motivated by profit and one that is funded by Vermonters, you know, that is not necessarily

a course that we go down very frequently, but all of those things are available to us.

Q. Just one or two more questions, Mr. Commissioner. Can you tell the board what this investment that experienced the $40 million loss was? Can you describe the investment?

A. Yeah. So I don't know what is necessarily public and what is private, but I will, I will, at a very broad level, describe what the strategy was, and anyone feel free to cut me off if I'm going into territory that I should not be going into, but I believe this is all public information.

So the investment is something known as a derivative base investment. So there are opportunities to leverage your investment. There are also opportunities to leverage it on the negative side so that you can limit the amount of losses that you might experience in a market downturn.

I think we all know that the market downturn in February and March of this year was significant and was volatile to a point that I think it's fair to say we've never seen before. We had, we had single-day highs and single-day lows repeatedly being met, you know, within a two- or three-week period. So all assets and all strategies were under significant pressure, and some

did not perform as well as others, obviously.
Q. So is it fair to say that the value of this investment depended to a large extent on the volatility of the stock market?
A. So, just to be clear, the volatility was something that was anticipated to be avoided, due to the strategy. I think it's safe to say that that volatility should not have impacted the assets to the an extent that one would expect. It was, it was an attempt to protect from downside risk.
Q. And does the department have any regulations or bulletins or informal practices that would limit the percentage of Blue Cross's surplus that could be in any one particular investment?
A. Yeah, of course. So what we just talked about were those, that statutory regime that exists, right? So but I want to make one point clear, that the assets and reserves that Blue Cross Blue Shield has, those are within the corporate entity of Blue Cross Blue Shield. These pension assets are under the pension trust, and they're separate. So they're not part of Blue Cross Blue Shield's reserves or surplus. They're separate and outside of that reserve calculation.
I talked earlier about how reserves had gone up about $23 million. I think they stand at something

like $130 million at the end of the year. Those, that is not impacted by what we're talking about now. The loss is outside of that statutory surplus or reserve number. So, as it relates to that number, though, we certainly have limitations as to the type of assets and how, the type of assets and how much of those assets can be invested in based on the quality of the asset.

Q. Okay. If the pension assets are outside of the surplus calculation, why does the loss of $40 million reduce RBC by 180 points?

A. Because it's still a loss to the corporate, to the global sort of structure of Blue Cross Blue Shield but not part of their reserves that are set aside to pay rateholder, you know, medical needs.

MR. ANGOFF: Okay. Thank you, Mr. Commissioner. I have no further questions.

MR. BARBER: Good. Maureen?

MS. USIFER: Thanks. Hi, Mike.

MR. PIECIAK: Hi.

MS. USIFER: Just a couple questions. When, when we look at the schedule, Exhibit 12, Page 37, which is kind of pro forma-ing where the RBC could potentially go, and the question I have is, If the pension valuation was taken out of these numbers -- right now in May, they're at 695. That doesn't include

the pension. And at year end prior to Covid, we would have been about 733, potentially, so finally in kind of the higher end of the range, you know, where it would have been out of being near the bottom.

But, I guess, at what point would you intervene to talk about giving back some? You know, certainly, 733 isn't over the range yet, but when would you have come in and potentially said, you know, We don't need to be this high?

MR. PIECIAK: Yeah. So good question, and I'll answer it in two different ways. One, if they were over, if they were over, Blue Cross Blue Shield was over its upper level threshold and we were about to engage in a 2022 rate process, you know, we might have an opinion in our solvency review that is different than we have in the past where we say, you know, based on, based on the current solvency and based on, you know, the need, you know, there is, there is potential to lower the rate or to have the rate not be as high as being requested, even though it might be actuarially justified, because they're outside of the range. So that would certainly be one possibility.

The other that I think is something that, that is something that we, that that we need to consider is, when you look at other lines of insurance, whether it's

auto or homeowners or worker's comp or commercial, you know, there's some degree of reduction that's happened across board. People are driving less. People are not in their workplaces, even if they're working. You know, whatever the impact might be that people have to pay for premium under a certain risk calculation, that risk calculation changed dramatically during 2020 and due to the, due to the pandemic.

So, if 2020 is over and it is clear at some point in 2021 that, you know, as we put in our solvency opinion, colloquially, Did Vermonters overpay in 2020 for their health insurance? If that question can be answered definitively, which I don't think it probably can until, you know, April or May of next year, in all honesty, when we have a sense of what does 2020 look like and then what does the rest of 2021 look like as well, you know, what's the extent of deferred care, then there's an opportunity to talk about, you know, potentially, you know, premium refunds or premium credits like we have with other types of insurance companies during the pandemic.

We've had about $25 million of premium credits or refunds provided to Vermonters during the pandemic to date from, you know, from dental insurance to auto insurance to all of those things, but I'll just point

out that those are, those are types of insurance where you know the event isn't going occur in the future. We know there's not deferred automobile accidents, for example. Those either have happened, or they're not going to happen. But with health care it's a little bit different. So you need a little bit more time to see how things play out before there's certainty as to, you know, was the pricing right, or was it significantly off to a point where, you know, premium credits should be considered?

So I think, either in the rate process or even in that premium credit discussion, I think both of those are appropriate. Whether or not they, Blue Cross Blue Shield, hits the top of the range or whether or not they're within their range in credits, for example, should be something that's considered as well.

MS. USIFER: And I agree with you that, you know, eventually, this will catch up. I mean, we can all debate should we give Covid money back now, or should we wait, but I guess a concern would be that let's say it does generate favorability and we see that as we get into '21 and beyond, but if this 180 sticks on, from the pension, you know, it's going to pull them down to the lower range, and, and, you know, they benefited, basically, because we got back all the AMT

tax credits and we got accelerated -- you know, all these things happened that we knew would improve their RBC.

It seems like there might be a dilemma then, if, if the Covid piece generates -- I'm going to make up a number -- you know, 50 to 100 basis points and the RBC gets hit by 180 because of the pension plan, and then they're kind of in the lower end of that range, and, you know, I know it's hypothetical, but where do you think you're going to come out at that point? If we know Covid clearly should have been given back, there was a benefit that should have been given back to the ratepayers, yet now the RBC is, you know, depressed by what currently, you know, would be almost a third of the RBC gone because of the pension issue.

MR. PIECIAK: So I think it's fair to -- so I would consider that like a, potentially, a worst-case outcome in terms of the pension matter, right? So and that's a fair to consider that. It's fair to consider that. And I think, at the end of the day, the solvency component, the solvency piece is that, if, if they are, if they, the company, sort of are at the lower end of their range, for the good of the members, you know, you want them to have, you want them to have that buffer and that amount of financial capacity in the event, you

know, something else uncertain happens in 2021 or 2022.

But I will say that, you know, I don't know how likely that outcome is. First, you know, first of all, as I mentioned regarding the pension asset, so, once the, once the assets were liquidated and turned into cash, they were reinvested into a down market where the market was coming back up. So just even that factor, you know, how does the market end the rest of the year will have potentially an impact of lowering that loss.

And then to what degree is litigation successful in returning anything to, to the, to the trust fund, you know, the pension fund? You know, I think we'll have to wait and see on that, obviously, but, you know, that's another possibility of money coming back in to, to fill the gap. So I guess I just want to, you know, sort of a long-term vision that you have to have on this issue right now, I think, because of the uncertainty with the virus and then the uncertainty with issues like this pension issue as well.

MS. USIFER: Right. And, I mean, you know, one thing we do know, though, is, if you have an investment and it goes down 50 percent, in order to get back to the same place, you have to go up 100.

MR. PIECIAK: Right.

MS. USIFER: So I agree the market's going

up, but, you know, we're going up on a lower base.

MR. PIECIAK: Yeah, exactly right. You couldn't have said it better. And it will be mitigated, but it won't be, you know, won't be --

MS. USIFER: Yeah, okay. Thank you. That's all I have.

MR. BARBER: All right. Member Lunge?

MS. LUNGE: I'm actually fine. I don't have any questions. Thanks.

MR. BARBER: Member Pelham?

MR. PELHAM: My only sense, question would be is, What's your sense about when both of these, Covid and pension, will be coming in for a landing?

MR. PIECIAK: Yeah. So with, with Covid, you know, I think it's, it's fair -- you know, at the end of the day, what's going to change everything is, is a widely available vaccine. I think everyone is aware that, that we're probably not going to get to what's known as herd immunity just by, you know, rolling, racking up infections among people in the United States or worldwide or in Vermont. The disease prevalence among the population is so low. You know, maybe in Vermont there's a study that came out that said maybe 2 percent of Vermonters had the virus and you'd need closer to 60 or 70 percent to get herd immunity. So I

think most people think that's not realistic, and it's also unknown how long that immunity will last from contracting the virus, which gives people real pause for that, from that perspective.

So it's really comes down to the vaccine, and, until the vaccine's available, I think we're going to be living with Covid. So that means this fall we'll be living with Covid. Likely, in the winter we will be as well, and sometime in the spring things will likely change, knock on wood, if the vaccine development continues as it is, but there's a, there's optimism that in late 2020 and early 2021, there will be a vaccine that's approved, but then the question is, How do you distribute it, and how do you scale it up so that there's enough available for everyone in the United States to get the amounts that they need, and that's a process that will take some time.

So even if, in early 2021, we have the vaccine, let's build in another six months until it's widely distributed, and that's just one, you know, that's just one possible path forward. You know, something could happen more quickly. Something could happen longer. But I think that's the viewpoint is we'll be dealing with it into 2021 is a reasonable estimate.

In terms of the pension issue, same timeline

almost to some degree. I mean, we'll have a sense by the end of that year sometime in March what the investment returns were for the year, and then, but then the other question of the legal issue is, you know, pandemic might be more certain than a legal process, which has a great deal of uncertainty over legal recourse. I'll put it that way.

MR. PELHAM: Thank you.

MR. BARBER: Okay. Board Member Holmes?

MS. HOLMES: Okay. Thank you, Commissioner. A couple questions for you. What are the legal limitations on how CTR may be used? Is there some percentage or dollar value that must be retained for unexpected medical losses? Or, you know, what kind of guidelines are there around CTR usage?

MR. PIECIAK: For the contribution to reserves?

MS. HOLMES: Yeah. Sorry.

MR. PIECIAK: You mean the amount that's asked for?

MS. HOLMES: No. I mean in terms of how you regulate it. So, you know, we've heard about asset allocations, and, you know, say, for example, Blue Cross Blue Shield wanted to build a new building, right, new build a new office building, and they wanted

to draw down from reserves to do that. Is that something that you would be regulating on your end, the usage of reserves for nonmedical expenses, and are there limitations on that, and is there a minimum amount that you want to keep in there for unexpected medical losses? How does that work?

MR. PIECIAK: Oh, I see. Yeah. So the contribution to reserve is just something built in every year that is like an --

MS. HOLMES: Sorry. I mean, sorry, the total reserve, sorry.

MR. PIECIAK: Yeah, the total reserve. so That's something where we obviously want to have a close eye on. So if you, regardless of it was medical or nonmedical related, because it's depleting the amount of reserves that's available to cover, you know, medical claims. So, if it, if it's an investment, Blue Cross has made a few investments in the last year that they think will either benefit their members from an ultimate, you know, cost perspective to make prescription drugs less expensive, for example, or it will benefit the company because it's moving into a new line of insurance like Medicare Advantage. So there are opportunities to make those investments, and, when they're wise and prudent, you know, those are things

that we will support.

When it's, you know, if it's something that is less likely to result in some benefit or savings to members, it's probably something to look at more skeptically. But, but, yeah, we're obviously very interested in how the reserves are used and spent and even invested, obviously, as well.

MS. HOLMES: Okay. Sorry. It's a little bit late. It's like, what, an eight-hour Zoom call? So I apologize for the use of CTR versus reserves, but I meant reserves, but you answered the question. Thank you.

So, you know, you talked a little bit about insurance rebates and the different types of insurance, you know, auto insurance being different than health insurance, and I'm wondering if you can just talk a little bit about why dental is different than medical knowing, you know, DFR approved premium, you know, relief for dental insurance.

MR. PIECIAK: Yeah, for sure, happy to. So dental emergencies were still available during the pandemic, you know, if you had a dental emergency. But I think the great, great, the great percentage of usage is more towards someone's annual cleaning and sort of those routine procedures that were suspended. So, in

all likelihood, someone has missed, you know, during that window, their routine procedure, they're not going to be able to get back into the dentist's office until their next, you know, six-month or year checkup.

So there is a little bit more certainty in the dental space than in health insurance where, you know, we could get -- you know, you could always have a dental emergency. I don't mean to suggest you can't. But I think there is, there is a greater likelihood that you'll need medical care, you know, either on an emergency basis or just on a more routine basis more frequently, and that's harder to predict than in the dental area.

MS. HOLMES: Do you know what percentage of, of dental claims are routine versus emergent?

MR. PIECIAK: I don't off the top of my head, but I do know, I do think there's a significant amount that, that fall into that sort of preventive routine bucket.

MS. HOLMES: Okay. And my last question revolves around Ms. Greene testified a little bit earlier this afternoon that the March bulletin that you, DFR, put out, as a result of that bulletin, Blue Cross Blue Shield felt the need to suspend their cost-containment and their fraud, waste and abuse

programs in order not to burden providers during the pandemic.

And so I am wondering, from your perspective, whether, with Covid cases now, you know, in the single digits and utilization, we're hearing, up over 100 percent in many instances, whether there's any plan from DFR's perspective to update the bulletin to allow carriers to reinstate cost-containment, fraud, waste and abuse programs.

Just to put it into perspective, the fraud, waste and abuse program, it looks like to me from the testimony we've seen, and, actually, it's on Exhibit 6, Page 59, the suspension of that program alone as a result of that bulletin is, will increase claims about $4 million above projections and has a 20 basis point impact on RBC, and it sounds like from testimony from Mr. Schultz that it also has a -- you know, if they were able to reinstate, go back to the full fraud, waste and abuse programs, there might be a reduction in premium of about half a percent.

So this bulletin actually is having a significant impact, you know, potentially on premiums and on RBC. So I'm wondering if there, you know, what your future outlook is for allowing insurance companies to regain, you know, redo that, those programs.

MR. PIECIAK: Yeah, for sure, it's a great question. And I haven't reviewed that bulletin since March, so excuse me if I have this not exactly correct, but I do believe that there was a distinction between routine audits and those audits that were designed to, that there's a sort of an emergent fraudulent issue that's happening or some sort of waste and abuse that's currently ongoing that there is an attempt to get to the bottom of, but I imagine that many of the routine audits are what ends up turning up fraud, waste and abuse as well. So I just want to make that distinction.

But, absolutely, 100 percent, you're right. I mean, we, we will reconsider that. We did it in March to alleviate the pressure on providers who were transitioning to telemedicine who, you know, we didn't want to have them be interrupted in treating Covid-related items, but, as you all, as everybody knows, now we are in a very different position, and the extent to which all of those providers were called on to treat Covid patients was different. Some had a very different experience than others in terms of their workload and capacity.

So I think that 100 percent is something that we will consider, and we'll do it in the short term.

MS. HOLMES: Very short term, like in the next couple of weeks as we're deciding rates?

MR. PIECIAK: Our short term is days, not weeks.

MS. HOLMES: Great. Thank you so much.

MR. BARBER: Mr. Chair?

CHAIRMAN MULLIN: Thank you. Good afternoon, Commissioner Pieciak.

MR. PIECIAK: Chair Mullin, how are you?

CHAIRMAN MULLIN: Hanging in there. It's been a long day. Plan fiduciaries include plan trustees, plan administrators, and members of a plan's investment committee. You're a specialist in financial law. Under this scenario that has been laid out before us, it seems like everything has been delegated to this National Retirement Trust. Under this scenario, who do you think those three entities are that have the fiduciary responsibility?

MR. PIECIAK: Yeah, so there isn't -- well, I just want to preface this by saying you know we have a targeted exam underway. We're trying to get to some exact -- we're trying to get 100 percent confidence and certainty ourselves. So I don't want to go too much into the details but I will say this:

You know, there is an investment advisor that's,

that's as part of this entity. Investment advisors generally owe fiduciary duties to their clients. So that would be likely the trust, depending on the exact relationship, and the trust obviously owns, owes a fiduciary duty to the members of the trust as well. So those are the two entities that strike me as owing fiduciary duty, that investment advisor and the trust itself.

CHAIRMAN MULLIN: If, if you or your staff at DFR received a phone call from a 60-year-old Vermonter at Blue Cross Blue Shield who has concerns about what has happened with their pension, it doesn't even have to be this set of facts. It could be a totally different set of facts where they believe that there was some interchange of funds between a related organization or something. Who do you refer that caller to, since you're not the enforcer?

MR. PIECIAK: Yeah. So we often get calls just like that, in all honesty. People have questions about their 401(k) or potentially a pension fund as well, and we usually send them to Vermont DOL, and Vermont DOL has better contacts with the national, the federal DOL. But, ultimately, it's the federal DOL that's the regulator of ERISA plans.

CHAIRMAN MULLIN: So it's labor that would

have that responsibility, and would they just have criminal enforcement, or is there also possible civil enforcement?

MR. PIECIAK: My understanding is that ERISA would be enforced from the federal DOL from a civil standpoint. If there was a criminal matter, it would be referred to the justice department, I believe. So I think federal DOL has civil enforcement authority.

CHAIRMAN MULLIN: Okay. And so, clearly, ERISA rules for fiduciary conduct say that all fiduciaries may be personally liable to restore any losses to the plan and that courts may take whatever action is appropriate against fiduciaries who break their duties under ERISA, including their removal.

Given that, is there a strong basis for a recovery from some of these entities that you have discussed that you believe would be possibly the trustees or administrators?

MR. PIECIAK: So I was waiting for someone to cut me off to answer that question, but I don't hear anybody doing it. So I'll just, at the high level, just say that there are a number of people in that chain that, you know, have some, have some explaining to do, including the ultimate product as well, not just the fiduciaries, but the ultimate product which, which

did not perform as, you know, expected. So, you know, how -- I don't want to, I don't want to get into the range of success, but, you know, there is a, there is a, there is a reason for the process, I'll just put it that way, if that makes sense.

CHAIRMAN MULLIN: Okay. Going back to March and the weekly meetings that you talked about between DFR and Blue Cross Blue Shield, was there ever any discussion about whether or not the Green Mountain Care Board should be alerted?

MR. PIECIAK: So I can't speak to the weekly meetings, because they were -- I don't -- that's with our expert staff and Blue Cross Blue Shield's expert staff, but I did have a conversation with, with Don George initially about this, and we didn't, we just, we didn't discuss that.

CHAIRMAN MULLIN: Okay. There has been a lot of hyperbole in the media about whether or not Vermonters are entitled to a decrease rather than a rate increase, and I'm curious. If the Green Mountain Care Board said, You're not getting any increase, wouldn't that be in violation of promoting insurer solvency under our duties under the statute?

MR. PIECIAK: Yeah. So, as you know, Chair Mullin, that you have the unenviable task of balancing

those two, you know, somewhat irreconcilable, you know, goals, affordability and insurer solvency. And, you know, certainly, we laid out in our solvency opinion the impact that various rate cuts would have to insurer solvency. So I think those obviously need to be greatly considered and done so with great caution.

You know, as we've said in the past, we think a, an unjustified, so a nonactuarially justified deviation from the rate, you know, would be, would have an impact on insurer solvency in the long term, and we still have that opinion. So, so I think that's, that's something you have to balance, but, you know, affordability is one of the criteria that the board has to consider, and we certainly acknowledge that.

CHAIRMAN MULLIN: So this will probably be a topic for another day, but, just to make sure that you know, that a high-ranking member of the same administration that you're a member of has repeatedly said to the media that they believe that there shouldn't be a rate increase as well. So I just wish that everybody would talk with each other. It's a wish. You don't have to answer anything there.

MR. PIECIAK: Well, the only item I'll point out there is we do have, at the department, we do have a statutory responsibility that's certainly different

from our potential, potentially our own personal beliefs or personal beliefs of others within the administration, but we have to execute on that sort of statutory responsibility that we have.

CHAIRMAN MULLIN: If you were a member of the Green Mountain Care Board and you had the statutory requirement of making sure that it promotes insurer solvency, was there anything in the questions that we asked Blue Cross Blue Shield that you think crossed the line?

MR. PIECIAK: I didn't hear, I didn't participate in the full day's hearing, but, from what I heard, I did not hear anything that crossed the line.

CHAIRMAN MULLIN: No. I, I'm referring specifically to the questions that I know you were copied on and we had a conversation about.

MR. PIECIAK: Oh, I see what you're saying. Sorry. I got it. I understand. Sorry. You know, I'll put it this way. You know, when we do our examination, it's done, it's done in a confidential process, it's not in a public process. So that's one, that's definitely one -- that's one, that's basically the only difference I would see between -- I wouldn't see your inquiries and the things that we're interested as differing substantively. I would only view them

different procedurally that this is a confidential process that we have the luxury of understanding and doing our due diligence, and then it results in something that we can or cannot make public, where this is just a public process that's difficult to have that kind of, you know, deep due diligence in this environment.

CHAIRMAN MULLIN: Well, I think there are capabilities to go into executive sessions and for requests for confidentiality that would have to go through our counsel, but I think that we, too, could have kept something confidential, but, instead, we were just denied the information, but that's a whole 'nother issue. I don't have any other questions. Thank you, Mr. Commissioner.

MR. PIECIAK: Yeah, of course.

MR. BARBER: Okay. I think we'll move on to Mr. Garland. Thank you, Commissioner.

MR. PIECIAK: Yes. Thank you very much.

MR. BARBER: So, Bridget or Mike, have you given any more thought to just going straight to executive session to talk about confidential marries? You're on mute. Bridget, you're on mute.

MS. ASAY: I hope that wasn't me. Having that same mute problem. Okay. I would -- yes, we're

fine going straight to executive session. I was just going to point you and the board to Page 6 of Exhibit 14 in which we laid the foundation for going to executive session. If that's sufficient for the board to take that action, then we can move directly there. If you want me to elicit that testimony on the record, I will.

MR. BARBER: Remind we what page it's on.

MS. ASAY: It's Page 6 of Exhibit 14, the last question.

MR. BARBER: So board members --

MS. LUNGE: Do you need a motion?

MR. BARBER: Yeah, but I think we should talk about the bases first, because I think there are two distinct bases. One relates to what is in Exhibit 14, Page 6, which speaks to kind of the -- so let me back up. So there's, under the Open Meetings Act, the board can go into executive session to consider contracts but only after making a finding that premature public knowledge would place a person at a substantial disadvantage.

There is also an exception to the Open Meetings Act, or not exception, sorry, provision that allows you to go into executive session to discuss confidential documents, and I believe some of you may have questions

regarding exhibits or materials within exhibits that have been determined to be confidential and that we have a duty to protect confidentiality of under our rule.

So, so I think that those two separate bases are important, because you would need to find, if you wanted to talk about contract negotiations but not specific to a confidential document in the binder, that there, that premature public knowledge would place Blue Cross at a substantial disadvantage, and that's what this prefiled testimony speaks to, I believe, and we need to be clear about the bases. You need to be clear about the bases for going into executive session.

So, with that said, would anyone like to move to find that public knowledge of the details of Blue Cross's provider contract negotiations would place Blue Cross at a substantial disadvantage?

MS. LUNGE: I would like to move that.

MS. HOLMES: I'll second it.

MR. BARBER: Any discussion -- oh, sorry. I'm not, not as up on the procedural process. Any discussion? Okay. Would all those in favor, please significant by saying "aye"? Any opposed?

(No response.)

Okay. And then I think the next step would be

would anyone like to make a motion to go into executive session to take testimony about the details of contract negotiations between Blue Cross Blue Shield and health care providers and about confidential materials in the exhibits?

MS. LUNGE: Yes, I would like to move that we go into executive session on those bases.

MR. BARBER: Is there a second?

MS. USIFER: I'll second.

MR. BARBER: Any discussion? Okay. All those in favor, please signify by saying "aye". Any opposed?

(No response.)

MS. ASAY: Mr. Barber, if I might interject, and maybe you were going there. Do you need to swear the Witness in on the record?

MR. BARBER: I don't know the answer to that, but we should probably do it anyway just in case.

MS. ASAY: Mr. Garland, it looks like Mr. Garland is unmuted.

MR. BARBER: Let me find Mr. Garland so I can pin him and see.

MS. ASAY: I don't think he has his video on.

CHAIRMAN MULLIN: He does.

MS. ASAY: Oh, he does? Okay. I can't pin

him. But --

MR. BARBER: We might have too many people pinned. I had to take some off.

CHAIRMAN MULLIN: You have to unpin people too pin new ones.

A N D R E W G A R L A N D,

duly sworn to tell the truth, testifies as follows:

MR. BARBER: Okay. So there's a couple matters we need to wrap up before we go into executive session. The first is who needs to be in the executive session. I think, obviously, the board members, the board's rate review staff, the HCA's attorneys, the carrier's attorneys, obviously, the Witness, and the court reporter. Is there any anyone else who is necessary to this executive session?

MS. ASAY: I think Blue Cross would like to have some of its staff in the executive session, Mike. Is that what you were going to address?

MR. DONOFRIO: Exactly.

MR. BARBER: Okay. Sunnie, is it possible to have this section of the hearing transcribed separately?

THE REPORTER: Yes. I need a minute to open a new file, but, certainly, I can come.

MR. BARBER: I think we owe the people who

are not going to be able to come an estimate of how long we will be. I'm just looking at a text. Any estimates? Board members, lots of questions? A few questions? General sense? Tom?

MS. HOLMES: Two or three questions, probably.

MR. PELHAM: That's where I am, two or three questions.

MS. LUNGE: I think I have four questions. Some of them may overlap with Jess's, though. So that may just -- I'm guessing we might have a mind meld going on.

MS. USIFER: By the time those guys are done, I probably won't have any questions. Put them first.

MR. BARBER: Jay?

MR. ANGOFF: No questions.

MR. BARBER: All right. So --

MR. ANGOFF: The two best words in the English language.

MR. BARBER: Yeah. So I'm going to, I'm going to think 5:40 would probably be about right, maybe a little before then? I know it's --

MS. USIFER: Let's try for 5:30.

MR. BARBER: Definitely a good thing to try for. Christina, can you -- we talked about making a

slide to share to just let folks know, if they join, although it's kind of late to be joining, that we're in executive session?

MS. MCLAUGHLIN: Yes.

MR. BARBER: Okay. Is there anything else we need to cover before we jump on the other line that we have for this purpose?

CHAIRMAN MULLIN: Just make sure you exit this line so nobody's overhearing.

MR. BARBER: Christina, you can keep this, obviously, this line going?

MS. MCLAUGHLIN: Yes, this will be going and recording.

MR. BARBER: Okay. Anything else to --

MS. ASAY: Nothing from Blue Cross.

MR. BARBER: All right. Then why don't we all hang up? Again, just only people going to executive session. Blue Cross get it. Everyone's going.

(An executive session was held. The testimony continues in a confidential transcript.)

MR. BARBER: All right. So we're back on

record in the open session. The board has voted to come out of executive session, and Board Member Lunge has, I believe, two questions that relate to nonconfidential materials.

MS. LUNGE: Thank you. Mr. Garland, could you give us an update on how the fixed prospective payment program is going in your ACO program?

MR. GARLAND: Yeah. It was going very well, a little slower than we would have liked, but we launched the program in April of this past year. Only one hospital was able to sign up in April. We have a few others that are very interested in participating, but they've been dealing with some internal IT challenges that have taken them a little bit longer to resolve than they were hoping for, and they want to be stable on their new platforms before they take the leap.

I did ask our contracting provider folks for an update on the one hospital that's participating, because I had a feeling you were going to ask, and it's been a little over a month or two months, I guess. So the feedback is so far, so good. They seem to be happy. So it's a great step forward.

MS. LUNGE: Great. And I'm glad you have more interest. My other question was, In previous

testimony we heard about utilization assumptions resulting from some understanding that hospitals were doing procedures on weekends or after hours, and I haven't been able to get an answer on the source of that information specifically. Which hospitals have you talked to about, you know, the specifics?

MR. GARLAND: Can I make that a follow-up?

MS. LUNGE: Yeah.

MR. GARLAND: We can put together a document, and we'll send that over to you. I don't have all that detail off the top of my head. I apologize.

MS. LUNGE: Yeah, that's totally fine. And I'm sorry, Mike. I had one more which was, In terms of the delay of the cost-containment programs that resulted from Covid, can you speak to when you would anticipate resuming those programs, and, if not soon, what the rationale for that is?

MR. GARLAND: Yeah. So what we're really talking about there is, is new cost-containment programs. I know Dr. McIntosh mentioned a few sort of small programs that got sidetracked during Covid, but we're largely talking about new programming, and the reason for it being sidetracked, frankly, is it takes a lot of attention on the, the plan side and the provider side to make one of these initiatives work and to make

it effective. So, I mean, the reality is the providers just didn't have the capacity to focus on this with us over the last few months. I would say that, as soon as they do have the capacity, we'll begin working on those things again.

MS. LUNGE: Okay. I was specifically referring to two programs that were included in the 2019 rates that, in the actuarial memorandum, indicated that they had been discontinued for the time being due to Covid, but, if it would be helpful to follow up on that, that's totally fine as well.

MR. GARLAND: Yeah, I think it would, and then we can provide a detailed written answer.

MS. LUNGE: Thank you.

MR. BARBER: Okay. Are we ready to move to Dave Dillon's testimony, Jay and Bridget?

MS. ASAY: I have nothing further. Thanks.

MR. ANGOFF: Yes, I'm read for Dave Dillon's testimony.

MR. BARBER: I think Mr. Dillon had to leave. No, I see him on the computer still, but he might be on his phone and not have the binders available. Dave, what is your --

MR. DILLON: Yeah, so I got kicked out of where I was, and now I'm piggybacking off of Starbucks

Wi-Fi. So I will be good as long as my Starbucks Wi-Fi holds on. So we are free to proceed. If I get a bad connection, please let me know, and I'll discontinue the video and just do audio.

MR. BARBER: Thanks for hanging in there.

D A V I D D I L L O N,

duly sworn to tell the truth, testifies as follows.

DIRECT EXAMINATION BY MS. ABORJAILY

Q. Hi, Dave.

A. Hello.

Q. Do you have the binders with you still?

A. I do. It may take me a second, but they are with me.

Q. Okay, great. Could you please state your full name for the record and tell us your employer?

A. Yes. I'm Dave Dillon. I'm Senior Vice President and Principal with Lewis & Ellis.

Q. And could you please turn to Exhibit 16?

(Exhibit 16 was shown to the Witness.)

A. Okay. I am there.

Q. And do you recognize this document?

A. I do. It is my prefiled testimony.

Q. And could you briefly describe the information that's in Exhibit 16?

A. Yes. So it basically goes through and discusses

the process that L&E goes through in terms of, you know, the assumptions we review, the process we have in place, and our communication mechanisms with Blue Cross.

Q. Okay. And is the information in this document accurate and correct to the best of your knowledge?

A. It is.

Q. And is there anything in this document that you would like to change or clarify at this time?

A. No, there is not.

Q. And do you wish to adopt this prefiled testimony as your testimony here today?

A. I do.

Q. Thank you. So I know you covered this briefly in the prefiled testimony, but just a few sentences, if you could explain your role in reviewing this filing.

A. Yeah, sure. So process we have in place is we have three credentialed actuaries assigned to each review. Kevin Ruggeberg was the primary reviewer. I am what we call the kind of primary peer reviewer, and then Ms. Jacqueline Lee is the secondary peer reviewer. So in my role I review the filing. Then I coordinate with Kevin to, you know, to coordinate with him on what he's seeing with the filing, do I agree, and then we'll discuss the questions that are submitted to Blue Cross,

and then, once we get those answers, we will assess that and determine if further questions are necessary, and/or then we'll make our recommendation that you'll see in the report based on that correspondence between Kevin, myself, and Ms. Lee.

Q. And the memo that you mentioned, is that Exhibit 9 of this hearing binder?

A. It is.

Q. Could you turn to that, please?

(Exhibit 9 was shown to the Witness.)

A. Okay.

Q. It's Page 3, specifically.

A. Okay. I am there.

Q. Okay. You see there's a standard of review at the top of the page? Is that L&E's standard of review, or is that the board's standard of review?

A. That is the board's standard of review. Our, while we do everything we can to assist the board, we do primarily focus on just a subset of that review. That is the, you know, excessive, inadequacy, and unfairly discriminatory pieces of that have standard.

Q. Okay. So, when we hear testimony about affordability, did L&E review this filing for affordability?

A. We did not.

Q. Okay. So, moving to recommendations, which I believe are on Page 23 of that exhibit --
A. Okay.
Q. -- what are the recommendations that L&E made with regard to this filing?
A. Sure. We made six recommendations. I would say a couple of them are kind of corrections of some minor errors. There was a weighted average trend correction. As we went through the filing, there was a slight miscalculation. So we recommended fixing that. The URRT, which is the federal, federally required document, there was a minor error there. That is, we recommended an update to that. That does not affect the rates.

We, we talk about the, the hospital budget information, which has been talked about quite a bit today, but, because that is unknown, we're basically recommending that, when it is known, that needs to be implemented. If it's an up, down, or sideways, it needs to be implemented once that hospital budget review is complete.

We talk about updated risk adjustment. That is a process, you know, where the company does not have full information about the marketplace. We made an estimate. We actually got CMS's information this

Friday. So we have that final information as well. So we recommend using that.

We made, we also make a recommendation against, about credit card fees. There was a minor discrepancy there that we recommend needs to get cleaned up a little bit. And then utilization trend, Mr. Schultz mentioned that earlier today, that we had a slight disagreement on a couple of the assumptions regarding the utilization trend. So we made that recommendation, and Blue Cross has agreed to make that change at this point.

Q. So, if all of these recommendations are implemented, then could you explain what the ultimate projected rate increase would be?

A. Yeah. So it would go from 6.3 percent to 5.5 percent, and, at that point, so our recommendation in our report states that we believe that that rate increase would not be excessive. We believe it would be adequate, and we believe it would be, it would not be unfairly discriminatory.

Q. Turning to some of the testimony today, were you able to listen to all of that testimony?

A. I had a few minor connectivity issues, but I think I got the bulk of it, yes.

Q. Okay. In your, you stated in your prefiled

testimony that you review several ACA filings a year. So, given the, a lot of the testimony today about the COVID-19 impacts, could you give us a brief summary of what other carriers are assuming regarding the impact of COVID-19?

A. Sure. So, to date, I have reviewed and my team has reviewed about 50 filings, and that's a combination of individual and small group. So a little bit of differences there, but, essentially, we're seeing a range of Covid impacts between zero percent impact to about 3 to 4 percent is the normal range that we are seeing.

As you guys are well aware, that, you know, I'd be hesitant to extrapolate that answer to Vermont, because Vermont is very distinct, but it does help to give some context to see what others are saying, and we're seeing zero to 4 percent. We have seen a few others slightly higher than that. We've seen as upwards of 8 percent for Covid. However, that seems to be limited to one parent company and their affiliates in multiple states.

Q. And what did you say in your memo specifically about Blue Cross's assumption regarding the COVID-19 impact?

A. So we reviewed the additional, the original documentation, we only had a few days to review, but we

did state in the report that we believe that their modeling approach to assess their wide range of scenarios was reasonable and appropriate. We did feel that all of the issues that should have been addressed were included in the modeling. So we did believe that it was a reasonable approach.

Q. And, since issuing the report, have you reviewed the information Blue Cross submitted both right before your report was issued and then also the newer modeling they submitted last week?

A. Yes, we have reviewed, you know, and, essentially, that was an update to their modeling based on June claims data being added. We've reviewed that, and we believe that their model and their testing is still reasonable and appropriate.

Q. Okay. So, having reviewed the supplemental material and listened to testimony today, is there anything that you would wish to change or add to your recommendation around CTR?

A. No, I do not. We believe, as we said, you know, the CTR was reasonable. We provided some metrics. Those have been discussed today. I do think, you know, uncertainty is something that actuaries would tend to increase a CTR for, and we're obviously living in a, in a very high, high uncertain environment right now. So

I do think there could be some downward pressure on that, but I do still believe it is reasonable based on Blue Cross's historical results of projecting the impact that, if they believe that the 1.5 is still appropriate, we still believe it is reasonable.

Q. Thank you. And, just to cover everything you've heard today, is there anything else that you heard or have read since your report was issued that would make you want to change anything with regard to your other recommendations?

A. No, there is not.

MS. ABORJAILY: Thank you. That's all I have.

MR. DILLON: Thank you.

MR. BARBER: All right. Ms. Asay or Mr. Donofrio, do you have questions for Mr. Dillon?

MR. DONOFRIO: No questions at this time. I'd just like to reserve the right to ask perhaps a couple of clarifying questions based on any further testimony. Thanks.

MR. BARBER: Okay, Mr. Angoff?

MR. ANGOFF: Yes, just a few.

CROSS-EXAMINATION BY MR. ANGOFF

Q. Mr. Dillon, can you turn to Exhibit 9, please?
A. Okay. I am there. What page?
Q. The first page.
A. Okay.
Q. And on that page you see that little table at the bottom, right?
A. Yes.
Q. Okay. And it shows Blue Cross's members dropping from 70,000 in 2017 to 39,000 in 2020, right?
A. Correct.
Q. To what do you attribute that?
A. So there's obviously lot of factors there. I, I believe the major consideration as we review the both filings is that Blue Cross, when we started this process a few years ago, they had a sicker population than MVP, and, over the last couple years, that has, that trend has continued. So and they also have more platinum members, which is also somewhat indicative of the health status of their population. So that tends to increase rates, and, while risk adjustment does compensate for some of that, it doesn't compensate for every condition, and so I think that is the primary reason for that reduction.
Q. Did you ever consider the possibility that, if their rates were lower, they wouldn't have lost so much

business?
A. So, while that is a theory out there, in my years of an actuary, I've never seen an, if we build it, they will come type approach work. Usually, if you race to the bottom, you usually end up at the bottom.
Q. Is the current trend, though, sustainable? Can Blue Cross continue to lose this much business, one-seventh of its business for the last three years?
A. So, while I have not done a formal enrollment projection myself over the next few years, I do anticipate that the two market players could end up in somewhat of a stasis in terms of MVP having somewhat healthier population, and we've gone through the growing pains of the transition, and Blue Cross could end up in a fairly steady state situation similar to the way it is now.
Q. And by stasis you mean they'd each have half the market?
A. No, I don't necessarily mean stasis in terms of a percentage. It could be the same percentage now, or it could be some other percentage, but I don't think it's -- you know, we're definitely not on a path where Blue Cross is going to zero and MVP is a hundred. I think we're got to hit a point where the sicker population will stay with their providers under the Blue Cross

plan and the healthier people, you know, could end up and stay with MVP.

Q. Could you turn, please, to Page 16 of Exhibit 9?

A. Okay.

Q. Okay. You there?

A. I am.

Q. Okay. And you see at the very bottom, the last paragraph, you see it says that you did an informal review of Blue Cross's Covid projections; you see that?

A. Yes.

Q. What did that informal review consist of?

A. So the informal review was primarily informed based on my experience with the SOA model that the Society of Actuaries has put out. So I have done some diligence. While I have not done any formal Covid testing, I'm very familiar with the Society of Actuaries' model and the assumptions that went into that, and so, when I saw the Blue Cross model, I was relatively informed in terms of, you know, deferral rates and costs and things like that.

Q. Did you review the, did you review the Blue Cross addendum? Did you review the, page-by-page, the Blue Cross addendum?

A. Yes, I have reviewed the addendum.

Q. Okay. And on the next, the top of the next page,

it says that you are, you did a cursory review of Blue Cross'sdocumentation. What did that cursory review consist of?

A. So I think the cursory review is just a synonym for the informal review that we did do just reviewing to make sure that those assumptions lined up with what we would expect.

Q. Okay. But you didn't do your own calculations? You didn't look behind the data at all, correct?

A. No. Correct. We reviewed things such as, you know, their assumed deferral rates and, you know, did an informal review based on what we have seen in those, you know, eight, nine other states and with our work with the Society of Actuaries' model.

Q. Okay. What, if anything, did you do to review the investment that Blue Cross made that lost $40 million?

A. We did not do any review. It is not typically an actuarial exercise to on the investment side. So we did not conduct a review there.

MR. ANGOFF: Thank you, Mr. Dillon. That's all the questions I have.

MR. DILLON: Thank you.

MR. BARBER: Are there any questions from the board? I'll just skip the roll call. Does any board member have a question for Mr. Dillon?

MS. USIFER: I have a question. Hi, Dave.

MR. DILLON: Hi.

MS. USIFER: Just a question on, when you go to Page 13 and 20, I guess, Page 20, sorry. Yeah, 13 and 20 doesn't make sense. I guess that's getting late. Item 13, Page 20.

MR. DILLON: Sure.

MS. USIFER: And, when we talk about the administrative costs, I guess, first in the buildup of the 7.3 percent that Blue Cross Blue Shield requested, 1 percent of that increase is driven by their increase in administrative costs. So it is fairly significant to what's driving part of the change. And, when you look at, you compare them to Blue Cross Blue Shield based on Blue Cross Blue Shield, other Blue plans, both on an administrative PMPM and where they rank and, when we look at -- I guess, the question would be maybe Blue Cross Blue Shield plans are all high, and, when we look at MVP, it's significantly lower on a PMPM basis and a change. So it's, Blue Cross Blue Shield is about 12 percent higher on their dollar fee.

So just wondering if you could give a perspective on how Blue plans compare to other plans across the country, and then why wouldn't we look just in our local market as well on a, you know, comparative basis?

MR. DILLON: Sure. So I would say, generally speaking, there's a couple dynamics at play there. I think one is the Blue Cross plans do tend to be sicker, tend to have more claims. So that is one factor. And then, generally speaking, most Blue Cross plans do tend to be regional or single-state. There are a few exceptions. But, because of that, the smaller Blues don't have as big a, you know, membership base to spread their admin as compared to the large insurers that are more national or super-regional. So I think those are two considerations that, that we, that we take into consideration when we evaluate, let's say, a single-state Blues plan.

MS. USIFER: Okay, thanks. That's all I have.

MR. DILLON: Yeah.

MR. BARBER: Any other board members? Okay. Mike, did you have questions, follow-up, Mike Donofrio?

MR. DONOFRIO: I do not. Thank you.

MR. BARBER: Okay. Thank you, Mr. Dillon.

MR. DILLON: Thank you.

MR. BARBER: Enjoy your vacation.

MR. DILLON: I will, thank you. Glad the video held up.

MR. BARBER: So the next witness I have is

Mike Fisher, Chief Health Care Advocate.

MR. FISHER: Good afternoon or good evening, maybe I should say.

MR. BARBER: Let me just take a minute to pin you. Are you ready to take the oath?

MR. FISHER: Sure, yes.

MR. BARBER: Could you please raise your right hand?

M I C H A E L F I S H E R,

duly sworn to tell the truth, testifies as follows:

MR. BARBER: Okay, Mr. Angoff.

MR. ANGOFF: I'm sorry.

MR. BARBER: Oh, were you going to ask questions, or was this going to be a --

MR. ANGOFF: Yeah, we thought that Mr. Fisher would proceed in the same manner as Commissioner Pieciak did.

MR. BARBER: Any objections from Blue Cross?

MS. ASAY: No objection.

MR. DONOFRIO: No objection.

MR. BARBER: Okay, Mr. Fisher. Go ahead.

MR. FISHER: Thank you, board, and thank you everyone who has stuck with this endurance test today. Today's been a marathon. I guess I want to start with a little apology. I just want to recognize that I am

experiencing a level of outrage that I would usually try and hold in check for an event like this. It's an outrage about the disconnects between the level of fear and the real harm that I believe Vermonters and small businesses and, and Vermont families are experiencing and how much the discussion, and the discussion that's taking place here today.

You know, thank you, Blue Cross, for recognizing that we are in unprecedented times in the opening, but, wow, I don't know how to reconcile these two worlds. It's a bit baffling to me. The board's decision -- the board's words in the decision on the, on the Blue Cross Blue Shield Vermont large group have a couple of interesting, important concepts that I just want to repeat and agree with.

I agree that it is the task to strike the appropriate balance between achieving the most affordable rates possible while also safeguarding solvency. I also agree that the pandemic has only exacerbated the inherent tension in our rate review criteria. Rising insurance rates in the midst of this unprecedented crisis will compound the difficulties Vermonters are facing and make it less likely that they can afford to access the care they need.

Yeah, these are unprecedented times. While we've

seen some recent improvements in the unemployment numbers, the numbers are still phenomenally troubling. This coupled with the ending of the federal subsidy for unemployment this week adds to a new level of fear and a new level of pain. Vermont's dependence on tourism adds to this challenge. Increased costs of basic living expenses again piles on the pain.

If the challenge of setting a carrier rate is balanced between insurer solvency and affordability, the challenge facing Vermonters represents a significant tipping of that balance.

On the other hand, if we accept the often repeated concept that affordability is something that you get to consider after you've made sure the insurance company is, is whole, wow, we're in for more trouble than -- we're in for real trouble. You know, if that's the logic, more and more we are going to have rates that may be actuarially sound but fewer and fewer Vermonters can actually afford. Yes, in response to something Paul Schultz said earlier today, it is affordability on the community level that I'm talking about here.

No, in the middle of a pandemic with substantial financial impacts on Vermonters in an environment where there has been substantial sacrifice, this is a time, if there ever is a time, when we must pay special

attention to the needs of our small businesses and Vermont families.

A few people have referenced the comments. I know that the board members will, if they haven't, take some time to read them. I want to say a special "thank you" to all of the over 800 Vermonters who have commented. Vermonters are paying attention. I appreciate them for taking the time to write so many thoughtful and detailed comments. When taken together, this is an impressive storytelling exercise. It provides an important opportunity to have a view into the broader set of Vermonters' lives.

I won't read all of them today, but I will take a moment to recognize a few themes. One person said, "My family has been unable to access care for almost four months. Although I'm still paying the same premiums, what has Blue Cross Blue Shield done for their insured Vermonters this year aside from collect premiums? For my family the answer is 'nothing'".

Another person said --

(The court reporter has a technical problem.)

MR. BARBER: Why don't we take five minutes?

(A brief recess was taken.)

MR. FISHER: So I'll continue.

MR. BARBER: Yes, please.

MR. FISHER: So I was spending a moment talking about some of the comments that came in. Another person said, "A lot of Vermonters didn't go to the doctor this year because of COVID-19. I didn't go at all this year. So, if you don't go to the doctor when Blue Cross Blue Shield receives a lot of money without having to pay for any services, so why do they need to raise their premiums?"

I don't say these two because I mean to hold them out as as individual ones. I say them because they were a theme. Many people said something similar to that, and we heard stories like that at the Health Care Advocate's office. There was a lot of Vermonters have had the experience of not being able get the care they need and struggling to pay their premiums.

There was, of course, another theme, and that was about the financial pressures, and I'll just say a few words I pulled out of the comments, and those words included "cruel", "appalled", "unsustainable", "unethical" to describe the situation as they see it.

Another thing we hear a lot from Vermonters is the level of fear that people are experiencing. This is a palpable fear that is driving some of their decisions, and I say that in lead to the next question that I've heard many people say today. We don't know exactly

what the incidence rate of the virus will be going forward. I agree. We don't know. And, while I'm sure it's true that our providers have gotten better at serving the needs of the Covid-positive population and the, and the non-Covid care, I also know that with an increased rate of infection comes fear, and I don't have any doubt that, if there was another spike of coronavirus in the remainder of this year or next year, that it would come with a, a decrease in non-Covid care.

And then, lastly, about the future incidence of Covid, it, I think this has been alluded to, but I don't think it's been made as clear as I think it needs to be. Exhibit 19 made, clearly spells out -- this is the Health Department's description of the incidence of the disease -- clearly spells out both the, the number of infections by age and the number of hospitalizations by age, and there, as we all know, there is a very heavy weighting towards the older population and, more specifically, the above 65, the Medicare population.

Lastly, I have listened to the testimony today about the need for reserves. I've heard the statement again and again in past years, and again this year. Insurer solvency is the most important consumer protection strategy.

I don't know what to say. Does that mean that, that consumers are okay if the insurers have enough money? Do you think anyone outside of, I guess, the people on this call would buy that reasoning? It just doesn't add up. I hear how important it is to Blue Cross to hold all that money, but I don't think there's any scenario that they or the industry, for that matter, would accept as a reason to spend some of that money, as a reason why, you know what, now is not the time to build reserves; now is the time to make sure people get care.

So I, I have to admit I'm going to say something that, that -- you know, I don't understand what insurer, what a surplus or what a member reserves is for. For year after year, we've heard, Well, of course we need to hold onto this money. What if we have a pandemic? Well, here we are. Maybe member reserves are by definition only for a future need, never for a now need, or maybe member reserves are really important for something that I'm not entertaining. Maybe it's important for Wall Street, you know, or some, some Wall Street rating purpose.

Vermonters are struggling in an unprecedented fashion. Claims are down for the year. There's been a sizable injection of unanticipated revenue due to tax

rebates and legal actions, and we're contemplating raising rates. Members of the board, it's raining. It's raining here in Vermont and across the country. Doesn't look like it. In fact, it's really a hurricane, and Vermonters are looking for a little shelter.

As a point of comparison, none of us will know what's going to happen in the state budget process for the next three months, the remaining three, sorry, the remaining three quarters of the fiscal year, but imagine for a moment if the legislature and the Governor decided to leave the state reserves intact and instead passed a tax increase to add more money. I don't think any of us entertain that that's even a possibility. I don't think it is a possibility. I don't think that that could possibly happen today. Is this entirely all that different?

Given the world of hurt that is playing out in Vermont's small businesses and in Vermont families, the discussion of a rate increase is baffling. I'll say it, to me, feels tone deaf. We at the HCA usually end with a, Don't raise the rates as much as the carrier asks for. We're going further today. I will join with what some have said before. Now is not the time for any rate increase. Now is the time for a level, for a

zero percent rate increase. And, and I thank you for taking the time to do this very long hearing and for listening to me at the end of this day. Thank you very much.

MR. BARBER: Thank you, Mr. Fisher. Mr. Donofrio or Ms. Asay, do you have any questions?

MR. DONOFRIO: No questions.

MR. BARBER: Board members?

MS. LUNGE: I have one. Mike, are you familiar with the federal requirements for exchange plans and actuarial certifications?

MR. FISHER: The specifics of which, no, but I am aware of the -- well, I am aware of the, of the, all of the discussion about the requirements for reserves, if that's what you mean.

MS. LUNGE: Well, if you could include perhaps in your legal memorandum how your request meets the federal requirements that a rate be actuarially sound, that would be very helpful.

MR. FISHER: Okay.

MR. BARBER: Okay. Are we read to move on to closing statements?

MR. DONOFRIO: Yes.

MR. BARBER: Mr. Angoff?

MR. ANGOFF: Yes, sir.

MR. BARBER: Okay. Then I think, Mr. Donofrio, you get to go first.

MR. DONOFRIO: Sure. I'm going to try to be incredibly brief, recognizing that we do have the opportunity to file a post-hearing memo where we'll really try to address the incredible breadth and scope of the testimony and evidence you've heard today. I want to start kind of where Mr. Fisher started with some of the language from your decision earlier today from the large group matter, and I'm going to quote:

"Raising insurance rates in the midst of this unprecedented crisis will compound the difficulties Vermonters are facing and make it less likely that they can afford to access the care they need. The pandemic has also created an additional layer of uncertainty and made it difficult to predict health care costs over the next year. Insurers as well as providers are having to make plans and propose rates and budgets based on still-emerging information in what is a very fluid and potentially volatile situation. This uncertainty implicates solvency and the need for insurers to be able to absorb future costs that are not currently known or quantifiable". That's the end of the quote.

That's sort of a perfect frame for where we are today. The, the actuarially justified rate increase

before you -- and there's really been no serious dispute on an actuarial level. There's agreement among Blue Cross's actuaries, the board's actuaries, and, and the Department of Financial Regulation's actuaries. When you put that next to a few undisputed facts that you heard today, I think that it argues, it demonstrates why approving the rate as proposed and as modified by L&E is the right result.

Now, first, Blue Cross chose, when the pandemic hit back in March, not to ask policyholders to foot the bill for the health care costs related to the pandemic. As, as Mr. Fisher noted, you've been told again and again this is what reserves are for, and Blue Cross has used its reserves in exactly that way. The fact that Mr. Fisher overlooked, Blue Cross has spent about $10 million of those reserves to cover those health care costs, which effectively reduced what the rate would have otherwise been by 3.2 percent, and that's undisputed.

Blue Cross has also chosen not to seek anything in this rate related to the pension loss, and, as Commissioner Pieciak testified, that, like the pandemic itself, those are two events that are going to play out over time and, and will, and will dictate at some point a move up or down in the rates.

You've also heard that Blue Cross has continued to keep its cost of insurance, the element of these actuarially justified rates over which it has the most control, at, at industry low levels, and you've also heard that Blue Cross has given you the best evidence that you have in this record in terms of how the pandemic might play out and what that might look like projecting into the future a couple of years.

The HCA's position that I think is perhaps most clearly framed in Mr. Angoff's opening and in the questioning of Ruth Greene would actually, it would increase the volatility and increase the uncertainty that's causing so much fear for Vermonters.

essentially, what the HCA is asking you to do is not to take that long view but to respond in the moment as events take place, events like the pension loss, events like the pandemic. Blue Cross, by making the decisions it's made, not to put the pandemic costs in these rates, not to put the pension loss in these rates, is giving you a path towards stability in the health care system in this time of tremendous uncertainty and instability.

Blue Cross has protected the health and wellness of Vermonters for over 40 years by providing prudent financial management, outstanding customer service,

first-class health care insurance coverage in the most cost-efficient manner possible, and these rates before you are consistent with that history.

So, to conclude, on behalf of Blue Cross and on behalf my colleague, Ms. Asay, I want to thank you, board members, for hanging in. I want to thank the HCA team and everyone's staff for hanging in. And I request that you reject the HCA's logic here and approve the proposed rates as modified by L&E's recommendations. Thank you.

MR. BARBER: Thank you. Mr. Angoff?

MR. ANGOFF: Thank you, Mr. Hearing Officer, and thank you, Mr. Chair and board members. Four points:

Number one, I hate to say it, but this system is not working. Every year since the board has been constituted, Blue Cross comes in for an increase. L&E, let's face it, essentially rubber stamps it. You know, there's a little, a tiny bit of reduction, but it's essentially a rubber stamp. Blue Cross gets essentially what it asks for, and, despite that, Blue Cross's, just in the last four years, enrollment has gone from 70,000 to 39,000. So the system has not worked for Blue Cross, and, clearly, it has not worked for Vermonters who just, every year as if rate

increases were some kind of natural law, every year pay more to Blue Cross.

Number two, Blue Cross's rate filing this year is particularly unreasonable, particularly unjustified. One of the big reasons is that their projections of what will happen as a result of the coronavirus are completely unreasonable. Vermont has been the best in the country. Vermont is a great success story. Vermonters, at a lot of sacrifice to themselves and a lot of suffering, have done a sensational job of containing the coronavirus. Yet the comparables that Blue Cross puts into its model include suburban New York, Westchester County, and Boston, not New Hampshire, not Maine, but their comparables aren't comparable.

In addition, Blue Cross's estimate of how much RBC will be improved is completely unreasonable, and who says that? Not the HCA, but Oliver Wyman. Oliver Wyman is not some far left consumer-oriented advocate. They are a very, very conservative, respected actuarial firm. They say the effect of the coronavirus will be to raise, on average, raise plans throughout the country's RBC by between 21 and 105 points. That's the average. Vermont is better than average. Vermont's not just better than average. Vermont is the best. So

Vermont should be on the upside of that, should be the 105 points, not the zero that Blue Cross assumes.

Third point, and this is the most troubling to me. The board is much, much more magnanimous about this than I would be. You have given Blue Cross increases year after year after year, pretty much what they asked for. You asked very reasonable questions, essential questions, you guys lost 40, to the, along the lines of, You guys lost $40 million. Tell us how you did it. Tell us what you did with that money. And Blue Cross does a couple of things.

Number one, they don't answer the questions you ask. Number two, they simply give you a six-page general filing, which doesn't answer the questions you asked. And I guess the most troubling thing to me is the CEO writes you a letter, a page-and-a-half letter just a couple of weeks ago, the tone being, Oh, by the way, not we lost, but our assets experienced a $40 million loss, as if it's the asset's fault, as if Blue Cross did nothing. They tell you that a couple weeks ago.

They knew about this in March, and what I found most appalling was the commissioner, and there's no reflection on the commissioner, but the commissioner was talking about when he testified discussing the

issue with the Blue Cross CEO, and he said essentially, It never occurred to us to notify the board. You all are the ones who give Blue Cross the money they ask for, and Blue Cross won't even give you the courtesy of answering your questions.

Fourth point, there is no natural law that rates must be increased this year. This year Blue Cross has behaved particularly badly, and Vermonters have behaved particularly well, at great cost to themselves, at great sacrifice. This year for the first time the board should order no increase. I believe a decrease is justified, but, for the first time, let's have no increase for Blue Cross. Thank you very much, Mr. Chair and members of the board. You've been very patient.

MR. BARBER: So I think the only thing I need to resolve is there is a motion or request to extend the page limit on the post-hearing memo, which I'm granting. Still due on the same date. Is there anything else we need to discuss before we head off back home or I head off back home? You guys are home. No?

MR. DONOFRIO: I have nothing further.

CHAIRMAN MULLIN: How many additional pages are you granting?

MR. BARBER: Five.
CHAIRMAN MULLIN: Okay.
MS. ABORJAILY: Mike, do we need to have a public comment period?
CHAIRMAN MULLIN: Yes, we do.
MR. BARBER: Yes. Thank you for reminding me. So, at this time, is there any member of the public who stuck with us and has a comment that they'd like to make?
CHAIRMAN MULLIN: Can we also point out that there is also the opportunity tomorrow night, starting at 4:30, to offer any public comment on either this rate request or MVP's in that, if people feel the need to get dinner rather than commenting tonight, tomorrow might be the better spot?
MR. BARBER: Yeah. I don't --
MS. GARFIELD: How do we ask to be recognized?
MR. BARBER: Oh, just state your name and provide your comment.
MS. GARFIELD: Yes. It's Audrey Garfield. I live in Brattleboro, Vermont. I'm a consumer, and I have questions, actually. I'm curious what board members' understanding of affordability for insurance is currently for Vermonters.

MR. BARBER: Um, so, if any board member wishes to try and tackle that, they can, but your name again was?

MS. GARFIELD: Audrey Garfield.

MR. BARBER: Ms. Garfield, this is a, a time to, to provide comments, so not questions, but, if the board would like to try and say something, you have the opportunity.

CHAIRMAN MULLIN: So I would just say this, that the board struggles every year, because under the statute we're tasked with making sure that it meets the affordability criteria but also tasked with making sure that it promotes insurer solvency, and the two do not align, and, therefore, often insurers will make the argument that they were not given a rate that, that actually promotes insurer solvency, and the public makes the argument that they were not given a rate that is affordable.

I have said previously in numerous public venues that I don't believe the existing insurance rates are affordable, and that's without any increase. So, as a percentage of Vermonters' income, I think the rates are problematic, especially in a key demographic, because those under 400 percent of the poverty level are given help from the federal government in making their

payments, but, once you hit that cliff, it is a cliff, and it's very difficult for people who are working very hard every single day to try to make the payments once they've hit that threshold. So it's not something that is an easy factor for the board to weigh, because it's in direct conflict with another factor that we are both tasked with under the statute.

MS. GARFIELD: Thank you. I appreciate you responding to my question, and, you know, I, again, I will -- I have many questions. I'm a layperson, but, because this is public comment and not a question-and-answer period, I'll try to limit my, my comments to comments.

And, you know, the idea of solvency -- again, I'm a layperson. I'm looking at Blue Cross Blue Shield's statutory statements of assets and liabilities, and I see that at the end of 2019 they had assets of almost $300 million, which was a $40 million increase over a year. And I really appreciate what the prior speaker had to say that each year the board consistently gives Blue Cross Blue Shield what they want and to listen to Mr. Dillon talk about affordability I have to ask, Affordability for whom, really?

It's a house of cards, and perhaps the best thing that can happen is that the board continues to give

Blue Cross Blue Shield what they want until the whole system crumbles, because that's what's going to happen. You know, its incredibly frustrating that, you know, the idea that this balance or imbalance of solvency versus affordability is in direct conflict with the board's purpose of improving the health of Vermonters, and Vermonters are suffering.

I used to be really proud of Vermont and our ability to provide insurance for, for everybody, and that's changed, and I just don't see how Vermonters, especially given the rates of unemployment, the fact that unprecedented numbers of Vermonters are food insecure. You know, I, myself, last year was unemployed for a period of time. I was on unemployment. I went without insurance for nine months, because I couldn't afford to be insured through the, through the Vermont Health Connect.

And so here I am groveling before this board who holds the fate of Vermonters in its hands, and it seems like an exercise in futility. It seems like a foregone conclusion that, you know, I don't think a lot of us Vermonters have much faith in this process, and that is unfortunate.

So thank you for your time. And I, I ask you to think, to consider Vermonters more in this equation.

You may not hear from as many of us. We may not have as strong a voice as Blue Cross Blue Shield, but we're here, and, you know, for those of us who aren't here, it's because we're working our second jobs or taking care of our children or trying to make ends meet with pennies. So please consider that in your decision this year. Thank you.

MR. BARBER: Thank you very much. Is there anyone else who would like to make a comment?

MR. HACKETT: I would.

MR. BARBER: Is that Dale?

MR. HACKETT: Yes.

MR. BARBER: Hi, Dale. Go ahead.

MR. HACKETT: I've been listening since 10:00 o'clock this morning, so there's just a few highlights that I picked up on. Blue Cross Blue Shield expects the Green Mountain Care Board to consider reserves when setting rates, to consider their solvency, yet they lose money, sorry, they lose money, they say, when the rate is too low. But Blue Cross Blue Shield does not hold itself accountable to explain its management of the reserves and the pension fund, as if that, too, can also be money that came from somewhere. Did it come from the consumer?

And, granted, there's legal implications why they

may not be able to answer some questions, but it was striking to see how they were refusing to take responsibility for their actions in answering public questions. Can they write a better reply as an explanation of what happened, be transparent as soon as possible with the facts? At least share what you learned from the mistake or bad decision.

I would ask the board to set the rate as if the $40 million still existed, since they may get something on, something back from what they lost. It's up to Blue Cross Blue Shield to find the $40 million, not Vermont, nor consumers, without better answers than given.

I would also comment that in, with Covid going on, there is something that's happening, I didn't hear it mentioned once, and that is an inadvertent rationing of care. For example, if you need a doctor's appointment, you can only see so many people per day, and that scenario, if you need a doctor's appointment and it's got to be within three days because of the medical issue, you're probably going to the ER. I know. I've actually had it happen. There is no other option. I asked. And the ER becomes the doctor's appointment as well as a place you go for more urgent needs.

Rates have to support the consumer, and a 5

percent annual increase does not support consumers. Blue Cross Blue Shield's solvency has become the primary issue, but is it more important than the consumer solvency? If they do get this rate increase, I would hope that someone at least considers and will testify to the impact to the consumers above 400 percent and below 400 percent. I would also hope that it is considered, when looking at hospital rates, will that be as supportive in making sure that they stay solvent?

And that's both on the side of the Green Mountain Care Board looking at their rates and what will Blue Cross Blue Shield do in negotiating rates with providers, hospitals, etc? Will they also consider the solvency issue of the hospitals? I'm not saying they haven't. I'm just saying, going forward, we can't drop the ball. We have to stay with the issues. And that's it. That was just a few highlights I picked up on.

MR. BARBER: Okay. Thank you, Dale. Is there anyone else who would like to make a comment? I don't hear anyone. So just, yeah, again, a reminder that we are having a forum specifically for comments tomorrow starting at 4:30 in the afternoon via Teams. The information for that is on our website under the rate review tab, probably in a couple different places,

but I know it's there. And I think we're going to wrap up and see you guys tomorrow at 8:00.

CHAIRMAN MULLIN: Thank you, Mr. Hearing Officer, for steering us through a very long day.

MR. BARBER: Thanks.

MS. LUNGE: Do we need a motion to adjourn?

MR. BARBER: That's a good point. Yes, you do.

MS. LUNGE: So moved.

MR. PELHAM: Second.

MR. BARBER: Me? Okay. It's been moved and seconded. Is there any discussion? All those in favor signify by saying "aye". Okay. I will see you guys at 8:00.

(Whereupon the hearing was adjourned.)

C E R T I F I C A T E

I, Sunnie Donath, RPR, do hereby certify that I recorded by stenographic means the video conference hearing re: GMCB Docket No. 005-20-rr, on July 20, 2020, beginning at 8:00 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing pages are a transcript of the stenographic 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 Westminster, Vermont, this 24th day of July, 2020.

//Sunnie Donath, RPR