STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-008-17rr

IN RE: Blue Cross Blue Shield
2018 Vermont Health Connect Rate Filing

July 20, 2017
9:00 a.m.
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115 State Street
Montpelier, Vermont

Rate Review Hearing held before the Green Mountain Care Board, at the Vermont State House, Room 11, 115 State Street, Montpelier, Vermont, on July 20, 2017, beginning at 9:00 a.m.

P R E S E N T

BOARD MEMBERS: Noel Hudson, Hearing Officer
Kevin Mullin, Chair
Maureen Usifer
Jessica A. Holmes, Ph.D.
Con Hogan
Robin Lunge, JD, MHCDS
Judy Henkin, Esq.

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

P R E S E N T

Kaili M. Kuiper, Esq., Office of the Health Care Advocate
Peter Horman, HMA Solutions
Jacqueline A. Hughes, Esq., BCBS
Ruth Greene, BCBS
Paul A. Schultz, BCBS
David Dillon, Lewis & Ellis
Jesse Lussier, Department of Financial Regulation
Scott Kline, Department of Financial Regulation

I N D E X

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CHAIRMAN MULLIN: Good morning, everyone. Today is likely to be a long day, and I just want to give everybody a heads up that, if we don't really finish public comments by the end of the day, that we are having a public hearing next Thursday at 5:00 o'clock, 5:00 to 7:00, and we will try to get through everything today, but there may be a case where we have to go into recess and take it up again. Because it's my understanding that the Sergeant-at-arms will throw us out sometime between 4:00 and 4:15. So we will do our best to get it done in one day, and I have every confidence that our Hearing Officer will run a smooth and fair hearing. That does not mean anybody should feel rushed, but it just means that we are under some time constraints here.

MS. HENKIN: Chairman, the hearing next week is over at the City Center on the second floor -- it is not here -- from 5:00 to 7:00 o'clock.

CHAIRMAN MULLIN: So on the second floor of the City Center in our board room, we will be hearing public comment from anyone who wishes to offer that, and we felt it was necessary based on the amount of correspondence and calls that we were receiving from the public to afford people who have daytime jobs to be able to make public comment at night. So, with that,

I'll turn it over to our Hearing Officer, Noel Hudson. Thank you, Noel.

MR. HUDSON: Morning, everybody. Welcome today. Before I get started, I just wanted to ask everyone to turn off all cell phones at this time so that we can produce and clear and distraction-free zone. We've spoken once about the Sergeant-at-arms already. He has an additional request to the audience that there be no food and drink in the room aside from water in a secured container.

I am Noel Hudson. I will be today's Hearing Officer. It is July 20th 2017. This is a hearing in the matter of Blue Cross Blue Shield of Vermont's Vermont Health Connect 2018 rate filing, Docket Number GMCB-008-17rr. This hearing is conducted under the authority of Title 8 of the Vermont Statutes, Sections 4062 and 4513, Title 18 of the Vermont Statutes, Section 9375, and Green Mountain Care Board's Rate Review Administrative Rule known as Rule 2.

The parties to this proceeding are Blue Cross Blue Shield of Vermont represented by Attorney Jackie Hughes and the Office of the Vermont Health Care Advocate represented by Attorney Kaili Kuiper. Welcome all. We will also be hearing from today from the Vermont Department of Financial Regulation as a witness, though

they are not a party, and we will also be having the aforementioned public comment section after we've heard all the witnesses.

So we have a court reporter with us today, Ms. Sunnie Donath. She will be recording the proceeding and producing a transcript within a reasonable time. At this point, I would ask Ms. Donath to swear in all of today's scheduled witnesses. They are Paul Schultz, Ruth Greene, Jesse Lussier, David Dillon, and Peter Horman.

(All witnesses sworn in by the court reporter.)

MR. HUDSON: Thank you, Ms. Donath. By way of disclosure, some of you may have noticed that we have the spider phone at the table today. There is a member of L&E -- that's the Board's actuarial staff -- who is auditing the proceeding today.

ATTORNEY HUGHES: Can you tell us who that is? Sorry.

MR. DILLON: Josh Hammerquist is listening in.

MR. HUDSON: And, at this point, we can move to stipulating the exhibits. Do I have a motion from any attorney?

ATTORNEY HUGHES: Yes. I move that Exhibits 1 through 12 and 13, 14, and 15 be moved into evidence,

and DFR filed an Amended Solvency Letter, which was Exhibit 12. We have copies of the amended letter, and I don't know whether you want to replace the one that's in the binder or just have that as an extra exhibit. We're happy to do it either way.

MR. HUDSON: It sounds like just taking in an extra exhibit would be faster than replacing it in the binder, so we'll do that. There are also -- first of all, are there any objections to Exhibits 1 through 15?

ATTORNEY KUIPER: No.

MR. HUDSON: Hearing none, let the record reflect that they are entered into evidence.

ATTORNEY HUGHES: And, just prior to the hearing, Attorney Kuiper and I spoke about an exhibit that was a supplement to the report by the Health Care Advocate's actuary.

MR. HUDSON: And that was my next question. Is there a stipulation on that?

ATTORNEY HUGHES: And we stipulate to that being admitted into evidence, and we have marked that Exhibit 18.

MR. HUDSON: Exhibit 18?

ATTORNEY HUGHES: Yes.

MR. HUDSON: All right. So that means that -- there's an Exhibit 17. Is that going to be Mr.

Schultz's prehearing memo?
ATTORNEY HUGHES: That will be Exhibit 17, right.
MR. HUDSON: Okay. And is there any objection to the proposed Exhibit 17?
ATTORNEY KUIPER: No.
ATTORNEY HUGHES: And Exhibit 16 will be the hospital budget analysis that we did based on the rates that were recently filed with the Green Mountain Care Board, and that was shared with the Board and with the Health Care Advocate.
ATTORNEY KUIPER: No objection.
MR. HUDSON: Do we have copies of these exhibits that can be distributed?
ATTORNEY HUGHES: Yeah, yeah.
MR. HUDSON: So I will note for the record that there was a clear absence of objections on all sides to the entry of these exhibits, but I do want to just review their numbering now that everyone has them in front of them. So Exhibit 16 is?
ATTORNEY HUGHES: 16 is the hospital budget analysis.
MS. HENKIN: 16 and 17 are marked. Just the one that's the replacement would be unsure.
MR. HUDSON: So is DFR's amended letter

Exhibit 19 then?
ATTORNEY HUGHES: Yes.
MR. HUDSON: Okay.
ATTORNEY HUGHES: And 17 would be our response to, our memo on the various points in the HCA's actuarial memo or report, and 18 is the supplement to that report.
MR. HUDSON: And that was submitted by the HCA? Okay. I think we have our exhibits in order. Thank you very much to all parties. Would Blue Cross Blue Shield like to issue an opening statement at this time?
ATTORNEY HUGHES: Yes, we would. Thank you. Good morning. My name is Jackie Hughes, and I'm a lawyer at Blue Cross, and we are pleased to be here today to present Blue Cross's 2018 QHP rate filing. This is the fifth year that Blue Cross is presenting a QHP rate filing to the Board. We realize there are several new Board members who are new to the process. Welcome. As in the past during this hearing, we will try to make the contents of the binder that you have in front of you as clear as we can, and we trust that you will ask us any questions that you have about that.
Blue Cross has long been an active participant in health care reform efforts in the State. It's also

been the longest term participant in the individual and small group markets. The State initiatives that Blue Cross partners the State with promote the public's access to affordable, high-quality health benefits. This filing that you have in front of you supports Blue Cross's vision to transform Vermont's health delivery system to one in which every Vermonter has health care coverage and receives timely, effective, and affordable care.
We know that members of the public have commented on affordability, and the very difficult and complex work that is going to be required to bend the cost curve downward in Vermont and, therefore, make these rates more affordable in the future cannot be done in Vermont by Blue Cross alone. We understand that the Board is at the center of health care reform efforts, and I know some of you probably feel like it's the epicenter from time to time. We think those reform efforts will take time.
The rates we are presenting here today incorporate and reflect the product of the Board's and the State's health care reform efforts to date including any savings associated with those efforts. It also includes the savings that Blue Cross, as an entity, has been able to accomplish through its various initiatives

and care management programs. We will get into that a little later. But we do have significant savings on the books that are baked, as it were, into these rates.
The review of our filing by the Board's actuary, Lewis & Ellis, has been rigorous. It has been very thorough, and we thank them for their efforts as well as their open and collaborative approach to understanding the filing that we made. We also thank HMA Solutions for its timely and thorough review.
This year, once again, Blue Cross has developed rates adhering to rigorous actuarial standards that produce rates that are adequate but not excessive and not unfairly discriminatory. The filing also produces rates that are reasonable in relation to the benefits that are going to be provided by the 2018 QHP health plans. The rates are designed to cover the increased costs and increased utilization of the provider services, hospital stays, prescription drugs, supplies, medical supplies, and equipment accessed by QHP members. Those amounts comprise almost 90 cents of every premium dollar that we collect.
We believe our rate filing meets all of the statutory standards, and you heard the long list read to you yesterday. We think this filing meets all those standards, and we will get into that. Blue Cross has

priced its products on the QHP per QHP plans so that it can compete vigorously in the Qualified Health Plan market without jeopardizing its financial strength.

Your actuary, L&E, has suggested a slight downward modification to the rates based on the federal, the final federal risk adjustment program standards. Blue Cross agrees with that suggested modification. Lewis & Ellis has found that every other input and throughput in the Blue Cross rate filing to be actuarially reasonable and appropriate. In short, your actuary found that Blue Cross has produced the evidence to support this filing.

HMA Solutions, the actuarial firm hired by the Health Care Advocate, has made 14 separate findings with respect to our filing. We will provide evidence here today for the Board's consideration as to why, for a myriad of reasons, the findings and recommendations of HMA Solutions should be rejected by the Board. The HMA Solutions report is designed to reach a lower increase than Blue Cross requested but at the suspension of overall adequacy. Underfunding rates is not payment reform, nor does underfunding make rates more affordable. It just postpones the full funding of the cost of health services that people in QHP plans access.

We do not agree that underfunding is a goal, as we think the rate approved by the Board should cover the expected costs of the care to be accessed by our QHP members in 2018. The rates should also cover the taxes and fees that are assessed on those 2018 QHP payments, and, finally, rates should cover the costs to administer the QHP plans, to process their claims, to manage our members' care, and to provide for the maintenance of reserve funds for member protection. As you heard from Ms. Lee yesterday, those points are the definition of rate adequacy. Other than the modification suggested by L&E, we oppose any further reduction to our rates as filed.

We know that, going in, some of the testimony will necessarily be dry, technical material and probably longer than in past years, but that dry technical material is the nature of a health insurance rate filing, and, while the HMA Solutions report will appear to create, in the words of Member Hogan, a lot of noise, our purpose in exploring each of the issues raised by that report is to provide the Board with the evidence and support for what it is going to take to adequately fund Qualified Health Plan coverage in 2018 for approximately 70,000 Vermonters, and it's also to eliminate any questions the Board may have. Thank you.

MR. HUDSON: Does the HCA wish to offer an opening statement?

ATTORNEY KUIPER: Yes. For those who weren't president here yesterday, my name is Kaili Kuiper, and I'm a staff attorney with the Office of the Health Care Advocate. We're a project of Vermont Legal Aid. We offer free help with access to health care for Vermonters including access to health insurance. We also represent Vermonters in rate review cases before the Green Mountain Care Board.

MR. HOGAN: Can you speak up a little bit into the mic?

ATTORNEY KUIPER: Sure. Today we're here to set appropriate premium costs that meet the Board's statutory authority. If the proposed rate -- if Blue Cross's proposed rate is approved, Blue Cross's VHC plans will have increased 38 percent since 2014. The public comments given to the Board in response to Blue Cross's 12.7 percent rate increase request explain Vermont's affordability problems better than I can.

One Vermonter from Starksboro wrote, "This requested rate increase on top of years of rate increases may price my family out of the insurance market. We already qualify for a subsidy, but even with our subsidy, this rate increase could mean more

than $1,000 of additional premium payments for us. In the past, these rate increases have also come with increased deductibles meaning even greater out-of-pocket costs. These are not costs we can continue to bear when our salaries are not increasing at a similar rate".

And another Vermonter from Rochester: "If the State of Vermont were to raise property taxes by 12.7 percent in one year, there would be riots in the streets. This is simply untenable. I personally have not had a pay raise in ten years, and I'm certainly not the only one. How about Blue Cross Blue Shield tightening their belts a little? I'm running out of notches on mine."

Now, we are not here to put the entire burden of health care cost increases on Blue Cross Blue Shield. We recognize that many factors are outside of their control. Additionally, predicting future rates is difficult and cannot be done perfectly. Fortunately, by increasing the scientific rigor behind Blue Cross's actuarial methodology, Blue Cross's predictions can be improved and also result in a lower rate increase.

Our expert witness, Peter Horman, is a certified actuary with almost 20 years of experience setting rates for health insurers. As an in-house actuary for

a nonprofit health insurance company, he has been in Blue Cross's shoes having to make difficult predictions of future costs. He will tell you about six points in the filing where Blue Cross has not justified its proposed cost increase because it was not, because it has not applied sound actuarial methodology. The Green Mountain Care Board should hold Blue Cross to the basic standard of using the best data and methods available to determine its rates.

So today I ask you to remember two things. One, Blue Cross has the burden of proof to show that every proposed increase is justified, and, second, this is a zero-sum game. Every dollar that goes to Blue Cross is taken from Vermont individuals, families, and small businesses. That is why Blue Cross Blue Shield's final rates must reflect sound actuarial science and affordability or Vermonters. Thank you.

MR. HUDSON: Before we proceed to hearing from witnesses today, I would like to make several requests of the parties and of the Board. Firstly, to the attorneys, please limit foundational testimony to the bare minimum necessary in order to proceed so that we can get straight at substance as soon as we can.

Secondly, I would request that any of the more sort of formalistic and ceremonial questioning about

statutory criteria in order be avoided as you know that also adds little to a record that has already plenty of information on this criteria going on. So let's try keep the testimony focused.

Similarly, to the Board, I would request that any questions during examination or cross-examination of witnesses be limited to any clarifications that are absolutely necessary and try and keep the substantive questioning of the witnesses until after the examination and cross-examinations are done.

MS. HENKIN: Yes.

MR. HUDSON: Do you have anything to --

MS. HENKIN: I just wanted to remind the Board, if you can hold your questions and keep your notes until witnesses are done, it's probably the easiest way to get through this smoothly. Thank you.

MR. HUDSON: And, with that, we can proceed to our first scheduled witness.

ATTORNEY HUGHES: So I'm going to call Paul Schultz. Mr. Schultz's CV is on Pages 305 and 306 of the binder, the very last two pages.

DIRECT EXAMINATION BY ATTORNEY HUGHES

Q. Mr. Schultz, can you tell us what your position with Blue Cross is?

A. Yes. I'm Chief Actuary of Blue Cross Blue Shield

Vermont.

Q. And what do you do as Chief Actuary?

A. As Chief Actuary, I'm in charge of the actuarial and underwriting departments. As part of that, I'm involved in all of the rate development that we do, and, in particular, I oversee the development of these QHP rates.

Q. And how long have you been the Chief Actuary at Blue Cross?

A. I've been the Chief Actuary for about two-and-a-half years.

Q. And before that?

A. Before that I was Actuarial Director at Blue Cross for almost two years. Prior to that, I worked for a for-profit health insurer in Pittsburgh, and prior to that I spent about a decade on the consulting side of actuarial science.

Q. Do you have any professional designations?

A. I do. I'm a fellow of the Society of Actuaries. I'm also a member of the American Academy of Actuaries. I've been a fellow for over 15 years now.

Q. And how long have you been involved in insurance rate filings and consultation?

A. I've been involved -- well, I've been working with, as a health care actuary for over 20 years. In

terms of insurance rate filings, I've been doing that for almost a decade.

Q. So Exhibit 1, can you identify that?

A. Yes. Exhibit 1 is our rate filing. So that includes our actuarial memorandum, supporting exhibits, and so forth.

Q. And how did that filing come into existence?

A. It was prepared under my supervision.

Q. And have you prepared similar filings for Blue Cross in the past?

A. I have, yes. I've been involved in the last four of these.

Q. And can you identify Exhibits 2 through 10?

A. Exhibits 2 through 10 are the results of questions that were posed by the Board's actuary, Lewis & Ellis, that we responded to.

Q. And how were those responses prepared?

A. Again, those were prepared under my supervision.

Q. So you're familiar with them?

A. I am.

Q. And you're also familiar with Exhibit 1?

A. I am.

Q. And do those exhibits comprise your written testimony with respect to the rate filing?

A. They do.

Q. Can you turn to Page 12 and 13 of the binder?
A. Yes.
Q. And can you tell us briefly what Section 1.5 is?
A. Section 1.5 is a brief description of the reasons for the rate increase that breaks out the 12.7 into the various component pieces.
Q. Can you review for the Board how the rate filing was prepared?
A. Yes, I can. So, with any rate filing, we have to start with a projection of allowed claims, and that is the total cost of care for Vermonters whether that's hospitals, physicians, prescription drugs. So to do that we start with base period experience. What I mean by that is we're looking at calendar year 2016. That's the most recent period of information we have available at the time that we're preparing this filing.

So we look at that experience, and that's for well over 800,000 member months of experience, so a large pool of experience. We then have to trend that forward to 2018, meaning trend is basically health care inflation. We apply any adjustments that are necessary for how we see the population changing from 2016 to 2018, and then, finally, we apply a set of factors that take us from allowed claims, the total cost of care, to paid claims which is the cost that's covered by the

health plan as opposed to out of the member's pocket. So that is the, the paid claims component of the premium, and that accounts for 7 out of every 8 premium dollars.

So the rest of the 12-and-a-half percent consists of a few components. One is administrative costs. We take a similar approach here. We look at what Blue Cross actually spent to administer this QHP program in 2016. We then trend that forward to 2018. That's a different trend than what we use for medical costs. That's basically a result, for administrative costs it's the result of inflation and wage growth. That comes to about 6-and-a-half percent of premium. So then that figure is very competitive both in Vermont and compared to national benchmarks.

To that we have to add various taxes and fees. We make estimates of those. The biggest one of those by far is something called the federal insurer fee or sometimes the health insurer tax or sometimes the 9010 tax. It all means the same thing. It's a fee that, for us, is 2.6 percent of premium, and that's the biggest component of all taxes and fees, the grand total of which comes to 3.8 percent premium.

We then add a 2 percent contribution to member reserves. Reserves are money that we hold because we

make a promise to ratepayers that, no matter what the claims costs come in at -- I, I testified that I'm projecting what these claim costs are. If I project that too low, Blue Cross is going to continue to pay claims anyway so that Vermonters continue to have access to health care and providers can keep their doors open. So, in order to make that promise or because we make a promise, our regulator requires that we hold a certain amount of reserves, and to maintain an adequate level of reserves, we look for 2 percent of premium to go directly into those reserves.

The final component, and you might say a missing component, is profit. We are a local Vermont nonprofit company. We exist solely for the benefit of our members. There is no profit at these rates.
Q. Going back to administrative expense for a moment, do you include one-time expenses?
A. No, we don't. We strip those out. So, when we look at 2016, what we spent to administer, if there were any one-time expenses, we take those out before we project. We don't charge for those again if we don't think they'll exist.
Q. And does Blue Cross have a parent company?
A. We do not, no.
Q. So, as you developed the 2018 QHP rate filing,

what were your and Blue Cross's objectives?
A. Our objective was to develop rates that will return a 2 percent contribution to reserves, and to meet that objective we wanted to use assumptions that are reasonable both individually and in the aggregate, and we wanted to use methodology, and we did, in fact, use methodology that was compliant with state and federal rules and regulations.
Q. And can you give us an overview of those assumptions that you just mentioned other than trend?
A. Other than trend? Okay. So, other than trend, probably the most important assumption has to do with population morbidity. So we look at a variety of measures here. We look at members who are new to the plan in 2017 and compare their, their characteristics, their age, basically, to the population in 2016, and we adjust for that. We take a look at members who have left the plan since the experience period of 2016, and we actually made a small downward adjustment for that, because we've found that the members who left us were slightly less healthy than the members who remained.

We include an assumption, an adjustment for plan selection, meaning that folks who need to use the benefit more tend to select the richer plans. We also include an aging assumption. So, to develop that aging

assumption, we took a look at experience for QHP's in Vermont from 2014 to 2017.

What we found is that the effect of aging increased claim costs from 2014 to 2015 by about a quarter percent. Then from both 2015 to 2016 and 2016 to 2017, continued aging will have an effect on claim costs of a half percent. So the half percent from '15 to '16, half percent from '16 to '17. We believe it's appropriate to assume that this trend will continue, and so we assume that that will continue to 2018 as well. That assumption we know from other public sources is consistent with what's going on in Vermont in terms of the aging of the population. So we have no reason to think that trend is suddenly going to stop. So that's population morbidity.

Beyond that we have to make some assumptions to develop an estimate of risk adjustment transfer between Blue Cross and MVP, and that was the subject of one of L&E's recommendations for, for changing. We make assumptions for pay-to-allow ratios. So we, we develop actuarial values. An actuarial value is essentially what part of the total benefits are paid by the plan versus the member's out-of-pocket cost sharing, and we also include a benefit richness adjustment. That adjustment is based on federal factors from a study

they did that shows that people who enroll in more, in plans that cover more benefits tend to use those benefits more often. So it kind of makes sense from a practical perspective. So we use federal factors for that.

Q. And how about administrative costs and regulatory fees; did you make an assumption on those?

A. We did. So we have to project those as well. Our administrative costs, we use an assumption of 2.4 percent annual increases in administrative costs. That includes 3 percent for personnel costs and zero percent for all other costs that we have.

Q. So let's turn to trend. How did you develop your trend assumptions?

A. So we view trend -- we kind of break it down into two main components. One is utilization trend which is a combination of the number of services that Vermonters use along with the mix of those services or the intensity of those services. So, for instance, they might be using the same number of services, but, if those services are more expensive, then you'll have positive utilization trend and vice versa as well. The other component of trend is what we call unit cost trend, and that's fairly simply increases in the amounts providers are paid.

So, to develop utilization trend, we look at a variety of metrics. Most notably, we, we make observations of our data. We see how it has been happening in the QHP population, that, that population of over 10,000 member months over the time that we've had the QHP business, and what we found was a general uptick in utilization trend starting around mid-2015 and continuing through the end of 2016. For example, from calendar 2015 to calendar 2016, we saw a 2.3 percent increase in utilization trend. Now, that's higher than what our assumption was last year. So we scrutinized that carefully to make sure that we wanted to make an upward adjustment in utilization trend.

What we found in that analysis is that about three-quarters of that utilization trend can be explained by three things. One is the cost of prescription drugs that are administered as part of the medical benefit. Generally, those are drugs administered in the hospital or in a provider's office. Rather than flowing through the pharmacy benefit, those go through the medical benefit. A lot of those drugs, the majority of them, the majority of the increase at least is because of cancer medications. That's something that's going to flow through the medical benefit.

In total, those drugs are up 16 percent per member per month from 2015 to 2016. We expect that trend to continue. A lot of these are specialty medications. We know that a lot of new specialty medications, miracle drugs, if you will, are coming onto the market, and that's great. These medications save lives, but they're also very expensive. So we need to reflect the fact that we're going to see this continued growth in pharmacy costs within our utilization trend.

The second thing we saw that was significant was preventive care is up about 5-and-a-half percent per member per month from 2015 to 2016, and we think that's a great trend. Appropriate preventive care now will save costs down the road. It might be five years down the road, it might be ten years down the road, but it will result in a healthier population, and it will benefit the cost curve. Preventive services generally are covered at 100 percent as required on QHP's. So we're trying to encourage additional preventive care, and we're seeing that preventative care come through. That's a trend we both expect and hope, in fact, to continue.

The third thing has to do with hospital admissions. We've seen hospital admissions over the years decrease as Vermont's done a really good job of

eliminating unnecessary admissions and eliminating or reducing to the great extent possible readmissions, and, in fact, Vermont's now under national benchmarks in that regard which is great news.

But what we are seeing is that, as the number of admissions decreases, severity of admissions for the necessary admissions that are left tends to be higher, so that it's, it's logical and we expect that to continue as well. So what we're seeing is admissions continue to decrease, but because the severity is increasing, we end up with a slightly positive hospital inpatient trend which is a change from what we've seen in recent years where it's been very flat. So from '15 to '16 we saw about a 0.7 percent increase. Hospital inpatient is a pretty big portion of the spend, and so that helps to drive the trend quite a bit. So that's how we came to looking at doing that analysis, looking at the recent experience is how we came to the 2 percent assumption that we're using moving forward.

In terms of unit cost, we have basically four different types of providers. We have providers who are outside the purview of the Green Mountain Care Board hospital review process who are within Vermont who we contract with. Separately from that, we have out-of-state providers, and then there's pharmacy,

there's prescription drugs, and so, to come up with, with cost trends there, we look at what has been happening with each of those categories, and we augment that with what we know about provider contracting efforts for some of these other providers not under the hospital budget review process.

So that leaves us with the hospital budget review process which is about 45 percent of spend for our QHP block goes to providers that are under the purview of that process. So for that what we -- we basically, we literally have a spreadsheet up where, for all of the hospitals in Vermont, we will input the results of the hospital budget review process. Now, obviously, we didn't know at the time of the filing what the results of that was going to be in this year.

So we start with an assumption that the Board will approve the same increase this year as they approved last year. We then augmented that with the April orders. Because of the hospital budget overages, there were some hearings and some orders that came out of that. We took those orders and put that directly into our calculation of unit cost trends. We also, our provider contracting folks had some discussions with hospitals about what they might be submitting in the hospital budget submissions, and, where we were able to

get some additional information there, we made adjustments for that as well. So unit cost trend for that piece of it, at least, is very much a calculation.

Q. I'm going to direct your attention to Exhibit 16, and that is one of the new exhibits that we handed out earlier. And does this exhibit in any way connect with the testimony you just gave?

A. Yes. So what this shows is, now that hospital budgets have, in fact, been submitted, we went back and took a look at how that compared, how those budget submissions compared to what was in our unit cost assumption. So you can see on Exhibit 16 these are the commercial rate increases that we were able to find in the hospital budget submissions. So we've documented those, and then toward the bottom of that exhibit, you you can see that our total medical cost trend, if we plug in these assumptions, goes to up to 2.9 percent.

What we filed was a medical cost trend of 2.6 percent. So the hospital budget submissions are actually a bit higher than what we filed. That would have a rate impact of about a half a percent.

Q. And are you requesting an adjustment based on this new information?

A. No, we don't intend to refile for this new information.

Q. And you talked about contracting efforts, and what are your assumptions about whether or not contracting efforts will increase or decrease commercial rates?

A. As it relates to the Green Mountain Care Board hospital budget review process, we, our contracting, we don't assume that contracting efforts will have any impact on the results of that budget process.

Q. And why is that?

A. We actually addressed that in one of our responses. I'll try to paraphrase so that, essentially, what hospitals have told us since the dawn of the hospital budget review process is that the Green Mountain Care Board has approved a certain commercial increase, and they believe that it's up to the Blue Cross Blue Shield members to fund that increase. So in negotiation hospitals have basically said, There's no leeway for us to go something lower than what the Green Mountain Care Board approved.

The hospitals are trying to manage to an overall budget. Part of that overall budget is the commercial increase that was approved by the Board, and to meet that commercial increase, Blue Cross has to actually increase rates at that commercial increase that was approved.

Q. So do the hospitals have other customers other

than commercial insurers?
A. I'm sure they do, yes.
Q. What kind of other customers do they have?
A. The other commercial players, there's Medicare. There's Medicaid.
Q. So what contribution to reserve has Blue Cross requested?
A. We've requested a 2 percent contribution to reserves, and that is the contribution to reserves that's necessary in the long term to maintain a level of solvency in light of the increases in health care cost claims and potential adverse events.
Q. So are you familiar with the term RBC or risk-based capital?
A. I am.
Q. Okay. Can you briefly tell the Board the concept of risk-based capital?
A. Risk-based capital is basically one kind of fairly easily calculated measure of solvency. It's based on you take surplus and divide it by something called the ACL, which is not something you tear, but rather it's the authorized control level of risk-based solvency. It's a measure of the risk of an organization.
Q. And does Blue Cross have a target range for RBC?
A. We do. We target 500 percent to 700 percent RBC.

Q. And what is the contribution to reserve required for 2018 QHP business specifically in order to maintain Blue Cross's current level of RBC?
A. I can't answer that directly because of Vermont law that prevents me from disclosing what our RBC level is, but I can tell you the answer at a couple points in the range. So, if we were at the high, at the top of our range at 700 percent, we would require a minimum of 1.9 percent contribution to reserves in order to maintain that 700 percent level. If we were at the low end of our range at 500 percent, we would require a 1.2 percent contribution to reserves in order to stay at 500 percent.
Q. And the prehearing memo that was shared with the Green Mountain Care Board which is Exhibit 17 --
A. Yes.
Q. -- did that address CTR in the -- did that address CTR?
A. It does, yes.
Q. And can you tell us what page?
A. CTR is addressed beginning on Page 4, and there's also an exhibit that's at the -- it's unnumbered, but the exhibit's at the back of the handout that you received.
Q. So is there a figure on the bottom of that page,

that exhibit?
A. Yes. So it, it says 1.9 percent is required to maintain target RBC, and that's at the 700 percent level.
Q. And did you calculate that figure?
A. I did.
Q. Okay. And how did you do that?
A. So what we did -- so RBC, because ACL, authorized control level, is very much driven by the level of claims costs, RBC is also driven by claims costs. So what we did is we took a look at our forecast RBC, our forecast ACL for the end of 2017, and we said, Well, what if nothing else changed except in Qualified Health Plan business we have higher premiums and we have higher claim costs? So we included what our filing tells us in terms of what the premium is going to be and what the total claims are going to be. We then, based upon that, are able to calculate what the total increase in surplus needs to be to maintain the same RBC percentage as the denominator ACL increases as well.
So, to get those additional surplus dollars, they come from one of two sources. One is investment income, and the other is CTR, contribution to reserves, from this filing. So everything we don't get from

investment income we have to get from CTR. For investment income we allocated that to QHP with the most aggressive, in the most aggressive way possible. Meaning what we did was we did not increase -- we did not assume any sorts of increases for other lines of business, and we allocated based on capital requirements, meaning how much of the overall ACL calculation can be attributed to RBC?
There are a few other ways that we could have done that. We could have allocated it based on membership. We could have allocated it based on the contribution of each line of business to surplus, and both of those would have resulted in a far lower allocation of investment income to Qualified Health Plans. So really, you can look at this as the, as the minimum answer of what would be required at 700 percent.
So, once we have that investment income, we know how much surplus needs to go up. The remainder needs to come from contribution to reserves. So we can just divide that by premium, and we get to the answer, which add was 1.9 percent.
Q. So, while you performed that calculation, is that Blue Cross's approach to its CTR assumption?
A. No, it's not. This is purely illustrative. We get this question -- we get a question about this every

year, and so we demonstrated for illustrative reasons. The way we set CTR is we, we prefer to use a long-term CTR assumption, meaning our intention is to file 2 percent as long as we are within our targeted range of solvency.

We think, by doing that, it avoids unnecessary rate fluctuation, and we think that, in fact, it increases affordability by not increasing CTR in the first quarter because of membership increases or some other reason. This illustration shows that we need a higher number. We don't want to do that. We stay with 2 percent regardless of what the illustration might say. That 2 percent allows us to stay within the range of solvency that we've worked up and we have approved with DFR.

Q. So the 1.9 percent that you calculated, would that take Blue Cross to 700 percent, the high end of its range, if that were approved?

A. No. So I want to be clear about that. The 1.9 percent doesn't take us to 700 percent. If we were at 700 percent to start with, 1.9 percent would keep us there. If, by way of example, we were at 600 percent -- and we, at 600 percent, this illustration calculates about a 1.5 percent minimum CTR that's required. If we instead get 1.9 percent, that would take us from 600

percent up to 606 percent. So, no, it absolutely does not get us to 700. And, that 606 percent, we would only see that if all of our assumptions were exactly right and if there were no adverse events that would otherwise review surplus.

Q. So what's an example of an adverse event?

A. One that's in the news lately is that there's some talk on Capitol Hill of potentially defunding CSR, not for next year, but for the rest of 2017 as well. It's something we've been following very closely. There's a lawsuit before the Supreme Court, and we're, one possible out come of that is that CSR could be defunded for the balance of 2017. If that happens, barring state intervention, that money would come out of our surplus.

Q. So can you tell us briefly what some of the items are in a long range approach to CTR? So, in other words, if claims increase, is that a reason to have CTR if you have adequately priced for them?

A. Yeah. So, right, so, as I, as I said earlier, one of the reasons we hold surplus is that we make a promise to customers that we will pay claims no matter what. So we, we need to hold that surplus now. If claims come in higher than my projection, then that money's going to come out of that surplus. That's why

it exists, and that's how we'll use it in that instance.

Q. Would Blue Cross ever file anything different from the 2 percent?

A. Yes, we would. So if, if we were in a position where our RBC fell outside of our target range, for example, if we were above the target range, we would file a CTR that is lower than 2 percent so that we would eventually get back within our target range. Similarly, if we fell below the target range, if we're below 500 percent RBC, we would increase our CTR requirement so that, again, we were able to find our way back being into the target RBC range. As long as we're within the range, our intention is to file 2 percent.

Q. So what was Blue Cross's average requested rate increase this year?

A. We requested a 12.7 percent rate increase.

Q. And, since 2014 when QHP plans were first offered in Vermont, what is Blue Cross's actual realized CTR for individual and small group business?

A. Negative 1.5 percent.

Q. So what was the expected CTR after regulatory action, meaning Board decision, over that same time horizon?

A. We expected 0.2 percent, a positive 0.2 percent.

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

A. Approved CTR was positive 0.9 percent. The reason approved and expected are different is because the Board sometimes makes orders about assumptions or elements other than CTR. Sometimes it's, a trend direction is ordered, for example, and, while we reflect those in rates, of course, as we're ordered to do, we don't reflect those adjustments in our forecast budget.

Q. So what would you conclude with those results that you just described?

A. So I conclude a couple things. One is that, given that we returned negative one-half percent, that I would say rates have been inadequate over that three-year time period. Further, I would say that this is clear evidence that our filing assumptions are not excessive. Our expectation was 0.2 percent. The reality was a negative one-and-a-half percent. That's clear evidence that, if anything, our assumptions have been too low.

Q. So let's go through the 12.7, the various components of that. Can you tell us what those various components are?

A. I can. So the starting point of any sort of analysis of rate increase is what actually happened versus your expectation. So, when we look at 2016, 2016 came in more expensive than what we had included in our 2017 rate filing, and, because of that, we have to get the starting point right. We're not trying to recoup those losses, but, when we project forward to 2018, we have to start from the right platform. So we can't start from the number that we thought was going to happen. We have to start from the reality, and that added 1.9 percent to rates.

The next major category is unit cost increases. Unit cost increases meaning amounts that providers are paid or amounts that Vermonters pay for prescription drugs, for example. That increased rates by 3 percent. Almost half of that is purely due to pharmacy. Utilization trend increased rates by another 2.8 percent.

The next category, the next big one, are changes due to mandated changes from the Affordable Care Act. The biggest change here again was the reintroduction of the federal insurer fee. That increases rates by 2.6 percent, and those dollars, by the way, the reason that fee exists is to fund advance premium tax credits. So that's how the, that's how those dollars are funded.

That fee is back in. That's 2.6 percent.

Green Mountain Care Board billbacks increased, which had a .3 percent impact on the rates, and that leaves another .3 percent that was due to Blue Cross's administrative costs increasing from the, from last year's filing to this.

So, to say that a little bit differently, if we were assuming that there would be no increases in what is spent on health care and if there were no changes to taxes and fees, the, also, that the only change was the money that goes to Blue Cross, we would be here today taking about a 0.3 percent rate increase.

Q. So the 3.0 and 2.8 for unit costs and utilization, was any of that offset by programs that Blue Cross has or activities that it has engaged in?

A. It was. Thank you. So we did improve our pharmacy contracts through a negotiation with our Pharmacy Benefit Manager in two different ways. One is we were able to enhance rebates significantly through a relatively small change in formulary, and we also had previously negotiated a discount in improvements that came into play as well, and those things combined to decrease the premium by 0.6 percent.

Q. And what about the aging of the population; did you make any assumptions?

A. Yes, that's right. So the, the, because of the population morbidity, we had an increase as well of 1.9 percent.

Q. And what about family size; have you made any observations?

A. That's part of it too. So population morbidity includes both aging of the population and an observed increase in family size. As we have more members per family, the costs are going to go up because we have more people covered that impacts the rates. So the total of those things was 1.9 percent.

Q. Are you familiar with the recommendations prepared by the Board's actuary, Lewis & Ellis?

A. I am.

Q. And is that, is their report found in Exhibit 11, the binder?

A. Yes.

Q. And how many recommendations were there?

A. There were two, and those can be found on Page 259 of the binder.

Q. And they're relatively short. Could you read those?

A. So they recommend that or they state, "This report considers the information available to the carriers at the time of this report. L&E recommends that the Board

consider the impact of the 2018 hospital budgets on unit cost trends once the 2018 budgets become publicly available". And that speaks to Exhibit 16 that we talked about earlier that shows that the submitted hospital budgets would cause an increase in our filed unit cost trend.

The second recommendation is to revise Blue Cross's projected risk adjustment calculation and move the coding group of both companies. This results in a decrease in rates of .3 percent from the modified proposed rate increase of 12.9 percent. We never did file an amendment, so our proposed rate increase is still 12.7 percent.

But, in any event, the nature of this is that L&E has access to information that we don't have, mainly the risk adjustment calculation. You need to know information about Blue Cross, and you need to know information about MVP. Obviously, we have all the information about Blue Cross, but we don't have the information about MVP. So L&E is in a unique position to be able to evaluate all the data that needs to go into that calculation. They've done so. I'm familiar with their methodology and the assumptions that they used and that they order that we use, and we're in agreement that the result of the calculation is

appropriate so that we do agree with that recommendation.
Q. Are there any areas of disagreement between Blue Cross and the Board's actuary?
A. Once we, once we implement this, this risk adjustment recommendation, there are no areas of disagreement between us and Lewis & Ellis.
Q. So, after incorporating that agreed-upon modification, can you tell us what the average rate increase Blue Cross is requesting at this point?
A. The average rate increase will be 12.6 percent.
Q. So are you familiar with recommendations prepared by HCA's actuary known as HMA Solutions?
A. I am.
Q. And is that in Exhibit 13 of the binder?
A. That's right.
Q. And how many recommendations are there?
A. There are 4 recommendations that come from 14 findings.
Q. And did you submit a prehearing memorandum to the Board concerning Exhibits 1, 2, 8 and findings -- excuse me -- 1, 2, 8, 11, and 13?
A. Yes, I did. That's Exhibit 17.
Q. And what was the general topic of the findings that were addressed in the memo?

A. These had to do with IBNR conservatism, so, basically, restating 2016 for information that became available after the filing date, our capitation schedules, the net cost of our reinsurance contract, and some allegedly misleading statistics about our Blue Cross administrative ratio, and that 13 we already addressed, and that was the reduction of CTR.
Q. And did you agree with any of the five findings made by HMA Solutions in its report on these five findings?
A. No, we did not.
Q. So your memo addressed Finding 1 and 2. Can you tell us what is the nature of finding Number 3?
A. Yes. So Finding 3 states that we're assuming that our average -- it has to do with aging. So it states that we're assuming the average age will continue to increase based on one data point, and that's incorrect. As I testified earlier, we looked at all the experience from 2014 to 2017, and that involves three years of data, the last two of which have been extremely consistent. 2014, as we remember, was a year of a lot of transition, changes within the ACA. It wasn't fully implemented until April. So the quarter percent point may be a bit suspect for that reason. The last two years have been very consistent at a half point per

year. So we don't agree with this finding.
Q. And did the Board actuaries find your approach and results on this issue reasonable and appropriate?
A. They did, yes.
Q. And what was the nature of the fourth finding made?
A. The fourth finding has to do with an adverse selection spiral, and an adverse selection spiral is basically what happens when you have a high rate increase or a series of high rate increases. What can happen is that your healthier members will decide they can't pay that increase, and they'll either look for coverage elsewhere, or they will decide to go uninsured altogether. So, when that happens, membership decreases and, as you're left with only the unhealthy members, rates can continue to increase further and further, and they'll spiral, thus adverse selection spiral.
Q. In your professional opinion, do you believe that Blue Cross is in any danger of an adverse selection spiral?
A. No, I don't.
Q. Can you tell us why?
A. Sure. So I have a couple reasons for believing that. One is that we think about members going

elsewhere, getting coverage elsewhere. The ACA actually adjusts for that through the risk adjustment transfer. So, if all the healthy members go to one carrier and all the unhealthy members are at the other carrier, they're, the risk adjustment transfer payment from one carrier to the other is designed to level that playing field. So and we found that it actually works pretty well in practice. So if it's a question of an exodus to MVP, because that's the one other place they can go on the Exchange, that should not, because of risk adjustment transfer, that, in itself, will not have any impact on our rates, so they will not continue to escalate.
Now, the other thing that could happen is that folks could decide to go uninsured. Now, there are certain things that are insulating Vermont from an adverse selection spiral if people begin to make those choices. One thing is that 25 percent of the population, which is about five-eighths of the individuals who are in the QHP environment, receive advanced premium tax credits so they are insulated from this rate increase. As the rates go up, the tax credits go up, and the rate increase tends to be pretty flat for those folks.
Secondly, Vermont had the wisdom to enforce a

merged market, so small group and individual are both in the same pool. That's, that's pretty unique. Not a lot of jurisdictions do that. And we're not allowed to sell any sort of off-Exchange products. So everybody in the individual and small group markets are in this pool. That's going to serve as a buffer against an adverse selection spiral as well.

Q. So do other states have a different perspective on this potentially?

A. They do, sure. In other states the individual market in most other states stands on its own, and so other states can be seeing this issue, absolutely.

Q. Do you think that a 12.7 or 12.6 percent increase is large enough to kick off or start an adverse selection spiral?

A. In my opinion, no, but I did want to find some support for that opinion, so we went back and looked at the last decade of increases in the individual and small group market in Vermont, and we found four instances where there was a rate increase of at least 12.7 percent. So we looked at those four cases. That included two associations, all the association, small group associations existed before the ACA in Vermont. So two of those are large increases at one time or another. We looked at non-group business, which is

what we called individual back when the pre-Catamount days, and we looked at small group non-association business. So we had those four examples.

Of those four, one of the small associations continued to see a couple years of 11 to 13 percent rate increases, and then the ACA came along, so the association is all, those folks joined a single risk pool. So I wouldn't say that spiraled, but we didn't have a lot of data on that one.

For the other three examples, we all saw smaller rate increases in the immediately following year, and in two of the three examples within four years we got to a place where the rate increase was zero or negative. So, of these four examples we have in Vermont, none of them caused an adverse selection spiral.

Q. So what would you conclude after looking at that data?

A. My conclusion is that I don't think Blue Cross is in any danger of an adverse selection spiral because of this 12.7 percent rate increase. The one other thing I'd add to that is that a significant component, about 3 percent of that increase, is because of the reintroduction of the federal insurer fee. They're not going to re-reintroduce it next year, so that's going

to help with the increase next year as well.

Q. And how about HMA Solutions's fifth finding, can you basically tell us what that is?

A. Yes. The fifth finding is an important one. It has to do with utilization trend, and they believe that our utilization trend is excessive.

Q. And did they evaluate how you came up with your utilization trend?

A. They did. They, they state in here that our utilization trend is based on certain statistical regressions, and that's not the case. We did perform some statistical regressions to help us understand directionally which way the trend was moving. Our trend rate, as I testified earlier, was based on a much deeper analysis than that, and we were able to conclude from that analysis that 2 percent was the best assumption for utilization trend.

Q. So do you agree with HMA Solutions's rationale on this point?

A. No, I don't.

Q. And did L&E opine on this trend?

A. They did. They found that our trend was reasonable and appropriate, and, furthermore, their best estimate of trend matched our assumptions.

Q. So they came up with the exact same result?

A. They did, yeah.

Q. How many approaches to utilization trend did HMA take?

A. So they rejected our approach or their understanding of our approach and then used three different approaches to adjust, to estimate the utilization trend. The first of those -- and this is -- I'm on Page 284 of the binder, Page 15 of the HMA report. So the first of these approaches in brief says that we should just use Blue Cross's utilization trend of last year. Last year we filed for a 1 percent utilization trend, and they assert that we could use that rather than the 2 percent.

Q. So is that a reasonable approach?

A. It's not a reasonable approach. It's essentially asking us to ignore an additional year of data for 70,000 members in the QHP. There's no reason to ignore that data. It's not a reasonable approach to just throw that data out.

Q. And what is the size of the Blue Cross QHP pool?

A. Again, there's about 70,000 members. There were about 840,000 member months in the experience period.

Q. And did you use a similar approach this year that you used last year?

A. Yes. Our approach to setting utilization trends,

so the methodology we used and the metrics that we looked at was similar, was consistent from last year's filing to this year's filing. So the, the change here we have really is the update in data. It's not a change in methodology. It's an update in the data that shows us the utilization trend is increasing.

Q. So HMA is suggesting that you use the trend that you developed last year without updating, and they, they found that the same process that you used last year somehow doesn't work this year?

A. That's my understanding, yes.

Q. Can you describe the second approach that HMA used for measuring trend?

A. Yes. So the, the second approach that's Approach B was an evaluation of relevant statistics. So what HMA did was to calculate 25 measures of rolling 12 trend. What's that mean? So the first measure is basically calendar year 2014 over calendar year 2013. Then you move by a month. Your next measure is the 12 months ending January of 2015 over the 12 months ending January of 2014 and so on. You keep doing that moving a month at a time, and you end up with 25 data points that are pretty highly correlated.

From that he then measured the mean of those data points. That's the average the way we normally think

about it. You add up the 25 and divide by the number 25, and you get a mean, you get an average. And he also looked at the median, which is usually defined as the point where there's just as many observations above as below. So, typically, you would define that as, if there's a set of 25, you look at the 13th point, the one right in the middle. There's 12 above, there's 12 below, and that's your median.

Q. So do you think that that that's a good approach?

A. I don't think it's an unreasonable approach. I don't think it's an unreasonable thing to look at, but there were a couple of problems with the execution of that approach. The most notable is that there was a significant shift in population from 2013 to 2014, and many of these data points include that 2013 population in the trend and compare it to 2014.

What happened was, with the advent of the ACA, we had a lot of Catamount members who left the individual and small group pool which included Catamount and went to Medicaid, and most of those members were higher cost. So we had some, some lower end of costs in the single risk pool as compared to the individual and small group environment before the ACA, and that's why you see data points. I can find it here.

Exhibit 18 is one of the new exhibits. That is

the supplement to Appendix B that HMA was able to provide. So, if you look toward the middle of the page, there's a, there's a box, kind of a taller box, the right side of the taller box. We might need a magnifying glass, but the HMA trend calculation, you can see that the first data point there is calendar 2014 over calendar 2013, and that shows a negative 6.6 percent trend.

Now, I don't know any actuary who would say that a negative 6.6 trend is a reasonable assumption, and the reason we're seeing this is because it, it would be necessary to make an adjustment to reflect the population change from 2013 to 2014 in order to validly compare those two years. So, if you don't make the adjustment, you end up with inappropriate data points.

Q. Was any such adjustment made?

A. No, I see no evidence of any such adjustment.

Q. Did you find any other problems with HMA's methodology in this exhibit?

A. I did. So I've done a bit of analysis on this. First, I can say that, if you, if you try to make some sort of adjustment for the population and, without trying to do anything too complicated, if we just do something very simple -- like, let's say, Let's throw out any data points where over half the data is for the

pre-ACA environment, so it includes all these Catamount members. Let's throw those points out. If we do that, we find that the mean is 1.7 percent and the median is 1.8 percent. Now, I wouldn't necessarily rely on this method to set a trend rate, but it does come up with trends that are very close to our filed utilization trend.

And the other problem I found is that this uses a needlessly complex way of calculating the median, and within that needlessly complex method, there are technical errors that are actually leading to the wrong answer in terms of the value of the median. If it would be helpful for me to elaborate on that, I'd be happy to do so.

Q. I'm sure the Board will ask you to elaborate if that would be helpful. So do you agree with the results that HMA achieved using this methodology?

A. No, I don't. It used it inappropriately, failed to adjust for a major population change, and it also included some technical errors.

Q. Okay. So you've gone through two of the three approaches that HMA suggested. What, what's the third approach they suggested?

A. The third approach is that we should use MVP's filed utilization trend, which was 0.7 percent.

Q. And is this not only a finding but a recommendation?
A. It is. It matches their recommendation of a 0.7 percent trend.
Q. And do you think using MVP's utilization trend is an appropriate methodology for Blue Cross QHP?
A. No, it doesn't make any sense to me. So MVP is a carrier who, in fact, because they didn't feel that they had enough lives in QHP, felt that they needed to augment that with their other Vermont business in order to even establish a trend rate, and, by doing so, their membership ranged from 20,000 back at the beginning of 2014 down to about 11,000 at the end of 2016. That, that's a much smaller population.

Even including not just QHP but all their Vermont business, that's a much smaller population than our 70,000-plus members. It's unreasonable to say we're going to ignore what's happening with those 70,000 members and instead use a trend that was developed on the basis of a much smaller population.

Q. And a different population?
A. And a different population, yes.
Q. So did you find any of the approaches that HMA used to be reasonable or appropriate?
A. No. I found two of them to be unreasonable, and

the one that, the other one did not appropriately adjust for key assumptions and contained a technical error. So, no, I don't agree with any of these results.
Q. So should the Board rely on this recommendation and finding from HMA?
A. In my professional opinion, no, the Board should not. The Board should look to both the evidence that we present and the evidence presented by Lewis & Ellis that I'm sure they'll be happy to talk about.
Q. So would you characterize their approaches as unreasonable and/or inappropriate?
A. I would, yes.
Q. So HMA's sixth finding, can you tell us about that finding?
A. The sixth finding is on Page 276 of the binder, Page 7 of their opinion. They find that our dental trend is too high and instead propose to use a trend from the 2017 Segal Trend Survey, which is a publicly available document.
Q. Do you agree with their approach or rationale?
A. I do not. The reason for that is that there appears to be no adjustment made from this national trend survey to reflect trend for a pediatric benefit, that there's no adjustment from a national number to a

number that would be applicable to Vermont, and there's no adjustment for a benefit that's been newly available and that the people have for the first time. So, for those three reasons, I think it's inappropriate to take a national number and just apply it to Vermont. I think it's more appropriate to look at what's actually been happening in the Vermont marketplace. We've had this benefit from 2014 to 2016. We've seen a 10 percent trend from both '14 to '15 and '15 to '16.

Now, I just want to elaborate a little bit on that. If we go back to 2014, we have no experience with pediatric dental on which to rely. So we hired a consultant and a dental expert who provided us a manual rate for this benefit, and we used that in the first couple of years of our filings. When we get to the 2016 filing, we now had experience from 2014, and what we found was that that experience was way lower, not just a little lower, way lower than the manual rate that was developed by the, by the consulting expert.

So we thought, Well, huh, that's interesting. Maybe people aren't aware that the benefit is there, but, for whatever reason, they're just not using it the way that national manual rates would expect. So we took a blended approach for the next filing. For 2016 we relied partially on experience, partially on this

manual rate. Now we've come a couple years farther along, and the dental experience is still way below what the manual rate was, but it's been trending at 10 percent per year.

So now we've thrown out the manual rate. We're not using that at all because Vermont experience is clearly very different from what this national expert expected, but, in doing so and relying on Vermont experience, it's actuarially appropriate to also rely on that experience for trend. So that's what we've done. The experience is much, much lower, but we're seeing trend at 10 percent year over year. We suspect that maybe because people are becoming increasingly aware of the benefit and using it more and it's trending more toward what we might expect nationally, but it's still way below what expectation is.

Q. So let's take Findings 7 and 10 together. What's the nature of those findings?
A. These findings basically both say that we could have lower rates if we were to include various programs that could help to lower unit cost or help to lower health care cost spend.
Q. So, without going into details, does Blue Cross currently administer any such programs?
A. We do. We administer a number of these programs.

Q. And how is the impact of those programs reflected in rates?
A. So it's reflected in a couple of ways. Inasmuch as these programs have been in place for a long time, the impact of those programs is already reflected in base experience, and for some of the newer programs like Blue Rewards, for example, we will also see the impact of that in trend. So, as Blue Rewards brings experience down, that will dampen the trend as well, so we kind of get a double bonus for some of the new programs that have been implemented over the past few years.
Q. So what is HMA's ninth finding?
A. The ninth finding is a recommendation to L&E that they update the risk adjustment calculation for the new information that came out on June 30th and that they reflect consistent methodology between us and MVP for both risk adjustment and the 9010 tax or the federal insurer payment.
Q. And had L&E already considered both of these recommendations in their opinion?
A. I'm sure they can testify to that, but, yes, in reading their opinion, it appears they did consider both of these things.
Q. And was one of them the subject of our agreement

with them to modify our rate?
A. That's correct. That's the, the risk adjustment was the subject of their recommendation with which we agree.
Q. And what is HMA's twelfth finding?
A. So that's Page 9 of their opinion, 278 of the binder. That finds that our administrative cost increase is excessive.
Q. And how about specifically, more specifically?
A. Sure. So they they're stating that, that we're using a 3 percent increase in wage growth from year to year. That's what we're projecting, and that is true, but that, historically, the net per capita employee cost increase results in a 1.4 percent increase, and that's, that's based on one of our answers to the various questions we were asked, but it's not the complete story.
Q. So one of the answers, is that found on Page 175 in the binder?
A. Yes, that's on Page 175 of the binder. That's in Section 3.
Q. So that provides a more detailed response to their finding?
A. It does, if I can just quickly go through it. So it shows that, while personnel costs have increased by

an average of 7.3 percent, the number of full-time employees have increased by an average of 5.8 percent over the same time period, primarily through the insourcing of certain IT functions and due to volume-based growth in our business. So that gets us to the 1.4 percent over a five-year period which includes an average 3.3 percent annual increase in employee benefit costs per full-time equivalent.
So and then it goes on to say that the average is significantly influenced by the change in personnel driven by the one-time events noted above. As we expect a more steady state into the future, we've projected a more standard increase in personnel costs of 3.0 percent. The data point that was applicable was a 4.1 percent increase from 2015 to 2016 despite a stable work force. So it includes some of the data.
There was a lot of work force movement. We were hiring a lot of IT positions that might be paid differently from the average, but now from '15 to '16 our work force has been more stable. The observed increase in personnel costs was 4.1 percent, largely driven by a pretty significant increase in the cost of employee benefits, and we think that that 3 percent as an assumption moving forward in terms of growth for personnel costs is appropriate on the basis of this

complete response.
Q. So what is HMA's thirteenth finding?
A. The thirteenth finding has to do with the reduction of CTR, and this alleges that that we've done -- it makes CTR seem like a calculation. In fact, it says, "Used in their CTR calculation". As I testified earlier, the way we set CTR, the way we file CTR is not based on a calculation. It's the proper long-term amount that's needed, the amount needed over the long term that's going to allow us to maintain our target level of solvency. That amount is 2 percent. It's not a calculated amount. It's what we intend to file as long as we are within our target solvency range.
Q. And was this also covered in your memo?
A. Yes, it was. So they, they, HMA does observe that there were some errors in the illustration that we provided, and that is correct. In trying to kind of condense and simplify the RBC calculation so that reviewers could modify the spreadsheet and see what the result was, we did make an error in doing that. So we've corrected the error and provided the updated exhibit.
Q. But the error was in an illustration?
A. It was in an illustration. It had no bearing at all on our choice of a CTR requirement.

Q. So what is HMA's fourteenth and, I'm happy to say, final finding?
A. The fourteenth finding has to do with historic losses and CTR impact. So it seems to me to be implying that we're trying to file for an excessive CTR to try to make up for some of our losses in 2016, and, if that's what it's implying, that is false. First of all, our CTR that we filed for this year is 2 percent. That matches what we filed and what was approved last year by the Board. Secondly, we, we never try to recoup losses from a prior year.
So he does identify correctly -- and this was from one of our questions and answers -- the three drivers of the loss, the three main drivers of the loss, the reason that experience came in different from expectations, and we have addressed all three of those in our filing as he correctly states, but it's not true that we are trying to increase our CTR requirement or that we're trying to make up for these losses.
Q. So you've given testimony about the increase in utilization trend. If that trend is increasing, why was that not a driver of the loss in 2016?
A. That's a good question, but it has an easy answer. We filed for a 2 percent utilization trend in the 2016 filing. So, when actual utilization came in at 2.3

percent, that was really close to our filed assumption, so it was not a driver of the loss, but it is nonetheless true that we did see a 2.3 percent utilization trend, which is the starting point of analysis we did, that resulted in our 2 percent utilization trend assumption in this filing as well.
Q. So are you familiar with Vermont standards for rate approval?
A. I am.
Q. And we'll go over these very quickly. We will not ask for examples. In your professional opinion, are the rates as filed inadequate?
A. No, they are not inadequate.
Q. Are they excessive?
A. They are not excessive.
Q. Are they unfairly discriminatory?
A. No.
Q. Are they reasonable in relation to the benefits --
A. They are.
Q. -- that are being provided by QHP health benefit plans in 2018?
A. Yes, they are reasonable.
Q. Do the rates as filed meet all statutory standards?
A. They do.

Q. Do they promote quality of care?
A. They do.
Q. Do they promote access to care?
A. Yes, they do.
Q. Are they fair?
A. They are fair.
Q. Are the rates affordable?
A. I've testified that these rates are designed to return a 2 percent CTR, which is what is required to maintain our solvency at an adequate level. So the only way these rates could then be unaffordable is if the underlying cost of health care is unaffordable.
Q. Thank you.
MR. HUDSON: Does the HCA have any questions for this witness?
ATTORNEY KUIPER: We do. Thank you.
CROSS-EXAMINATION BY ATTORNEY KUIPER
Q. Good morning.
A. Good morning.
Q. I apologize. I'm going to be jumping around a little bit.
A. Oh, okay. I'll try to follow along.
Q. So let me start at the age demographics issue. So at Tab 6, Question Number 2 in response to questions from the HCA that went through L&E, you, we asked you

how, what you relied on to calculate your age factor, and you said that you relied on census data and information on gross domestic product growth; is that correct?
A. I'd actually like to clarify that. You didn't ask what we relied upon in making that assumption. What you asked was how we reviewed any macroeconomic data as well. So, as I testified earlier, what we relied upon was the actual experience that we're observing in the QHP population. So, to answer the question of how we reviewed macro information, yes, we answered that question to the best of our ability, and it, it appears to us that information available from public sources in Vermont points to an aging of the population as well, but, no, we didn't rely on that to make our assumptions.
Q. I apologize. I misspoke.
A. No problem.
Q. So your data, though, is, has it baked into your claims, right, your past, your past trends are baked into your claims?
A. Yes.
Q. And so, when you're projecting forward, you, we were asking what you relied on to figure out if the past trends we've seen have continued, and for that you

looked at census data, or likely to continue in the future, for that you looked at census data and gross domestic product growth; is that correct?
A. For that, again, we observed what's actually happened in our data from 2014 to 2017. So we've looked at what's happened in this market, and, in the absence of evidence that that aging is going to suddenly stop, we believe that it's perfectly appropriate to base our trend assumption on those 70,000 members and our observation of how that data has been changing over time.
Q. And, just to be clear, when you talk about aging, we are also, it also includes changes in your population. So it's not just the general fact that everybody gets older, but it would also incorporate if someone retired and left the plan if they were on a business plan and someone new was hired and someone went on Medicare, and it would incorporate those sorts of changes?
A. So I'm glad you asked that. We have a number of different metrics that we look at in terms of population change, and aging is just one of them. So we're looking at the aging of the population other than folks that are brand new and other than folks who leave. So we look at the whole variety of statistics,

and we spend a lot of time to make sure there's no overlap. So, yeah, aging is one assumption that we look at, but, yes, we also look at how changes in overall population due to terminations or due to new additions are going to impact the population morbidity as well.
Q. You stated that customers who get cost-sharing reductions -- I'm sorry. I actually meant to say that premium subsidies are inflated from the cost increases; is that correct?
A. Largely.
Q. Yes, but that's not true for your population in particular; would that be correct? If, because you are, the more expensive, you have the more expensive plans, and assuming your rate increase is already higher than MVP's, if anybody stays on your plan and they have premium subsidies, they will feel the entire increase?
A. They won't feel the entire increase, but you're right. They will, based on that calculation -- and I haven't done a lot of analysis of that, but, yes, based on that calculation, the APTC is based on the second lowest Silver plan. I could follow up, but I can't tell you right now what that second lowest Silver plan is projected to be and how that's changed from last

year to this year. But you're right. It's not necessarily based on our rate increase. It's based on the increase in the second lowest Silver plan.
Q. So it would be the -- so any differential between the MVP benchmark and your plan, the customer will have to cover?
A. Again, I'd like to follow up on that and actually do the analysis, but, yes, it's not necessarily based exclusively on all our increase; that's correct.
Q. And, when you testified about looking at past experience to review an adverse selection spiral, you looked at some examples from Vermont?
A. Yes.
Q. But you would agree with me that each one of those is very unique circumstances, unique populations with unique base costs for the premiums that they built upon, and so it's somewhat difficult to extrapolate this situation, what will happen in this situation from those situations?
A. Yeah, it is. I'm not going to sit here and say the exact same thing is going to happen, but, at the same time, we've seen no evidence of a rate increase of this magnitude leading to an adverse selection spiral in this marketplace. That was the point I was trying to make.

Q. When you talked about utilization mix, you mentioned one of the drivers has been or one of the drivers of the trend has been preventive care, increased preventive care, correct?
A. Yes.
Q. And it's been covered at 100 percent since 2014, and you had testified that you've encouraged preventive care in your population, which is obviously a good thing?
A. Yes.
Q. Yeah?
A. Yes.
Q. Would you agree with me that, at some point, that will level off, that the preventive care will not necessarily decrease, but, at some point, people will stop learning about the benefit and everybody that's going to do preventive care will do preventive care.
A. So, yes. I'm really glad you asked that question, because I do read all of the public comments, and in a lot of those public comments I see people saying that they don't go to the doctor, because of the deductible, they haven't gotten their annual checkup because of the deductible. So I think -- and I'd love for us to work with you on this. I think there's still a lot of consumer education that can take place so that people

understand that preventive visits are covered at 100 percent. You don't have to satisfy your deductible first.

It, a lot of those comments are heartbreaking for a number of reasons, but that one is, is that way as well because there's no reason why people shouldn't be going to get their annual checkup, and it's -- I'd love to get that message out there more so that everyone in Vermont or everyone in this population is getting their annual physical. There's no reason that they shouldn't because of the cost sharing.

Q. So you testified that your contribution to reserve calculation that you said you don't use a calculation, but, if you were to use a calculation, that you, that you gave an example of, your example targets the very top of your range, correct?

A. Yes.

Q. And, if you had, in that calculation, set targets mid-range or at the low end of the range, your results would have been lower?

A. That's correct.

Q. You also testified that, that you needed to, one example of why you needed to target or why it's good to target the upper end of the range is for things that could happen in the future such as the federal

government defunding CSR, and you mentioned it could happen this year, correct?

A. Yes, but let me be clear. The only reason that we show the illustration at the top end of the range is because we're not allowed to say what our current RBC is. If the law were different and I could say what my current RBC range, that's what I would illustrate, but I can't do that.

So I testified to the answer at a variety of points. The illustration says 700. I testified that at 500 it's 1.2 percent, at 600 it's 1.5 five percent. So I have to pick a number because I'm not allowed to disclose what the actual number is. It's just that simple. So we're not trying to increase our RBC to 700 percent. We're trying to stay within our range of 500 to 700 percent. A 2 percent CTR, 2 percent return -- and I, I would like to see an actual 2 percent return at some point -- would be a number that allows to us to stay within that RBC range. So that's what we filed. It's not an effort to get to 700. It's an effort to stay within the range.

Q. One example you gave for the need for a stronger RBC number is the cost insurance subsidy unknowns related to cost-sharing reductions on the federal level?

A. Yeah, that was an example of potential adverse effects. There are -- I could list you another dozen, but, yeah, that's one thing that could happen that, barring state intervention, would require us to dip into reserves in order to pay for that because we would continue to cover those people.

Q. Okay. But, just to be clear, you've stated that you did not, that, when you filed your rates -- Blue Cross stated, when they filed their rates, that they did not consider potential changes on the federal level, correct?

A. That's right.

Q. So that actually wasn't something that you'd considered when you set your CTR level?

A. That's right. That, that was, that was not part of this rate calculation.

ATTORNEY KUIPER: All right. I have no further questions.

MR. HUDSON: At this point, I'd like to open it up to questions from the Board.

MS. LUNGE: Shall I start?

MR. HUDSON: Go ahead.

MS. LUNGE: Hi, Paul.

MR. SCHULTZ: Hi, Robin.

MS. LUNGE: So I have some questions that I

think are more appropriate to Ruth, so I'm going to hold those. If any of the questions I ask you are really more appropriate for Ruth, just defer them. That's great.

MR. SCHULTZ: Okay thank you.

MS. LUNGE: Just to follow up on a couple of the trend questions, so in terms of the preventive care trend -- and, again, this may be one to defer -- what have you done to promote preventive care to your members, or what do you plan to do in this next plan year to promote the preventive care?

MR. SCHULTZ: That's a good one for me to defer to Ruth.

MS. LUNGE: Okay. Great, thank you. In terms of the dental trend, when would you expect the new benefit uptake in utilization to subside in general? Like, if you were looking at sort of new benefits in general, when would you expect that to subside?

MR. SCHULTZ: That's a good question. I would -- so, a lot of times when we're looking at that, it's in an employer setting, and employers are able to communicate with employees and really get the message out there.

MS. LUNGE: Sure, yeah.

MR. SCHULTZ: And, again, speaking back to the question that I fielded a little bit earlier about preventive care, it's a similar thing here. I think we, we collectively can do more to raise awareness of what these benefits are. So, in this particular setting, I guess it's different from a typical employer setting. I think it might take another year or two. I'm sure we will eventually see a tail-off in what that trend is. It's still a little bit discouraging that the, that the utilization of that benefit remains so far below what the national expert thought it was going to be based on other similar populations. So I just wonder about that. Is it, are we not -- you know, more utilization there is a good thing. We want kids to get their checkups.

MS. LUNGE: Sure, absolutely.

MR. SCHULTZ: And so can we be doing more to kind of make people aware of that benefit and promote it? And I think we should look at that.

MS. LUNGE: Okay. And have you looked at the percentage of kids in the QHP plans that are using the benefit compared to the total population?

MR. SCHULTZ: We have. I don't have that number in front of me, but I can get that to you for sure.

MS. LUNGE: Okay, thank you. In terms of the adverse selection spiral and the analysis you did on the two points, when you looked at the individual market and saw those increases in the 12-plus percent range --

MR. SCHULTZ: Yes.

MS. LUNGE: -- at what point in time was that in relationship to Catamount?

MR. SCHULTZ: That was pretty early on. So that was, that was in, like, the late 2000's, 2007 or 2008 when there was one instance of a 20 percent increase there.

MS. LUNGE: Okay. So that was actually after Catamount, because Catamount was in 2007.

MR. SCHULTZ: Oh, I'm sorry. Okay.

MS. LUNGE: Okay, thank you. I was just curious to see how that data might have correlated with policy changes. Because, of course, when Catamount was introduced, that, part of that policy was meant to protect against adverse selection spiral in the individual market. So I, I was just trying to understand that in the context of my historical knowledge of the policy.

MR. SCHULTZ: Okay.

MS. LUNGE: In terms of the cost-sharing

reduction calculation, you, you had calculated that, if the cost-sharing reductions are not funded, that that would have an impact of 1.9 percent across the market of your, in your plan?

MR. SCHULTZ: Yes.

MS. LUNGE: Did you also look at the impact on Silver only?

MR. SCHULTZ: We did not, and I think the, I think the point we want to make here -- and I think Lewis & Ellis said it well -- is that Vermont is, again, a very unique environment. So we have to worry about small group because of the merged market as well.

MS. LUNGE: Yes.

MR. SCHULTZ: So there could be some really kind of strange impacts of putting it all in the Silver plan when you consider small group as well in terms of people changing plans and things like that. So that could get to be a pretty detailed analysis, and we would prefer to talk, to work with stakeholder groups to come up with what the right solution is in Vermont kind of before we delve into doing that analysis.

MS. LUNGE: Okay, thank you. And when you -- does 1.9 percent include an assumption about the Vermont cost-sharing reduction program, and, if so, what is your assumption?

MR. SCHULTZ: The 1.9 percent was only for the federal program. So we made -- we assumed that Vermont would continue as it is.

MS. LUNGE: Okay, great. I think I had one more question about the capitated claims. So that was referred on Page 9 of the actuarial memo. Could you explain -- I think you explained in your supplement why you had targeted that to 100 percent of fee-for-service, and that's because it's primary care?

MR. SCHULTZ: Yes, it's primary care. So the reason that we target 100 percent with that capitation is to try to promote the panel management that's going on in those doctors' offices. So we're not looking to penalize them. We are looking, in fact, to make sure that they're able to be effective with what they're doing. So I'm actually involved. Every couple of years, we do take a look at what's happened with that capitation versus the actual fee-for-service claims to make sure that's still running at about 100 percent of fee-for-service.

MS. LUNGE: Okay. So the purpose, then, of truing that up, so to speak, is both to promote the primary care as a benefit and also to add some flexibility for providers; is that right?

MR. SCHULTZ: I think that's a fair way to

say it, yeah.

MS. LUNGE: That's my questions.

MS. USIFER: A couple questions. You talked about how you're limited on what you can do with hospital budgets and, you know, negotiations because of, you know, things that the Green Mountain Care Board has implemented. What about pharmacy costs which are, you know, really driving up? I mean, what programs are you guys doing both in Vermont and then leveraging, you know, nationally through Blue Cross Blue Shield to really offset some of the increases in pharmacy which are really driving costs up, and are there any things that maybe could be implemented further in the rates this year?

MR. SCHULTZ: It's a good question. I think Ruth can speak a bit more to some of the clinical programs. In terms of the, the cost of the benefits, we are always looking for ways to reduce costs. I testified that there was a 0.6 percent premium reduction because of a formulary change that we made in order to provide significantly more rebates. We also have discounts that are improving based on our contract with our Pharmacy Benefit Manager. Every three years we go through an RFP process or, at the very least, a market check to make sure that we're getting

best-in-class pharmacy discounts and pharmacy pricing. So we, we work with the PBM to make that happen.

In terms of clinical programs, we do have a number of those in place, and I'm sure Ruth can provide a lot more detail than I can, but we do have utilization reviews to make sure we don't have adverse reactions in lots of programs like that. So I'm sure Ruth will field that better than I just did.

MS. USIFER: And, just on the reserve calculation with the 2 percent, I mean, you seem to have a pretty strong policy to maintain that 2 percent rate until you exceed, you know, the 700, and I know you can't talk about where you are, you know, within that range. But do you take into consideration at all the overall increase that's occurring, you know, when you look at the 12.7 percent increase and the pressure that's, you know, putting on the increased rates year over year to even consider whether there's any room to do that?

MR. SCHULTZ: That's a good question. We do. We think about those things in speaking with senior management about what we're going to file for, and we, we believe it's important this year, especially on the heels of an $18 million loss on QHP business in 2016, to make sure that the rates are fully funded and to

kind of stabilize where we are within our RBC range. So, yeah, we do talk about those things, sure.

MS. USIFER: And the last question is, On your, you know, IBNR, you know, since the filing, has there been any new news on, you know, what's coming in for those claims and what you're accruing and any changes on maybe your thoughts there?

MR. SCHULTZ: Yeah. So we included that in the -- that's Exhibit 17. So it was our response to Finding 1. So you can see a chart on Page 2 of that exhibit, and that shows that from February, from the estimate as of the end of February to the estimate as of the end of April, total claims went down by 0.12 percent. So they did restate slightly downward, and we have a four-year history on that chart that shows that over those four years the total restatement is 0.00 percent. So --

MS. USIFER: Okay, thanks.

MR. SCHULTZ: Sure.

MR. HOGAN: Good morning.

MR. SCHULTZ: Good morning.

MR. HOGAN: Thanks. You may have to do the same thing you're doing for Robin if I'm asking questions that someone else should answer.

MR. SCHULTZ: Okay.

MR. HOGAN: I want to chase a little more on this adverse selection spiral. Round numbers, MVP has about 10,000 people in this program, and you have about 70,000.

MR. SCHULTZ: Yes.

MR. HOGAN: That's about 14 percent, so it's not a tiny number. If MVP is correct in its assessment that they will increase that number by 50 percent, that brings, if they are successful, that brings their number to 21 percent of the total population covered.

MR. SCHULTZ: Sounds right.

MR. HOGAN: Doesn't bother you?

MR. SCHULTZ: Well, sure it bothers me. We're in a competitive environment. We want to put out -- we want to have the most affordable rates possible.

MR. HOGAN: No, but what I'm saying is that as it relates to the adverse selection spiral.

MR. SCHULTZ: Thank you for refocusing me. As it relates to the adverse selection spiral, no, I don't. If they were able to take, to grow by 50 percent, that would be about 8 percent or so of our membership. Because of risk adjustment, if the people they're taking are the healthiest members, I don't think that's going to have any impact on rates. Obviously, we don't want to see any members walk out

the door, but if that happens, no, I don't think that will have an impact on Blue Cross Blue Shield's rates that will lead to an adverse selection spiral, absolutely not.

MR. HOGAN: I'm thinking even beyond rates. I'm thinking about the future of the company.

MR. SCHULTZ: Sure. We, so this is a difficult question for me to answer because I can't speak to MVP's filing or why they're filing the increases they're filing. What I can speak to is the experience that we see in holding that large portion of that block of business. My job is to come up with the right rates, and that's what I've done to the best of my ability.

MR. HOGAN: All right.

MR. SCHULTZ: Why MVP's are lower is something that you'd have to ask them, you know?

MR. HOGAN: Okay. RBC, I want to be careful here because of the rule.

MR. SCHULTZ: Thank you.

MR. HOGAN: But I think I can say that in '16 you had an 11 percent reduction in RBC. That's not the number, but that's --

MR. SCHULTZ: That sounds correct, yes.

MR. HOGAN: Okay. What will -- and, again,

we don't know the results of '17 yet, but if you suffered another 11 percent reduction in that, without exposing the number, where would you be?

MR. SCHULTZ: I'm doing some quick math in my head. We would still be within our target range, and that might be as much as I can say.

MR. HOGAN: You might want to retake another look at that.

MR. SCHULTZ: Okay. Yeah, we won't be comfortably within it. I think I can say that much.

MR. HOGAN: Yeah. I've been fortunate in my life to run three big organizations and done pretty well with them, and in every budget I ever submitted there was a 1 percent reduction for efficiency. Now, I've raised this a couple of years ago and didn't get anywhere with it, but why would not an efficiency number be an important part of your budget planning?

MR. SCHULTZ: I'd say that it is, and I think Ruth is prepared to speak to what we've done with our admin over the last several years.

MR. HOGAN: Okay, okay. Could you be more clear about the savings in care management? It's a tough one, I understand that, but, basically, that you had several savings.

MR. SCHULTZ: Right.

MR. HOGAN: How do you know that? What were those savings?

MR. SCHULTZ: So that's a very good question. For, I would say that, for what I do for most of these programs that are already in place, it's really difficult to kind of parse out of experience the impact of a particular program, but what my testimony was trying to get at was that it's in there. It's part of the experience. So it's part of my starting point for my projection. It's already dampening trend. So that leads to my choice of a trend selection. So I think that's how I would answer it. I would say it's very, very difficult to say, This program is worth this amount, but for all of those programs that, that's all reflected in the experience that I used to make my projection.

MR. HOGAN: And that experience is what?

MR. SCHULTZ: That experience is the, is the claims experience of the 70,000-plus members that we have in the QHP block.

MR. HOGAN: How do you calculate that?

MR. SCHULTZ: Specific to the clinical programs?

MR. HOGAN: Um-hum.

MR. SCHULTZ: So, yeah, we don't -- I don't,

or I have not explicitly calculated the value of those programs, but because those programs exist, they're part of the overall claims cost. If none of those programs existed, claim costs would be higher. I'll give you an example. So we have fraud, waste, and abuse programs at Blue Cross. They saved about, I believe the number is 1 percent of claims costs in 2016 were recovered by our fraud, waste, and abuse programs. So we know that fact. We know that it's in the --

MR. HOGAN: That's clear. That one's pretty clear.

MR. SCHULTZ: So that's one example. I think Ruth has some others. I'm not sure if she'll be quoting numbers at you for savings, but that's one that's a little easier to measure.

MR. HOGAN: Okay. The hospital, total medical hospital expenses, and I take this off the companywide balance sheets --

MR. SCHULTZ: Okay.

MR. HOGAN: -- okay? Not this program in specifically, but those numbers since 2012 have gone up 10 percent -- I'm rounding -- 38 percent; 12 percent; and then in '14 down to 7.1 percent; '15, 13.5; and '16, 6.6. These are big numbers. Does this speak to the ability to negotiate with the hospitals on these

numbers? Because these numbers are really driving a lot of what we're looking at today.

MR. SCHULTZ: That's, that's true. Those numbers are also influenced by our volume of business.

MR. HOGAN: Yeah.

MR. SCHULTZ: So you're looking at total claims. We have had some volume increase over that time period.

MR. HOGAN: You haven't had companywide volume for the last two years increases? They've been steady?

MR. SCHULTZ: Yes, yes. So those trends, those numbers which, which do speak to medical trends, medical increases, they're driven by a number of factors that I think I've testified to. One is certainly the hospital budgets, but I will say as well that the Green Mountain Care Board has done a very good job of asking hospitals to tighten their belts and have a lower net patient revenue increase. That sometimes does and sometimes does not --

MR. HOGAN: That's the first compliment we've gotten in six years. You mentioned the commercial insurance rates. Do you have a sense of them over time?

MR. SCHULTZ: Specific to the hospitals?

MR. HOGAN: No, specifically to your work.

MR. SCHULTZ: To my work? Yes, I do, sure. So I'm trying to think of -- you're thinking about what are the increases over time?

MR. HOGAN: Yeah, right.

MR. SCHULTZ: How have they been increasing?

MR. HOGAN: Yes, yes.

MR. SCHULTZ: So we've seen for the QHP population specifically, which is a, which are the huge, very credible book, that we've been kind of in the high single digits for the last several years. This year, if you take out the increase in federal fees, we're again in the high single digits. So that's been fairly consistent and over the last four years, at least, and that, that's what I've seen.

MR. HOGAN: May I come back later for a second round?

MR. HUDSON: Okay.

MR. HOGAN: Thanks.

MR. HUDSON: Yeah, if we can get everyone.

MS. HOLMES: Okay, thank you. Thank you very much for very clear testimony and a very clear report. Much appreciated.

MR. SCHULTZ: You're welcome.

MS. HOLMES: It's tough to be in the hot seat

for --

MR. SCHULTZ: I don't know either.

MS. HOLMES: -- a half hour. It's been flying by.

MR. SCHULTZ: It's flying by, yeah.

MS. HOLMES: But so I do have some questions. In Exhibit 1 where you talk about the 2.1 percent that's related to the aging of the population and family size, so 2.1 percent adjustments for both aging and family size, I just want to get some clarity on that, that 2.1 percent, because I thought you heard you say in testimony today it was 1.9 percent for that combined aging families. So I, first of all, wanted to get that clarified.

MR. SCHULTZ: Would you mind pointing me to the 2.1 percent?

MS. HOLMES: The 2.1 percent, I have it on Exhibit 1, Page 4 on the binder of Page 12 if that helps. Sorry. The last bullet.

MR. SCHULTZ: Oh, right, yes. So the 2.1 and then the two bullets after that we have a negative 0.2, and I, to get to the 1.9, I just kind of lumped them together.

MS. HOLMES: So let me -- so, digging a little bit deeper into that, I also thought I heard you

say that the aging factor, which I know has been a bone of contention issue here, I thought I heard you say it was .5 percent was related to the aging of the population.

MR. SCHULTZ: That's right. So it's .5 percent per year. Our experience period is up to '16. So two years of that gives you a percent.

MS. HOLMES: Okay. So, I guess, part of me is trying to back out the family sizing part, because I was surprised to see that given our fertility rate decline, our -- you know, I'm trying to figure out what is family size driving if we know fertility rates are declining? In fact, Vermont has one of the lowest fertility rates in the country. So what is that piece?

MR. SCHULTZ: I'd like to think that it's families choosing Blue Cross because that they know we can be counted on to be there for them. But the answer is looking at our specific population, comparing our population in 2016 to what we know about our population at the time of filing in 2017. Vermont has set tiers, all right? So a family is going to be in that set tier no matter what, whether you have 2 kids on that or 22 kids on that.

So, as family size increases with a set tiering set of tiering factors, it can lead to an increase in

rates. If it goes the other way, we would find the opposite. So this year from 2016 to 2017, it was kind of just a pure measurement. We didn't assume that that would continue. That's kind of a one-time thing, and it really oscillates from year to year, but what we know about our current population is that it has a high family size, and because of the set tiers, that has an impact on the rate.

MS. HOLMES: Okay. Thank you for that clarification. In terms of the areas that are outside of Blue Cross Blue Shield and MVP's control, one is the federal insurance fee that's now been reinstated.

MR. SCHULTZ: Yes.

MS. HOLMES: And I'm not sure if you can exactly speak to this, but your estimated federal insurance fee is quite a lot higher than what MVP submitted, and I'm just trying to figure out, since that's out of your control, what is the basis for which your estimate was relative to -- I know it's hard to talk about it in the filing, but I was struck by that.

MR. SCHULTZ: Yeah, we were struck by that too. So we looked into it, and MVP, as it turns out, is a 501(c)(4) corporation, which is treated differently from both a federal tax perspective and from the perspective of this insurance tax. So they

get an automatic 50 percent reduction of what the calculation is to on their other lines of business that don't meet this. You can see that they calculated a 2 percent insurer fee. For this line of business, it's 1 percent because of the 50 percent reduction.

The rest of it is federal taxes. We do pay federal taxes. The health insurance tax is not tax deductible. So, in order to collect the same amount that we have to then send along to the federal government, we have to gross that up for taxes. So that gets us from the 2 up to the 2.6.

MS. HOLMES: Okay. Perfect, thank you so much for that clarification. To build a little bit on Member Hogan's question about the potential loss of market share that may emerge from the different rates, different carriers --

MR. SCHULTZ: Yes.

MS. HOLMES: -- I'm wondering how, if there is indeed a substantial migration from Blue Cross Blue Shield to MVP, how does that impact your need for reserves, for example?

MR. SCHULTZ: That's a good question. That would reduce our need to reserves if we see that kind of migration.

MS. HOLMES: And that would not have been

part of the calculation that you would have done for the filing because you, of course, wouldn't have seen, right?

MR. SCHULTZ: Exactly.

MS. HOLMES: Another question was actually with respect to the hospital, the calculations of the unit trends with respect to -- you know, I understand you took the hospital budget orders into account --

MR. SCHULTZ: Yes.

MS. HOLMES: -- particularly the April budget orders, and I notice in this updated version which has the updated submissions, I just want to make sure to clarify whether -- there was one particular hospital, Copley, which we adjusted downward in January by about 3.7 percent for some subset of services. I'm wondering if that is anywhere. I know it's one hospital amongst many, but I was wondering if that was factored in.

MR. SCHULTZ: Yeah, I will verify that. I'll make sure that that was in there. But, yeah, I think L&E has done a lot of work to make sure that we were able to translate correctly from the budget orders to the unit costs.

MS. HOLMES: Okay, great. And my last question is sort of a little bit of a bigger picture question. How do you address, in particular, specialty

drugs? We've been hearing about specialty drugs, and, in fact, I think you said it was half of the unit cost trend was coming from pharmacy, and we know that drugs are a big driver of costs.

MR. SCHULTZ: Yes.

MS. HOLMES: And I'm wondering, for example, how you account in your overall costs, expected costs, the net impact of new technology. So we know, when a drug comes online, that it can be extremely expensive, but it may be replacing a more costly alternative, you know, of care. So, for example, just, there were a couple of drugs that you broke out specifically. There was that new MS drug, the multiple sclerosis drug.

MR. SCHULTZ: Yes.

MS. HOLMES: And one of them was just recently approved in March of '17, and one of the interesting things when I read about it in the news was that they were potentially going to disrupt the market, and, in fact, they were coming in at a cost that was 25 percent less than what the cost of the next best available alternative was, and, in fact, there was some speculation that that entry into the drug market was actually going to depress all prices for multiple sclerosis drugs.

And so I'm wondering -- you know, and then I know

Sovaldi was the other drug that we've heard about for several years, but one of the interesting aspects of that is that it's very expensive for that first year, but then it cures hepatitis C potentially for 90 percent of patients, and then it reduces the long-term costs of, you know, having people on maintenance drugs for hepatitis C that prevents expensive liver transplants that are much more expensive than the antirejection drugs.

I guess I'm just -- how do you account for the fact that some of these new interventions have actually saved payers, are suspected to save payers money?

MR. SCHULTZ: That's a very good question, and we -- so this was potentially hard to find because it's not in the specialty drug section, but, for the MS drug in particular, we very explicitly took that into account. So, if you look on Page 19 of our memorandum, it's Page 27 of the binder that's within the medical unit cost section, and here we speak about Ocrevus, which is the new treatment for multiple sclerosis, and we included a reduction on the medical side of the cost that's expected to be replaced by the introduction of this new specialty medication.

So that's one where we were very explicitly able to make the change. Some of them have other longer

term impacts, and that will make its way into experience over time, but where we have the information and we're able to make the explicit adjustment, we do so.

MS. HOLMES: In fact, this, actually, the introduction of this drug, to some degree, if you net both out, should have a reduction in the premiums, right? You're taking those 18 people that were on the higher cost alternative drug and you move them into the lower cost drug, that should actually net out to be a reduction?

MR. SCHULTZ: I would have to do the math on that in terms of our assumptions, but yeah.

MS. HOLMES: I know it's a very small slice of it, but my expectation would be, once we get it out, it should actually lower it.

MR. SCHULTZ: Yeah. I can follow up specifically on that example, but that --

MS. HOLMES: Okay. But in general --

MR. SCHULTZ: Yeah, we see medical costs going down, and then we see medical costs changing and pharmacy costs. So where we have that information, we'll change both of them if there's a replacement therapy or something like that.

MS. HOLMES: Okay. I think that is -- let me

just make sure, but I think that was, takes care of some of my questions. Thank you.

MR. SCHULTZ: You're welcome.

CHAIRMAN MULLIN: So, following up on that discussion on prescription drug utilization, you talked about your company's efforts to try to help providers understand the different cost alternatives that are available and what efforts you have made to try to lower the cost of those drugs?

MR. SCHULTZ: If I may, I'll kick the first part of the question over to Ruth to speak to those programs. For the second part, in terms of lowering the cost, we do that through negotiation with our Pharmacy Benefit Manager.

CHAIRMAN MULLIN: And do you have a shared savings arrangement?

MR. SCHULTZ: We have begun negotiations to enter into shared savings arrangement or to enter into shared savings arrangements with manufacturers, yes. We're working with our PBM on those sorts of things right now. We haven't implemented that yet, but that is something that's on our horizon.

CHAIRMAN MULLIN: So, currently, what are the arrangements as far as the savings from the rebates or the discounts?

MR. SCHULTZ: Yes, and the rebates we pass through 100 percent to the, to the premium rates. The discounts we negotiate to see continual improvement in discounts from year to year. We're aiming for best-in-class pharmacy contracts.

CHAIRMAN MULLIN: Is there any situation where the consumer paying the out-of-pocket costs for their drugs would actually be paying more than what the ultimate price is for that drug after the rebates and discounts?

MR. SCHULTZ: No. Well, after discounts, no. Rebates happen after the point of sale. So they come in much later, and those get reflected into the premium rates. That's not -- rebates aren't the point-of-sale transaction, so it's kind of separate from the process, but they never pay more than the, than the discounted cost of the drug that we've negotiated.

CHAIRMAN MULLIN: Do you believe there are situations that could occur where they're paying more after the rebates were factored in?

MR. SCHULTZ: That's a good question. I, I'd prefer to get back to you on that. I think, if you look at, because rebates are after the fact, I, I don't know that it's impossible that that's happening, but it's, it's really the difference between, Do you

consider that -- if you consider that the point of sale, then it would be each individual that is paying an amount and getting a rebate on it versus, since rebates are after the fact, those rebates go into the overall premium calculation so everybody's paying a little bit less in premium because of the rebates that come in. But, since they're not a point-of-sale transaction, I'd have to go back and look at some examples to see if that might be the case, but it's, rebates just aren't calculated at that point of sale.

CHAIRMAN MULLIN: Okay. Can you turn to Exhibit 16?

MR. SCHULTZ: 16, yes.

CHAIRMAN MULLIN: Your testimony this morning was that, after you recalculated for submissions, that you believe that the hospital cost trends were higher than you anticipated?

MR. SCHULTZ: Yes.

CHAIRMAN MULLIN: And that kind of surprised me. Could you talk a little bit more about that?

MR. SCHULTZ: I can't tell you a whole lot more about the hospital budget submissions, but I can tell you our process was to just go into those submissions, which included the references on this page of where we found the commercial rate increases, and

we, we quite simply took those commercial increases and replaced our assumptions with this information, and that, that did drive that higher number.

So I think what that means is, in most cases, I think that means that you have some hospitals that, that increased what they filed for over what they filed last year. Where we started was we assumed it would be the same number as it was last year, as what was ordered by the Board last year. We then changed that or updated it for information that we thought the hospitals were going to file based on what our provider contracting folks spoke about with them, and we did find at least one case where they filed something higher than what they may have indicated to us they were going to file.

And I can't go hospital by hospital, but I'm not sure that the hospitals who were ordered in April to file specific commercial rate increases, I'm not sure if they necessarily all followed that to the letter, and I'm sure they have reasons for that, and it will be interesting in the hearings to go through that, but this was just a mechanical process to say, What did they file? We pulled that out. We put it into our spreadsheet, and the answer was higher than what we had filed.

CHAIRMAN MULLIN: So, when the average Vermonter reads in the press that the largest percentage of covered lives for a hospital service area would be the UVMMC network and they have such a small increase in their budget.

MR. SCHULTZ: Yes.

CHAIRMAN MULLIN: So you were anticipating that minimal increase?

MR. SCHULTZ: Yes, we were. That was part of the April budget hearings and the orders that their commercial rate increase should be 0.72 percent. That does appear to be what they filed. That was anticipated in our unit cost assumption, yes.

CHAIRMAN MULLIN: Okay. So in your testimony this morning, you were asked, I believe, by the attorney for the HCA a question about affordability, and I think you, if I can paraphrase your answer, I think what I heard you say is that the only way that your proposed rate request is unaffordable is if the underlying costs of health care in the system are unaffordable. Did I hear that correctly?

MR. SCHULTZ: You did.

CHAIRMAN MULLIN: Okay. Do you believe that you have an important role in trying to make sure that systemic health care costs are kept to as small amount

as possible while still making sure that consumers get the best care possible?

MR. SCHULTZ: I certainly do, yes.

CHAIRMAN MULLIN: Okay. So, with that statement that you made this morning, who do you think has dropped the ball as far as containing costs?

MR. SCHULTZ: That's a provocative question. I think there are -- so I went through the reasons for rate increase, and there are a number of them. We know that pharmacy is a very significant contributor. Those costs continue to escalate. Some of that is for new specialty drugs that can be life-saving, and that's great. I don't think that's necessarily true of all pharmacy spending. So I think pharmacy is one place where we have --

CHAIRMAN MULLIN: So in that what have you -- what has your organization done to help better educate providers on what the best cost alternatives are?

MR. SCHULTZ: Again, I think Ruth can speak to that, but we do have a formulary. That formulary is developed for primarily clinical reasons, but we also look to, if two drugs are similarly effective, the drugs that are more cost effective in addition to that will be on a lower tier of the formula. So it's a fairly typical way of doing that, but that's certainly

a large amount of what we do.
CHAIRMAN MULLIN: Okay. Do you think you could be doing more?
MR. SCHULTZ: I, I would welcome the opportunity to work with various stakeholders to continue to develop means of payment reform and health care reform. We're, Blue Cross is very committed to those initiatives, and, yes, we, as a state, can do more. We, as Blue Cross, look forward to being part of those efforts, absolutely.
CHAIRMAN MULLIN: Okay. This morning you answered several questions about the financial health of Blue Cross and Blue Shield, and because of the confidential nature, you have to be careful how you walk that dance. Yesterday I think you were in the room for your competitor's hearing.
MR. SCHULTZ: I was not. Some of my colleagues were, but I was not.
CHAIRMAN MULLIN: Okay. So they seemed to focus on a different measurement of financial stability, not the RBC, but rather a measure which is basically reserves for premiums --
MR. SCHULTZ: Yes.
CHAIRMAN MULLIN: -- which was roughly about half of what, if I'm doing the math correctly -- maybe

you could help me, but I believe that, if we did that for Blue Cross Blue Shield, it would be about 24 instead of 12 for MVP.
MR. SCHULTZ: I'll have to take your word for that. I haven't looked at MVP's numbers, and I haven't looked at our numbers on that metric either.
CHAIRMAN MULLIN: Do you think RBC is the only metric that should be used for financial liability?
MR. SCHULTZ: No, absolutely not. I think a variety of metrics should be used and are used, especially by DFR, who is our primary regulator when it comes to solvency measures.
CHAIRMAN MULLIN: Thank you. That's all the questions I have.
MR. SCHULTZ: Thank you.
MR. HOGAN: I just had one. You must have seen earlier that you were going to have a big rate increase.
MR. SCHULTZ: Yes.
MR. HOGAN: If, for nothing else, the feds pulling out. Why did you give a rather large raise when you knew that you were going to have difficulty with rates this year?
MR. SCHULTZ: I don't -- I'm sorry.

MR. HOGAN: You gave a 3 percent raise to employees.
MR. SCHULTZ: I, well, that's above my pay grade. So I'm -- I will defer to our CFO on that one.
MR. HOGAN: Whoever can answer it, I'd love to hear it.
MR. SCHULTZ: I'll defer to Ruth on that one.
MS. LUNGE: And, again, feel free to defer to Ruth. So, related to payment reform and health care reform, as I'm sure you know, we're also looking at Accountable Care Organization budgets including OneCare, Vermont's, which I understand the contract is still outstanding and you are all negotiating that, but I had a couple of questions about how you would see, at least theoretically, that sort payment reform effort impacting on trends in the future.
Understanding that it hasn't happened yet so it's hard to predict for 2018, but, moving forward, how you might reflect that in your filing around both trends in hospital-specific trends and/or unit costs, which, of course, would be different because you're not going to be, with a capitated payment to hospitals, you're not going to be looking at unit costs and utilization. You're going to be looking at trending in capitated rates. So I wanted to get your thoughts briefly,

because I know we have timing issues on how that might be reflected in the report.
MR. SCHULTZ: Yeah, gosh. So I can, I can tell you a few things. One is we've had shared savings initiatives in place with ACO's for the last several years, and the ACO's, we haven't seen any savings generated from that. So that, that informs our decision to not include any savings in the 2018 filing. Down the road will there be savings? We sure hope so. That's why we're embarking on this initiative. We believe it will be successful.
It's a, one thing to think about is it's a difficult thing in terms of what we put in the rates and what we put in the target for the ACO's. We've drawn a very strong correlation between rates that are approved, our rates that are approved by you need to inform directly the targets for the ACO's, so it's important to think about how that plays together.
If we start reflecting savings before the experience shows that savings, you're lowering the target and making it difficult to generate the savings, so you're kind of preventing the ACO from sharing in anything. So we just have to be cognizant of that fact. We do think it will help to lower the cost of care eventually and that will play its way into

experience and into trends and dampen both of those over time.

MS. LUNGE: So, specifically in -- I believe at least the ACO information that we have indicates that there's a potential that there would continue to be a shared savings component in the negotiation where within their risk order they would share any savings with you. Presumably, that savings would then be reflected in a premium factor in the future?

MR. SCHULTZ: Oh, yes, absolutely. Any, any sort of savings that we see, whether it's an ACO environment or not, if utilization is reduced, that is absolutely reflected in trend in premium rates the following year, yeah.

MS. LUNGE: And then just my last question on that is, How would you see capitation for, in a hospital system being different from the capitation that you currently use in a primary care?

MR. SCHULTZ: That's a good question. I believe that the negotiation, the negotiations at this point, what I understand is that that's going to be more a question for the ACO's relative to the hospitals. I believe we'll be dealing with the ACO's, and how they pay the different providers, and divvying that money up is going to be up to them, I think, for

the most part. So that's my understanding of the situation. As to how those rates will be set and so forth, I really can't speak to that today.

MS. LUNGE: Okay, thank you.

MR. HUDSON: Hearing no further questions, thank you, Mr. Schultz.

MR. SCHULTZ: Thank you, Mr. Hudson.

MR. HUDSON: So I have a request from the table for a brief five-minute recess. Hopefully, we will reconvene as soon as possible.

(A recess was taken from 11:22 a.m. to 11:30 a.m.)

MR. HUDSON: Good afternoon, everybody. We're about to start the hearing.

ATTORNEY HUGHES: I'm going to call Ruth Greene.

MR. HUDSON: If I could just make one quick announcement. Good afternoon to all the members of the public who have shown up since the hearing started. Welcome. Thank you for coming. Also, a lot of very technical testimony happening in this hearing today, and there is a lot more to come. We very much appreciate your patience as we go through it and also appreciate you being here and focusing on this hearing and all the testimony. We really do appreciate it.

I just wanted to announce that we do have a

sign-up sheet for the public comment section of this hearing. If there are a great number of public commenters, which there may well be, that sign-up sheet will decide the order of the commenters. We will be having also a public comment section next Thursday at the Green Mountain Care Board on the second floor Board Room from 5:00 o'clock to 7:00 o'clock as well.

I am targeting a 3:00 o'clock start time for the public comment section, and I am targeting a 12:15 start time for our lunch recess. We'd very much like to get through the next two witnesses by lunchtime, and so that's a provisional schedule. I want to put out there I would appreciate all parties working diligently to cross-examine and question judiciously as we move through this next portion of the hearing. That applies to the attorneys and to the board members.

So, that said, Attorney Hughes, you've called your next witness, Ms. Greene. In prehearing we were scheduled to hear from Ms. Greene about solvency issues primarily, but keeping in mind that we've heard a great deal about that from Paul and we are expected to hear more about that from DFR and the Board questioning has already set up a robust menu for Ms. Greene to testify on some similar, but not necessarily the same issues, if we could limit the testimony at this point to those

issues, that would be much appreciated.

ATTORNEY HUGHES: And Ms. Greene is our CFO, so any financial questions do properly belong with her, and we will try to adhere to what you just said, but there are some things that Ms. Greene has superior knowledge about Blue Cross and its financial condition, and so we would probably try to be as brief as possible.

MR. HUDSON: And we would appreciate it. Thank you.

DIRECT EXAMINATION BY ATTORNEY HUGHES

Q. Yes. Can you state your name for the record?
A. My name is Ruth K. Greene.
Q. And where do you work?
A. I work at Blue Cross Blue Shield of Vermont, and I'm --
Q. And sorry.
A. I'm the treasurer and CFO, and I also oversee the services operations.
Q. And is your CV in Exhibit 15, Pages 301 through 303?
A. Yes, it is.
Q. And can you briefly give us a little thumbnail of your professional experience?
A. I've been at Blue Cross Blue Shield of Vermont

coming up on five years. I have been heavily involved in all of the rate filings during that time. Prior to that, I was working in the employee benefits industry for a disability insurer, and in that role I developed rates and oversaw all aspects of the financial management of that company as I do currently for Blue Cross Blue Shield of Vermont.

Q. So we're going to jump right into the meat of it.

MR. HUDSON: That's good.

BY ATTORNEY HUGHES:

Q. What is Blue Cross doing to contain the costs of care?

A. So Blue Cross Blue Shield of Vermont, the questions earlier, I think, were very aligned with what we wanted to talk about. We've shared with the Board in the past through other forums, whether it was folks from Blue Cross Blue Shield of Vermont coming to meetings or, in fact, in our large group filing, we provided a long list of programs that we implement to contain the costs of care. I can go through those in some detail. It is available, or I can give you a reference to go through them.

But, in those documents that reside with the Board, we talk about the prescription drug programs alone saved over $20 million across our business. The

Qualified Health Plan plans would benefit from that, and that is an annual savings that we're constantly looking for ways to improve upon and increase over time with new programs sunsetting old programs that maybe aren't as effective. We also know that the medical programs over the same period or in the same context save another $20 million as a collection.

So I think sometimes it is difficult for us to describe the fullness of all those programs because it is so much a part of what we do, whether it's, you know, how we partner with providers or how we work with our Pharmacy Benefit Manager to put in programs. So I'm happy to go through some of these. There was some questions there. But, before I do that, I just wanted to make the point -- and Paul mentioned one of these statistics in his testimony -- that, when we look at the overall results achieved from Blue Cross Blue Shield of Vermont in terms of utilization results across the categories -- take inpatient utilization, for example -- our results are 21 percent below for the Qualified Health Plans, 21 percent below the national benchmark for well-managed plans.

So you have to think about where we start, and then, as we implement programs, we're constantly trying to improve on that already good starting point. It

shows up also in our outpatient services utilization. We're 8 percent below the middle care guideline which is a national average. We're 8 percent below that national average for outpatient services.

So, again, as we're looking to make sure that our members get the right care at the right time for a reasonable cost, we're constantly measuring our overall results. ER utilization is 24 percent below the national average in terms of total outcome from the Qualified Health Plan segment.

The other thing to keep in mind is, with these programs, to contain the cost of care that we can't just unilaterally implement these programs. We talked about this at last year's rate hearing. It takes a number of years and months to get a program designed and implemented in partnership with the providers. It's got to meet their needs, it's got to meet their patients' needs, and it's got to fit with what we believe is all important quality, access to quality care.

So I just want to remind the Board that this is a big part of what we continuously do and have been doing, and then, when we develop a rate -- Paul's done a nice job of explaining how the results of all of those strong utilization results and cost savings get

into those starting points for the claims experience and into the trend projections.

So that, that's the high level. I am prepared, as Paul indicated, to go through some really specific program examples if the Board would like me to do that. So should I move on to the next one?

Q. I'm sure you'll get questions about the details, but you did say that the list is in the large group filing, and that was previously submitted to the Board, and so we would ask the Board to take administrative notice of that portion of the filing so that we can expedite this portion of Ruth's testimony.

MR. HUDSON: I agree. Administrative notice is taken.

MS. GREENE: And, just to be specific, it was in the, the questions and answers between L&E and ourselves on the large group filing. So, when you're looking for it, it's in that question-and-answer.

MR. HUDSON: Thank you.

BY ATTORNEY HUGHES:

Q. This is one area that I think is of particular interest to the Board as well as to Vermonters, and that is efforts in mental health. Could you talk about Vermont Collaborative Care?

A. Yes. In fact, that would be, if the Board wanted

to know about programs that we have implemented, Vermont Collaborative Care is one of my favorite to talk about because, when we look at ER visits, if someone has a mental health or substance abuse issue, the ER visits will be 50 to 60 percent higher for those folks than if it's just people who have other medical or chronic illnesses.

So we partnered with Brattleboro Retreat to train care coordinators who the same person knows about coexisting conditions, whether it's medical or mental health and substance abuse, and those folks are working with the providers to make sure that members get the right care and the right preventive services so that it prevents them from having to visit the ER, and we have had tremendous success with that, and so the statistic that I mentioned earlier about the ER utilization being so much lower than the national average, we believe that that's in part because this program's been in place for a few years.

And, as it turns out, many of those trained care coordinators work with the providers and the various care delivery folks throughout the communities to make sure that people are getting the right care at the right time, and it's irrespective of whether it's a medical issue or a mental health issue.

In addition to those care coordinators, our, our folks in the provider contracting area are very involved in hub and spoke. They're very involved in other types of mental health substance abuse activity going on throughout the state so that we can bring what we call the whole-person approach to figuring out what is the best care so that it ultimately reduces cost.

Q. And so I'm not sure whether the Board is, all members of the Board are familiar with hub and spoke. If you are, we won't go into it.

MS. LUNGE: We are.

MR. HOGAN: We are.

BY ATTORNEY HUGHES:

Q. You are? Okay, good. Is Blue Cross efficient and committed to responsible cost management?

A. I have to say an emphatic, Yes, we are. We've shared with the Board a couple of times our statistics around this. We're very proud of it. I do feel obligated to clarify that, in our May 11th presentation to the Green Mountain Care Board, we shared some statistics, and that seems to have made its way into the Health Care Advocate's actuary's report saying that it was misleading. I just feel it's really important to mention a couple of things for clarity.

We have, in fact, reduced our overall costs from

over 10 percent of premium to just over 6 percent of premium over the last eight or nine years. Some people say, Well, it's a percent of premium. If premiums go up, that's not a very impressive statistic. Okay, if that's some perspectives.

Another way to look at it is to look at the per member per month cost of administrative expenses at Blue Cross Blue Shield of Vermont, and that has decreased 25 percent over the same timeframe. So it's gone from well over $35 per member per month to almost or just over $27 per member per month. So those statistics with that May 11th presentation was, by design, intended to be a total company view, and so our commitment and obsession in a lot of ways around being efficient as a company affects all of our customers in terms of building in as low a cost as possible in developing our premium rates.

The other thing that I wanted to clarify from the May 11th presentation was that we mentioned that we compare well against industry benchmarks. The specific benchmark that I was referring to was a Blue Plan benchmark with 16 Blue Plans. It's performed by an outside entity. They spend several months working through all of the participants' data to make sure that the data's comparable and on an apples-to-apples basis,

and the result in that survey, the last survey we participated in was we were the fifth most efficient out of sixteen plans, and we believe that that's a very strong indication that we're efficient because we're a small plan and we do have the additional challenge of scale. A lot of other plans have lots and lots of members. So we continuously look for ways to be more and more efficient, but we do benchmark our results externally.

And, finally, I just wanted to speak to we have this program internally called Blue Ideas where we do challenge everyone to find more and more efficiencies, and each year, to Con's question, in our budget we include some challenges around ideas that have been identified as opportunities for savings, and some years it's about insourcing something or outsourcing something, and in another year it might be changing our staffing models for some service that we deliver, but it's a continuous process each year.

Q. So where is Blue Cross's office?

A. We're in Berlin, Vermont.

Q. And how many folks work up there?

A. We have approximately 400 people working there.

Q. And does that encompass your care management contingent?

A. Yes. So all of the care management programs that I've mentioned just now, all of the work that Paul described where we're contracting with providers, all of the service, you know, all of our members can call any time, and we have world class service. We've been recognized. All of that happens with the 400 folks, give or take, in Berlin, Vermont.
Q. So what do premiums pay for?
A. So premiums pay for -- and this gets back to Paul's earlier comment about the affordability -- and a lot of premium, in fact, 90 percent if you exclude the federal insurer taxes, goes to paying for health care for Vermonters. We, we understand and saw that someone had taken our 12.7 percent rate request and translated that to a dollar amount which is very useful. It was equated about to about $52 million of an increase that is in our rate request.
If you break down that $52 million, $13 million of that goes to this reinstatement of the federal insurer fee. So that, as Paul explained, that was 2.6 percent of the increase. $36 million of that $52 million goes to paying for health care in 2018 for Vermonters. So, if you add those two together, that's about $49 million. So the other $3 million I can, you know, break down to be a little less than a million that's

related to the contribution to reserves for members and about a million seven for administrative costs and another million, as Paul mentioned earlier, we've had an increase in the billback from the Green Mountain Care Board, and that was in that increase as well. So, when you think about the vast majority of $52 million, it's going to paying for the care for Vermonters.
Q. So Qualified Health Plan members used about $450 million in health care services in 2016; is that right?
A. That's right. Another way we thought it would be helpful to put our, into context what the premium rate pays for is by saying, illustrating that for 2016 $450 million went to pay for health care for Qualified Health Plan members, and if you break that $450 million down, one of the questions that we've had today about pharmacy it's not surprising because about $107 million of that $450 million is due to all types of pharmacy costs. That's a large number. In fact, it's higher than all of the inpatient costs that we covered for Qualified Health Plan members in 2016. Inpatient costs were $90 million.
So I think it's important, as we think about, How do we bring our collective experience and, and commitment to bear on these costs, we really should be looking at that cost of care.

Q. So is adequate rate funding for Blue Cross important?
A. Adequate rate funding for Blue Cross is absolutely important, especially on Qualified Health Plan rates. This book of business for us is, makes up more than half of our surplus protection. So, if you think about what Paul was talking about, the member reserves that are there to protect and pay for claims no matter what, over half of that is wrapped up, if you will, in the adequate funding of our Qualified Health Plan membership, 70,000 members.
Q. And, on a member basis, what is the reserve protection?
A. So, overall for Blue Cross Blue Shield of Vermont, and this was a statistic that we shared with the Board back in May, but, if you were to take our member reserves and divide it by the total members that we are servicing, it's $640, and so we, we like to put that into context because that's really, you know, one ER visit and an X-ray or two related to that is well into that ball park. So, you know, the reserves themselves might sound like a large number, but for the membership that we're covering and paying claims no matter what, it's, it's really not that huge.
Q. So what if funding inadequacies emerge?

A. So, for any insurance company and for our financial regulator within the Department of Financial Regulation, one of the important strategies or sort of foundational rules of financially managing this business is to stay financially healthy. If you get behind and you have losses and your solvency starts to deteriorate, it takes a couple of years to get rates turned around in the marketplace in order to resolve or fix a situation like that.
So it's, it's one of those things where it takes a while to turn the ship, and if you have a serious problem, what we say is you'll be in the problem more deeply. You know, you won't see it coming. It will happen, and then you've got to dig out. So that's why it's important to do everything possible to make sure that all of our premium rates are adequately funded.
Q. And did Blue Cross experience a loss in the last five years?
A. So Blue Cross has experienced a loss in the last five years. In 2016 we lost $18 million. That was about 72 percentage points of RBC which is about a third. If you think about our range of 500 to 700 percent, that loss took a third of the space in that range. Paul explained earlier that, you know, sometimes that's going to happen, and that's what we're

here for, and that's what we're happy to fund, but we do need the contribution to reserve to be steady. That's why we have the long-term assumption of 2 percent over time is to make sure that, from time to time, excuse me, from time to time, we will have those losses.

If you look at the five-year summaries a bit from our statutory, statutory filing, the five-year underwriting loss is a cumulative negative $22 million. So I believe we, I believe we lost money in three of those years and made money in two of those years.

Q. So, despite that, was Blue Cross there when its members needed access to services under their health plans?

A. Right. So, just to follow on from what Paul said, that's the nature of our estimation of premiums. We estimate what we think it's going to cost for the health care for the Vermonters that will be covered in 2018, and then, if it turns out to be higher, that's what we're there for. We pay those claims no matter what. If we turn out to be lower, in fact, the ACA has rules that, if we are much, much lower than the expected claims, the, the so-called MLR rules will require that we return some of that to policyholders.

But, as Paul testified, if we had several years in

a row where we under or overestimated the premiums, and that accumulated such that we went to the higher end of our range, we would adjust our CTR accordingly. So we're not, there is no other place that we, we put the money, so to speak. It's all in the surplus calculation and carries forward.

Q. And you used the term MLR. Can you just give the Board a --

A. Sure. The minimum loss ratio is what it's called, and what it does is it takes all the benefits that we pay for health care for the Qualified Health Plan members that are covered and divides it by the premiums that those members have been charged, and if it's, if that ratio is lower than -- I think it's 80 percent for group and 85 percent for individual. Actually, it might be the other way around. I think it's the other way around. Thank you -- then insurers are obligated by that federal law to return that money to policyholders. So we're there. If, if claims are higher, we pay. If they're, if they're way too low, then there's a mechanism for correcting for that, and that's what the MLR is there for.

Q. So that, with this rate filing, is Blue Cross intending to recoup the $22 million in losses that you talked about?

A. No.

Q. So how can Vermont lower the cost of health care?

A. So this, this is where I was thinking some of the questions asked earlier might, might be relevant. So, with 90 percent of the premiums going to the cost of health care, then that's really where we need to go, and pharmacy is one of those areas. As I mentioned, a big portion of that is pharmacy. We have existing programs in place for that, but we are also always looking for what we call step therapy, or, to the extent that there's new drugs that come out, we're constantly actively managing that.

We also work with our Pharmacy Benefit Manager and negotiate as best we can with them for the rates each time. We, we've thought a lot about what we can do to lower costs, and one of the things that I want to put across to the Board is that there's this, this tension between lowering the cost of care but continuing to provide access to quality care. So most of the programs that we implement will have an element of, How far do you go and where, where is it the right balance between making sure? Because it's always about the right care at the right time and for reasonable cost.

So we could do things like we could increase prior authorizations. That's like, you know, a lot of

providers are, you know, would be loath to hear me say that even out loud, but it is an area that we've historically gone to. We could limit access to providers. A lot of the health plans around the nation, one of the ways they get their premium costs way down is that they will actually limit the network. So you find out when you get to the doctor that, that they're not in the network. So it actually turns out to increase the cost of care for that particular member. We have not gone there. I mean, Vermont has a long track record of requiring and promoting access to good care.

Another area that the Board has asked us to go heavily into is our negotiations with the hospitals, you know, be able to take our huge market share and get better rates with them. And Paul spoke about and pointed to the record where we've indicated that we, Green Mountain Care Board involvement with the hospitals, although it's been good and it's lowered the rate increase for commercial rates over time, there is an element of, when we go to talk and negotiate with the hospitals, they are thinking that they've been approved at a certain level, and so the, the appetite to go further than that is really, is hampered to a degree.

But make no mistake. We're always negotiating as hard as we can because we're, we're having to compete in the marketplace with other carriers like Cigna, MVP for other types of business. So we have to have our contracts with providers as lean as we can possibly get in our negotiations, and just to illustrate how far we go, we believe we go right to the edge of where negotiations would begin to disrupt our membership.

So what happens when Blue Cross of Vermont and a provider, let's say, a large facility provider can't come to an agreement and we just hold out and say, No, we're not, we're not going to take that; we need a lower rate? What ends up happening is the, the contract for the coming year is delayed. If it's delayed to the point where we have to send notification to our members to say, Your provider, you know, is not in network yet for this year, so you might need to find another place to go, if the patient or the member doesn't have any other place to go, they might go to that provider who turns out to be out of network, and that ends up backfiring with higher costs.

So we do our provider contracting as aggressively as possible, but we have traditionally not gone to the level of disrupting our members and getting our, our processing for access to care disrupted for our

members, and, when you step back for a minute and say, Okay, well, what are we losing by not doing that? I think we've made a choice of, if we might have gotten another quarter point maybe off a rate increase by going to that level, it certainly isn't, in our view, worth the significant member disruption that that creates.

Q. So besides provider negotiations are there other tools that you could use that might help to limit cost?

A. Yeah. There's other -- from time to time, we hear about other things being done in other markets, and we, we have a look at them and we see, Does it fit with us? We talk to providers, and we really collaborate heavily with the caregivers and the providers in the marketplace to see what will work.

But a good example of one that came up relatively recently was one of the health plans nationally was not, was declining ER, reimbursement of ER visits if there was an urgent care open during those hours and within a certain distance. We haven't gone down some of those roads because that, that means that in Vermont people tend to go where they need to go and they're not stopping to figure out if I should go to the ER or the urgent care.

That said, we have been working with our providers

and our membership on other approaches to saving money. Telemedicine is a good example. We're very enthusiastic about telemedicine. We want our members to use it when they need it, and it creates great access to care and hopefully will prevent some of the ER costs. The jury is out, though, as to whether or not that's actually going to happen. It could be that people just use it for things that they haven't traditionally gone to the doctor for so that they, it actually increases cost.

So it's another good example of how each program has to be thought through and implemented in partnership with the providers, and then we watch the results of the program and look at it each year to see if it's achieving the results we're looking for.

Q. So is there a solution?

A. So the solution that -- I think Paul mentioned this earlier, that it really is multi-stakeholder solution set here where the providers and Blue Cross Blue Shield of Vermont and Green Mountain Care Board policy, other policymakers, we need to work together to figure out. I think we need to look at the pharmacy spend, what else can we do in that area, whether it's working to support federal legislation around cost control around pharmacy.

We could work together on, obviously, the ACO's. I had the follow-up question from Robin on my list. We're working with the ACO's and looking for every opportunity with that mechanism to bend the cost curve. And then, you know, other things that we could work together on is just broadening sources or funding of health care. There's, one of the things that's come up at the federal activity recently is there's federal waivers, 1332 waivers that could be pursued around high-risk pools and things like that. So I think there's this kind of whole-picture approach with all of the stakeholders involved that really is, is the solution to the long-term problem.

ATTORNEY HUGHES: Thank you, Ruth.

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

ATTORNEY KUIPER: Very briefly.

CROSS-EXAMINATION BY ATTORNEY KUIPER

Q. So you've given us a lot of numbers here. Are you aware of how much your plan costs have increased for Vermont Health Connect in particular from 2014 until today?

A. The, the premium costs? They've gone up 7 or 8 percent each year, and this year they'd be going up another 12.

Q. So would you say, cumulatively, if you include the proposal today, that the entire 12.7 modified to 12.6 would be about 13 percent; does that sound right?
A. That sounds like it would be right, yeah.
Q. And can you agree with me that, if health insurance costs were to continue to outpace wage growth in Vermont, over time this would be unsustainable?
A. Yes, I believe that's been known for a while, and many of us have been working on the urgency around that issue.
Q. Thank you.
MR. HUDSON: Are there any questions for Board members at this time?
MR. HOGAN: Yeah, it's more of a comment if I may. I found myself thinking about this a lot. First of all, a compliment. It's a very well-managed company. L&E has gone overboard to tell us on several occasions that the quality of the information we get from this organization is better than any other set of information they get from any other state insurance company, not state, but insurance company around the country.
So I have no doubt as to the accuracy of the information that we get, but I'm looking at the entire company balance sheets, and I don't think you can

really look at why we're here today without looking at the whole. You're not growing. You haven't grown for two years. You're likely, if MVP is correct, to lose more customers because they're aiming to go from 10 percent to 15 percent of the market. Your RBC dropped 11 percent last year in '16.
I have no idea where you're going to end up in '17, but, if that happens again, you've got your hands full. The rates for '18, everybody has to say that they're huge, which is only going to complicate your life. Surplus in capital for the first time was down since I started following your balance sheets in 2008. You lost $39 million last year. That's the largest loss, again, since '08.
MS. GREENE: I'm sorry. Can you clarify the $39 million?
MR. HOGAN: That's on your balance sheets, public balance sheets, and, by the way, that's where this information comes from, the ones that you publish. It was a $39,000 net loss. 39, excuse me, $39 million net loss. You're facing, as we all are, the absolute uncertainties in this federal mess that we've got.
MS. HENKIN: Can I ask something?
MR. HOGAN: They could blow this thing up. Excuse me. I'm going to finish. They're going to blow

this thing up, everything we're trying to do, if they make the wrong move. I think I will not say you're in trouble. I will say that you're on the edge of getting in trouble. I think you need to seriously start to think about a new kind of model for your insurance company. Now, I could be completely wrong, and, if I am, I'll be the first to admit it, but I'm seeing some signs here that are not what they need to be. I'll stop.
MS. HENKIN: Can I just say something, Con? I know you're referring to documents that we don't have in evidence and we don't have here. Can we at least get that verified? Because I see there's some confusion as to numbers you just put out there, so --
MR. HOGAN: They're welcome to have it, anything I have.
ATTORNEY HUGHES: If I may, we did bring the five-year historical.
MR. HOGAN: Yeah, right. I've got it right here.
MS. GREENE: So on the five-year historical data, our underwriting loss in '16 was $18.2 million, and our net loss was $9.7 million. That's Lines 9 and Lines 12 respectively on the exhibit that Jackie's handing around.

MR. HOGAN: I'm looking at your net underwriting gain or loss, this one, 9, but these aren't, these numbers don't line up with the balance sheets, the reference number. If I'm wrong, I'm wrong, but I think I'm right.
MS. GREENE: If I may, I'll get back to the bigger point that you made about the concern around our financial situation. I have to say -- I just feel I need to say that Blue Cross Blue Shield of Vermont, anyone who knows us and knows the 400 people that work in Berlin, know that we are customer-focused, member-focused.
MR. HOGAN: Agree.
MS. GREENE: I feel that a 12.7 percent rate increase is not something we want to do. It is definitely impactful. We understand that that has a big impact to people, our customers. I mean, they're our customers. We don't want to do that. But Con makes the point about the funding of rates for the Qualified Health Plans is the number one financial lever for our ongoing financial soundness, and so that's why we're here with a large increase, and we do hope that the 2016 result doesn't happen again. That we do believe that the rates that we have for 2017 are holding up relatively well. We're not, as I sit here

at this moment, we haven't had a huge rush of utilization that we weren't expecting. It is only July, and a lot happens in the second half of the year with our financial results.

So I, on the one hand, I can take Con's point about we should be concerned, and, yes, we are, and I have to tell you that a 12.7 percent rate increase tells you that we're, you know, we understand the necessity of our financial soundness to back the health care system of Vermont, and, unfortunately, it does lead to this large rate increase.

MR. HOGAN: Well, and, you know, in proportion, the MVP rate is just about a third of yours. I mean, that's a huge difference. But I'd be glad to enter into a conversation with you at some point to make sure my numbers are correct.

MS. GREENE: Sure, I'd be glad to do that.

MS. HOLMES: I just had one quick question. With respect to the, obviously, the disparity in the MVP and Blue Cross Blue Shield rates and the potential for, as I mentioned earlier, migration. Would administrative and overhead costs go down if there was a significant migration out of Blue Cross Blue Shield to MVP?

MS. GREENE: You mean go up or go down? They

won't, the per member --

MS. HOLMES: Costs, sort of the administrative costs of running this with fewer members.

MS. GREENE: Right. We have -- it would take a pretty significant out-migration to change, because, as I said, as a total company, we're trying to make as much of our scale as we can to benefit all of our customers, and QHP's are included in that, and, if MVP doubles 10,000 members, I'm not worried about a significant shift.

MS. HOLMES: Thank you.

MS. USIFER: I had just a question on -- you know, you talked about the cost-containment programs and, you know, the amount of time that it would take to capture savings off those programs. I would imagine, though, over the past every year, you know, it's got to be a big driver to do cost-containment programs. You've done them five years, four years, three years, two years ago. So where are we seeing all the benefits from those prior cost-containment programs, you know, rather than keep saying in the future we're going to see them? You know, I think we're seeing some with the prescription program. I would expect, you know, we need to go a lot deeper if we're going to attack that

90 percent cost.

MS. GREENE: So another way to think about it, and I really appreciate the Board's interest in understanding how this works, but another way to think about it might be the $20 million that we save across our book of business for pharmacy programs and the $20 million for medical, think about it as that our claims costs would be $40 million higher in our starting point if we weren't running that race.

So, so the trick is to be always trying to get more and more, because we're now banking on the benefit of those programs to the tune of $40 million a year, and so we have to do $41, $42, $43 million to get the improvements going forward. So that's the way, that's what Paul was explaining earlier, that the longstanding programs that have been in place for many, many years are both the savings have come through and benefited the rates up to this point, and the trend is benefitting from those program results, but then that that sort of stays. It gets to a certain level, and it stays.

You have to add programs to keep improving, and that takes partnering with the providers and finding the next place where we can balance access to care with, you know, a win-win around cost containment. You

know, using an urgent care instead of the ER is a really easy one to talk about because, for some services, you get the same quality of care, and we definitely want to encourage people to use the urgent care in that case. So that's another area where we're really focused to see if we can move the dial above the current level.

MS. USIFER: And just one other question on, I think, on your overall administrative costs at 6-and-a-half percent, and we saw yesterday MVP's at 10 percent. So, obviously, you know, clearly you have some scale advantage there, which is great. You know, someone brought up before there's a 3 percent salary increase in your numbers. Just from a perspective, can you tell us what each percent, if you, if did only a 2 percent increase or something like that, what that would translate to?

MS. GREENE: Well, I'll have to get back to you on that in terms of just the actual math on that, because the percent of salary is a small percent of the overall rate. So I'll --

MS. USIFER: I mean, I imagine it probably wouldn't move the needle too much on the 12.7 percent increase that we have forward. I mean, you know, it's something people are going to be looking at. There's a

salary. You all are getting salaries in a tough environment with the increase, because your 6-and-a-half percent is already so low and salaries are probably a low percentage, it probably wouldn't help drive the needle down too much, but it would be --

MS. GREENE: Right. The bigger picture, if I may, is we, we have to attract and retain quality people to do this work. We were just describing whether it's the programs or the provider contracting or the world class customer service. So we, we budget merit, and we're 3 percent merit. We're committed to making sure that the performance management program at the company is such that people who are performing well get the merit and others don't.

The assumption in our filings is that we budget 3 percent because we want to make sure that we're keeping and rewarding the people that are delivering this great service and figuring out and partnering with folks on how to reduce the cost of care. So the, the need for sustainability of the merit -- and the employee benefits health care costs have also gone up, which we did not include in our 3 percent assumption. That would be over and above the 3 percent assumption. All of those things are, we're very committed to Vermonters make this all happen for us. So, you know,

we had a loss, but we also don't give people extra when we have a gain.

MR. HOGAN: May I apologize for that last number? My eyes aren't what they used to be, and I took the dollar sign to be a 3. So it's 9.7. You're absolutely correct. I was wrong on that one number.

MS. GREENE: All right. Thanks. Well, I guess we resolved that one.

MR. HUDSON: Member Lunge?

MS. LUNGE: Yes, thank you. On the cost-sharing reduction uncertainty, I was interested in whether or not your company had done a legal opinion on the interaction between the Vermont cost-sharing reduction program and the federal in terms of what happens if the federal goes away and whether that actually flows to premiums or whether that flows to the State which, obviously, creates a different budget issue for a different set of people, but --

MS. GREENE: Right. To my knowledge, we haven't done that analysis.

MS. LUNGE: Okay, thank you. And I think Paul answered my other questions related to the cost-sharing reduction, except I did want to ask you in terms of, should that come to pass, which we all hope it does not, what kind of timing considerations would

you want us to take into consideration?

MS. GREENE: Very urgent. So, to the extent that the cost-share reduction funding goes away for 2017, that is, coming back to Con's comment, that is a concern that keeps me up at night. That will affect our, our surplus for this year. There's no way to change our rates or do anything different for 2017. For 2018 the timing is, I think, more connected to what's required to adapt or change rates in order to meet open enrollment, which starts in November. So, so there is a relatively urgent timeline attached to knowing what's going on there because it can make a large difference to the rates.

MS. LUNGE: Okay, thank you. In terms of when you were speaking about hospital negotiations and the challenges for, in negotiating lower rates in the hospital budget process, I'd be curious to hear a little bit more about out-of-state hospitals. Because it was noted earlier in Paul's testimony hospital budget impacts 45 percent. So what about that other 55 percent? Because that's the 55 percent that we don't have regulatory control over.

MS. GREENE: Right. So, really broadly -- if we need to go deeper on this, I'm happy to follow up with some of our experts, but, broadly speaking, our

Blue Card network is our mechanism for accessing the negotiated discounts that the other Blue Plans have negotiated out of state. So we're, we're estimating and reflecting in our rates what we expect to get from their efforts in their local markets. So there may be an exception to that, but that's broadly how that works.

MS. LUNGE: Okay, thank you.

MS. GREENE: And, likewise, they rely on ours for their members to come to Vermont.

MS. HOLMES: Can I ask a quick follow-up? Does that include Dartmouth-Hitchcock?

MS. GREENE: Dartmouth-Hitchcock we negotiate directly with. So thanks for the clarification. So out-of-state comes in a couple of different flavors. Dartmouth-Hitchcock would be, they're contiguous to our region, so we negotiate.

MS. HOLMES: But out of our regulatory authority.

MS. GREENE: Yes. Thanks for that clarification.

MS. LUNGE: I still have one more. Earlier, I had asked Paul, and he deferred to you around preventive care trends and dental trends in terms of it seems like part of what's driving those trends is, I

guess I would say, slower consumer education about the availability of those benefits. Can you describe a little bit about what you do? Because, of course, both of those preventive services are really important services for people to have.

MS. GREENE: Right. Well, one of the questions that you asked about, Do we promote the preventative care generally? I'll leave the dental for a second. The Blue for you features on our product are designed to make people aware of the value of preventive services. So there's incentives for folks to get the annual physical or get their -- the adults are incentivized to get their dental appointments taken care of. We're hoping that, through that, there will be a building awareness that the pediatric dental is part of that. That they'll, you know, in conversation with the dentist, perhaps they'll find out that, actually, their children are also covered. So we are expecting that to be part of the overall benefit of promoting that wellness feature of the product.

MS. LUNGE: Okay. And then just the last question is related to the, the new payment models being established through the ACO contract, and I just wanted to invite any thoughts you have in terms of how that might be reflected in future rate filings in terms

of either changes in population or trends for risk sharing.

MS. GREENE: Yes. As Paul testified, we've been in several risk-sharing shared savings, I should say, shared savings programs, and we've found it difficult to see any savings, so --

MS. LUNGE: Sure, but capitation is a different ball game than shared savings.

MS. GREENE: Right. So it really takes knowing what the contract incentives are and knowing exactly who's doing what for care management. As I mentioned, the access to care and the care coordination, that will play an important role in us understanding whether or not we can actually put something in the rates or if we have to wait and see it work and then have it come into rates through experience.

MS. LUNGE: And are you, around the care management, are you actively including some thoughts around ensuring that there's no duplication there?

MS. GREENE: Absolutely. That's actually a very big piece of the conversation going on with the ACO's as to who's going to do what, and, as you know from my earlier comments, we've got $40 million riding on this, and before we let off those programs, we need

to be absolutely sure that the other party's going to be able to replace those results. So it's a huge part of our discussions with the ACO.

MS. LUNGE: Okay, thank you, thank you.

MR. HUDSON: Mr. Chairman? All right. I think, at this point, we've heard a lot of questioning from the Board and we're reaching a time where we probably need to break for lunch. We had a half hour scheduled for lunch in the prehearing schedule. We would like to restart on the dot at 1:00 o'clock.

(A recess was taken from 12:30 p.m. to 1:00 p.m.)

MR. HUDSON: Okay. Good afternoon, everyone. We're going to reconvene the hearing. Hope you all enjoyed lunch. This hearing did not have a public order, but we are going to depart from the plan a little bit. We are going to hear from DFR later in the day if possible. If we are running out of time, we are going to defer DFR and closing statements to a continued hearing at a later date, and, right now, we're going to move on to hearing from the Board's actuaries, L&E.

DIRECT EXAMINATION BY ATTORNEY HENKIN

Q. Good afternoon.

A. Good afternoon.

Q. You have been sworn in, correct?

A. Correct.

Q. Could you tell everyone who you are?

A. Dave Dillon. I am vice president and principal of Lewis & Ellis.

Q. And what is Lewis & Ellis?

A. So we're an actuarial consulting firm since 1968.

Q. What is your educational background? We'll go through this stuff quickly.

A. So I have an undergraduate degree in mathematics from Oklahoma State University and at graduate degree in statistics and actuarial science from the University of Iowa.

Q. How long have you been an actuary?

A. Oh, about 21 years.

Q. How long have you been an actuary to the State of Vermont for the Board specifically?

A. Started work in 2014.

Q. Can you tell us what professional certifications and memberships you have?

A. Sure. I'm a fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

Q. And have you done other exchange filings for this Board?

A. Yes. We have done exchange filings since 2014, early 2015 filings.

Q. How many rate filings have you done altogether for the Board, exchange or otherwise? Do you have a --
A. A little under 50 filings.
Q. Do you do filings, exchange filings, for other states?
A. Yes. Since the passage of the ACA, we have done rate reviews for approximately 12 states. We are currently doing seven states this year.
Q. So do you get a comparative look at what rates people are asking, different states are asking for?
A. Yes, we get a wide range of filings, and so we can get a broad-brush look at industry impacts and changes to the market through the health care reform issues.
Q. Can you tell us a little bit about the process for reviewing a filing from the time it comes to you and how it comes in?
A. Sure. We, for any staff, we assign three people at filing with different levels of responsibility. Josh Hammerquist, who's on the phone listening in, is a fellow of the Society of Actuaries. He is what I would call the lead reviewer. Then I am the primary peer reviewer, and then Jacqueline Lee is a secondary peer reviewer. So, typically, what we do when we get a filing in, Josh takes a look. I take a look. Immediately, I look at kind of the high level things

such as loss ratios, things like that, to get a sense of what the rate increase is going to be even before I look at what the request is.

So, for this filing, the loss ratio was in the low 90's.

Q. What does that mean?
A. So 90 percent, approximately 90 to 93 percent of every dollar spent of premium was spent on claims. So loss ratio is claims divided by premium. So that was the 2016 experience. Most companies target between an 85 to 90 percent loss ratio. So I take that adjustment. I adjust for things like the health insurer tax coming on board this year again.

I'm looking at trend. So, if I take kind of a getting back to an expected loss ratio, adjusting for health insurance tax and adjusting for trend, even before I looked at Blue Cross's request, I came up with a range of about 11 to 17 percent just based on those high-level numbers that we see in the market. So then, that way, that helps set the expectation if they filed a rate higher than 17 or lower than 11 then I know that there are really some things that we'll have to look at.

Q. When you look at these filings, do you do independent calculations, or do you just do a review of

what is sent to you by Blue Cross?
A. It's really a mix. It depends on the materiality of the assumptions and impact on the rate. One of the assumptions discussed a lot today is utilization trend. Since that was so material to the assumption, we did a little bit more of an independent calculation, but some of the other things, we will, we will take the information provided. We may ask for additional information to help support the assumption in the filing, but we may not do additional calculation for some assumptions.
Q. What is the process of getting additional information from the carrier?
A. So, through the SERFF, which is the System for Electronic Rate & Forms Filing through the NAIC, we submit objection letters through that system, and Blue Cross will respond via that mechanism.
Q. How long a period do you have from the time this comes in, the filing is made, and the time that you provide any type of deliverable in the form of a report to the Board?
A. We have 60 days.
Q. Okay. And, during that 60 days, are you always done with the whole process of review?
A. The, the 60 days is a pretty tight timeline.

Vermont's rate filing is one of the shortest. And so it is a continual, almost daily combination of analysis and back-and-forth, you know, sending the letters and things. So it is a pretty constant process throughout the 60 days.
Q. And you understand that's your statutory timeline?
A. Yes.
Q. So let's look at your report real quickly. We'll go through. You've heard a little bit about it today. It's Exhibit 11, and if you go to the second page of that, it's Page 248 of the binder. When you review these, you do put into your report that there's a standard of review, and can you just tell me a little bit about what you look at and what your standard of review is and which of these factors are relevant to your review?
A. So, if you look under the "Standards of Review" paragraph, you know, there are many elements that the Board is charged with in these filings, but only a portion of those are really actuarial in nature. So we, we utilize -- we review those primarily excessive, inadequate, and unfairly discriminatory, and then, once we give the recommendation to the Board, they can utilize that information to help inform themselves on the other elements in their charge.

Q. And we've heard from some today about things being unaffordable. Is that the same as excessive under an actuarial term?
A. No. Excessive really gets at kind of the phrase of benefits in relation to the premium. So, for a given set of benefits, what we assess that if the proposed premiums are reasonable to that.
Q. What about inadequate?
A. So inadequate is just really the flip side to that is, based on the expected claims at admin for the filing, are the premiums charged enough to satisfy those obligations to the consumer?
Q. And you've reviewed this entire file at this point?
A. Yes.
Q. And that includes -- there was an update provided that's now Exhibit 17 from Blue Cross, and the materials provided this morning in Exhibit 17 is the letter from Blue Cross July 17th 2017.
A. Got it. Thank you.
Q. There was an amended solvency letter. Let me ask you this. Have you had an opportunity to look at the amended solvency letter and the update from Blue Cross that's a response to Mr. Horman's report?
A. Yes, I have.

Q. You recommended very little change from what was proposed by Blue Cross, correct?
A. That is correct.
Q. Let's look at what you recommended. I believe it's on Page 259 in the binder. It's Page 13 in the report. Can you tell me what you recommended there?
A. I'm sorry. Could you mention the page number again, please?
Q. It's 259 in the, in the binder, and it's Exhibit 11.
A. Okay, I got it.
Q. You got it?
A. Yeah.
Q. What were your recommendations there?
A. So the first recommendation was regarding the budgetary process. Obviously, for the Board the budgetary process is a very key element to the rate filing, and the proposed 2018 hospital budgets came out after our report, and so, therefore, we did not have the opportunity to comment on those. So we felt it was, that we should have a recommendation for the Board to take those into consideration.
Q. Have you since look at those hospital budgets as they've come in?
A. Yes.

Q. And, based on what you've looked at, do you have changes suggested for Blue Cross on the basis of hospital budgets?
A. No, we did not.
Q. And what's the other recommendation?
A. The other recommendation was regarding the risk adjustment calculation. This is a very, very complicated calculation, so I'll try to keep it as simple as possible. But, essentially, Blue Cross knows a lot about themselves. They don't know much about their competitors, but as -- and they, in their filing, they made an assumption about their competitor.
Q. Why don't they know about their competitor?
A. So it is confidential information, and so the Department of Health and Human Services only provides each company the detailed information on themselves. They don't get the detailed information on their competitors. So one of the, one of the assumptions Blue Cross made regarding MVP was what we would kind of call coding intensity, which is kind of how much sicker the formula estimates MVP is, and we made a recommendation that the coding intensity factor that they included for MVP and for themselves could be removed, and so that, and that reduced.
And so I should also mention that there was one

adjustment post-filing. The, one of the issues with risk adjustment is, when the filings are made, the full risk adjustment report has not been released, and so both companies have to make information, have to make estimates based on nonfinal information. During the rate filing --
Q. So that's what I want to clarify here.
A. Yes.
Q. Because this is 12.9 --
A. Correct.
Q. -- so that 12.9 was never filed, and we heard testimony from Paul Schultz today that they didn't file for a change, but that's based on risk adjustment?
A. Correct. So the original was the 12.7 rate increase. Once the risk adjustment report was finalized, they provided an updated confidential exhibit which showed what their updated risk adjustment number would be.
Q. And that's the 12.9?
A. And that would be the -- that would create the 12.9, and then based on that updated calculation is where we made our recommendation about removing the coding intensity factors for both companies, and then that reduces the estimated 12.9 based on the final numbers down to the recommended 12.6.

Q. In your report you also go through a bunch of factors that you review. I want to just pull out a few, and I know that that's the only part of the recommendation, but there was some discussion, and I think it's also in the HCA's report, about demographics aging. Did you review the aging factor and do any of your own calculations, or was that just a review of Blue Cross?
A. So we did review the assumption there. Based on the information provided in the original filing, we felt it was necessary to get additional information supporting their assumption. So I believe that was in our first May objection letter.
Q. If you look to Exhibit 6, the first page of that exhibit is 219, and it's Paragraph 2. Is that what you're referring to as what you requested?
A. Yes, yes. And so we were provided additional information supporting the historical pattern of the aging increase, and so, rather than just utilizing one year of information, we did use multiple years of information, and we concluded that Blue Cross's assumption for aging was reasonable.
Q. Let me ask you about administrative costs, and this is not going into a lot of depth in that, but you also didn't make any comments that that was incorrect,

as Mr. Horman has said, and there was a comment in the HCA report about there's no direct comparison. Did you try to do any direct comparison of Blue Cross's admin costs versus what would be an apples-to-apples type of --
A. Yeah. So what we did with the admin, the first step was we did kind of just reviewed the assumption by itself just to make sure all of the pieces were reasonable and in line with what we have known historically about the company, and then the next step we did is we did benchmark their admin against all other 66 Blue Cross affiliates that file ACA business. And so we compared their admin versus all other 66 of the 66 Blues plans, and we utilized information out of the annual statements which is the information Con has been referencing a few times about the financial information.
There's a report in that, in those statements called the "Supplemental Health Care Exhibit", and that provides a lot of details regarding claims, premiums, and admins and so forth. So we pulled that information for all of the carriers, all the Blues plans. One of -- it's Line 10.4 out of they're Supplemental Health Care Exhibit is general administrative expenses. That did not include things such as brokers and commissions

because some of the other states do have brokers and commissions line items in their expenses. So you do have to adjust those out when you're doing a comparison.
So, once we did that and compared Line 10.4, we did it in the benchmarking. We compared it on a percentage premium and a per member per month basis, and, when we did that Blue Cross of Vermont's admin was in the bottom ten of the 66. So they were roughly 54th, 55th at the lowest. And so, based on our review of the filing that the, the assumptions looked okay and that they were in line with the benchmark, we believe that their assumption was reasonable.
Q. Another thing I wanted to ask you about is utilization. I believe there's been discussion and there's some discussion with the HCA also on utilization. There's been some questions about it. On your report, which, again, is Exhibit 11 -- it's Page 251 in the binder, Page 5 in the report -- you did say the 2 percent utilization trend appears reasonable and appropriate. Do you still agree with that?
A. Yes.
Q. Did you determine a range of what would be a reasonable trend?
A. Yes. So, as I alluded to earlier, this is one of

the key assumptions. So we, we definitely did a lot of independent calculations regarding this assumption just to get comfortable with the assumption. You know, the unit, unit trend and the utilization trend items are very difficult to analyze because it really does depend on time periods analyzed and things like that.
So we looked at multiple time periods. We looked at multiple methods, and we, we actually used -- we primarily focused on what I would call time series approaches. Because, in things like utilization trend, next month's utilization trend is highly correlated or should be very similar to the previous month's. There may be some changes.
But we definitely use what I would call time series approaches, and, when we, when we looked at all of those multiple approaches, the reasonable range was 1 percent to 2-and-a-half percent utilization trend as reasonable, and, since Blue Cross's 2 percent was low within our range, we concluded that their assumption was reasonable.
Q. If they had filed this with a 1 percent utilization trend, would that also have been reasonable?
A. Since my range of reasonable was 1 to 2-and-a-half percent, yes, if they'd have filed a 1 percent, I would

have concluded that it was a reasonable assumption.
Q. What about in the HCA's report they suggested using MVP's 0.7 percent. Would you have used that as a reasonable range number?
A. We would not for a couple of reasons. One, the .7 is outside of our range of what we deem to be reasonable, and then a similar argument to what Mr. Schultz commented earlier is that we do not believe it's appropriate to utilize a different company's trend assumption, especially one that is much smaller and not as stable, for use for this purpose.
Q. Let's just move on a little bit to the contribution to reserves. We've heard a lot about that today, too. We heard about the annual statement. Now, whose primary responsibility is it to review the solvency?
A. So the DFR, we have always been told since we've been here since 2014 that the DFR does have kind of final say, but we are not precluded from commenting to help inform the Board of our opinion on the CTR. So we, we definitely take a look at the CTR, and we did not exclude that from our analysis.
Q. Do you also look at some confidential information concerning RBC for the carrier?
A. Yes. Again, to the NAIC annual statements, we

utilize the RBC information out of those filings, and then we also -- I think it was alluded to earlier. There are other measures. I think Chairman Mullin mentioned some other measures. And so we also look at capital and surplus as a percentage of premium on a per member per month basis as part of our analysis.
Q. You must remember what they proposed as a contribution to reserve business filing.
A. 2 percent.
Q. And did you find that was reasonable and appropriate?
A. So, you know, when you assess the CTR, this is, it is a very gray area assumption. This is not, not one where we necessarily have a whole lot of credible data to analyze to assess what is appropriate. Because, really, what the CTR's for is uncertainty in the markets and things like that, how -- you know, I think it would be hard for anyone in this room to quantify the level of uncertainty that's currently going on in Congress and things like that.
So what we would do is we have looked at the actual expected results. The company provided that information for us in their filing. So we looked at what they thought the profits were going to be or, I should say, the risk margin, and we looked at that and,

based on that, historical look, I would have assumed a range up to about 4 percent as something I wouldn't have been surprised by somebody submitting, and then I looked further at some of the analysis they provided regarding RBC that was discussed earlier, and 2 percent was definitely reasonable.
Q. Did you -- are you aware of what the RBC range, the target range, is for Blue Cross?
A. Yes. 500 to 700 percent.
Q. Have you calculated in your modeling what you believed would be needed? Now, there was a comment in the original report where Blue Cross had stated that they needed a 3.2 to sustain their RBC, and I realize that was corrected.
A. Yes.
Q. And do you remember what it was corrected to?
A. I believe that it was 1.9 percent.
Q. What have you calculated with what you know today about Blue Cross and RBC what would be needed to keep them in the mid-range of their target?
A. So my estimate is that a 2 percent contribution to reserves would put them approximately right in the middle of their range.
Q. If you were to -- if they had submitted a 1 percent contribution to reserves, would they still be

within their range?
A. So, if we think about the range of 500 to 700, I'm going to break it up into pieces, four pieces. So, if we focus on the middle 50 percent, so let's say between 550 percent to 650 percent, that that is where I would focus. Anything less than the 550, I think, is starting to get into territory that would cause some solvency concerns.
Q. So does 1 percent put them in their 500?
A. So, yes, the 1 percent, it appears, based on our calculations, would fall within the 550 to 650 middle percent range.
Q. Would the .7 put them within the target range?
A. I don't believe I calculated that number, but, based on my calculations, I would say that it would be very close to that border, getting close to below 550.
Q. Have you looked at the last ten years' RBC levels?
A. Yes.
Q. How would you characterize those levels for Blue Cross when you look across a ten-year?
A. While there have been, obviously, some year-to-year fluctuations, it has been very stable, and all ten years have been between the 500 and 700 percent.
Q. There was also characterized at one point that

they've had a downward trend over three years. Would you, would you have characterized that in your report as, as being a downward trend?

A. Well, they have had some losses in the last couple of years. I would not necessarily consider two years as a trend. It has not been a consistent pattern as a consistent negative pattern.

ATTORNEY HENKIN: Thank you.

MR. HUDSON: Attorney Hughes, does Blue Cross Blue Shield of Vermont have any questions for this witness?

ATTORNEY HUGHES: Yes, we do. Thank you.

CROSS-EXAMINATION BY ATTORNEY HUGHES

Q. I'd like you to turn to Page 175 of the binder, and this is actually just for purposes of clarifying the record. Earlier, you pointed to Page 219 at the source of the information on aging. Is there anything on Page 175 that also went to that point?

A. I thank you for the correction. Yes, Response, Question 18.

Q. Could you turn to Page 275 of the binder? And this is the HMA report.

A. I'm there.

Q. Could you read the first sentence in Finding 5 Right under the heading "Finding 5 Utilization Trend"?

Will you read the first sentence?

A. Excessive and not supported?

Q. No, the sentence.

A. Oh, "I've reviewed the Blue Cross Vermont utilization trend assumption of 2 percent and believe that there is no evidence to support the increased level of utilization trend over the competitor's estimate and Blue Cross's own past year's filing."

Q. And now can you turn to Page 251, which is part of your report? Could you read the second full paragraph on that page, Page 251, when you get there?

A. Starting with the word "due"?

Q. Yes.

A. "Due to the increased utilization trend compared to prior filings, L&E requested and analyzed more recent claims experience that became available after the initial filing submission. The following table summarizes L&E's analysis based upon the claims paid through April of 2017."

Q. And can you walk us through that chart?

A. So, essentially, what this shows is -- I mentioned earlier there is a lot of different time periods and a lot of different methods to analyze. This table summarizes Blue Cross's, some methods that Blue Cross used, 12 month, obviously using the last 12 months; 36

month and so forth in the different time periods kind of the ending point that's the columns above, and so, based on those different methods and different time periods, those were the utilization trends that were realized.

Q. And can you read the paragraph that follows the chart?

A. "The additional utilization trend that L&E analyzed demonstrated that the utilization trends have increased relative to recently approved utilization trends which is consist with the company's analysis. The company's assumed 2.0 percent utilization trend appears reasonable and appropriate."

Q. And is that still L&E's opinion?

A. Yes.

Q. And do you agree with the HMA's report that asserts Blue Cross did not provide any evidence to support its increase in trend assumption?

A. I believe Blue Cross provided sufficient information to support the 2.0 utilization trend.

Q. And could you go to the next page, 252? I want to ask you about the range. In particular, footnote Number 8, could you, in sort of common English --

A. I'll try my best.

Q. -- explain what that footnote is getting at?

A. Yeah. So one of the things the Board has asked of us from the beginning is they like to have ranges regarding our estimates, and we have always said that that can be tricky because it's, you know, all of the estimates are not equally likely. So, with something, with the allowed medical trend of 4.7, you know, it might be easy to think of a typical bell curve, and most of us know the bell curve where most of the observations are towards the center.

And so, basically, what this footnote is saying is that, you know, roughly two-thirds of the observations around an estimate are packed into the middle so that the majority of them are packed into the middle, and then there's the more of the extreme one-third is split into the two halves of higher and lower.

So what we highlight here is, while we do have a range, that range is not uniformly distributed. So we are not saying that 2.3 is as likely as 4.7. We are saying that it could possibly happen, but it is probably pretty rare. We expect that the majority of what we believe will be realized will be centered around the allowed medical trend of 4.7.

Q. So, if the Board were to, for example, set the point at the lowest 10 percent, could you explain the likelihood of that event occurring versus the one

that's in the middle that you --
A. Yeah. I'll use the example of my, my answer regarding the utilization trend. As we looked at the utilization trend, we felt that the most reasonable, you know, range was 1 to 2.5, while it is possible it is lower than that. We believe, if, if an assumption lower than that, that would be unreasonable, and so this is regarding the total medical trend here, but, if we, if that is on the low end, we would not consider that a reasonable assumption.
Q. And could you turn to Page 259?
A. I'm there.
Q. And could you read your second full paragraph with respect to the CSR defunding?
A. "Should the CSR program ultimately be defunded, L&E believes the Board should consult with the carriers and other stakeholders to arrive at a decision regarding the proper method for the market as a whole. Regardless of the approach selected, L&E recommends that the Board requires that all market participants to use the same method. Otherwise, it is anticipated that significant volatility and instability would be introduced to the market."
Q. Is that still L&E's belief?
A. Yes.

Q. And could you turn to Page 277? And this is part of the HMA report. Oh, yes, that's right. Could you read Finding Number 9?
A. "The rate filing reflects outdated risk adjustment information and inconsistent development of both the risk adjustment and the 9010 tax estimates. I believe L&E should recast these factors using more recent information and consistent methodology."
Q. So we've already talked about the risk adjustment more than once, but, with respect to the 9010 tax, did L&E recast Blue Cross's assumptions and conclusions on the 9010 tax?
A. No. As we looked through the tax information, this was an assumption that was not there in the prior year, and so there wasn't any, you know, really recent data. There was no older data. We felt that was the most appropriate data. We felt that their calculation utilized the most up-to-date information available, and so we did not believe recast was necessary for that estimate.
Q. So did you read the report prepared by HMA Solutions?
A. Yes.
Q. And were there any surprises in that report?
A. No. I guess, obviously, we knew that HCA would

have their actuary produce a report, so we had obviously considered what they might ask, and we were not surprised by any of, maybe some of the issues to be discussed.
Q. So did you consider all the points that they raised, whether or not that made it into your opinion?
A. Yeah. So all of the assumptions, they did not raise any assumptions that we did not consider in our review. So, yes, all of their, all of their issues were considered in our assessment.
Q. And do you intend to amend your report based on any of the findings in the HMA report?
A. No, we do not.
Q. And do you intend to amend your opinion based on any of the findings in that report?
A. No, we do not.
ATTORNEY HUGHES: Can I have one moment? Great, thank you.
MR. HUDSON: Does the HCA have any questions for this witness?
CROSS-EXAMINATION BY ATTORNEY KUIPER
Q. So you've testified that, when you do a, when you did a review of this filing, that you applied standards for excessive, inadequate, or unfairly discriminatory; is that correct?

A. Correct.
Q. And those standards, according to the actuarial standard of practice, include a -- you're supposed to include a reasonable level of conservatism; is that correct?
A. That can be included, yes.
Q. And you, your company, L&E, does work preparing rate requests for commercial insurers; is that true?
A. I don't believe we filed any major medical rates primarily because of the conflict because we do so many rates, but, yes, I have filed rates for non-major medical products.
Q. And do you apply the same standards for excessive, inadequate, or unfairly discriminatory when you create those rates as you do when you review filings in situations such as this?
A. So, yes, generally speaking, we do. However, you know, things such as conservatism, excessive, things like that is highly dependent on the data available and things like that and the statistical credibility of the data used.
ATTORNEY KUIPER: Thank you.
MR. HUDSON: Questions from the Board for this witness?

CHAIRMAN MULLIN: So you've mentioned that there were other measures for financial stability. So you mentioned that there are other measures of financial stability for a company. In fact, yesterday, when MVP had their filing case, they kept referring to the measure that they use which was reserves to premiums, and I believe those were around 12, maybe a little bit above that. If that measure was used for Blue Cross, what would that number be?

MR. DILLON: So I am not familiar with the New York statute that they were referring to. We have not done work in New York, so I don't know the particulars on if that's a min, max, middle. I don't know how that was calculated, but what I can speak to is, you know, RBC is not necessarily a measure of strength, and that's why we use the other measures.

There have been several studies put out by actuarial firms that show that somewhere, it's somewhere in the 20 to 25 percent of premium is appropriate for managing the business. So, if, I do not know off the top of my head, if we cut that in half, what that would do in the RBC level, but it would be a significant drop.

CHAIRMAN MULLIN: But it is safe to say that, using that measure of reserves to premiums, that Blue

Cross has a ratio that's close to double that of MVP, correct?

MR. DILLON: On the surface, the numbers are double, but, again, they may be -- again, I don't know what the New York law states. However, you can't just take that New York statute as the only measure, because RBC is a requirement as well. So I would have, without actually calculating the numbers, I would have concerns that, if the 12 percent was used for Blue Cross, that the RBC level would be severely threatened and they may not comply with RBC requirements.

CHAIRMAN MULLIN: I'm not trying to suggest that we use the 12 percent. I'm just trying to point out that, using the measure that the competitor is using, that this company would be considered to be twice as financially stable.

MR. DILLON: Yeah. And, again, I would just follow up again that, you know, companies are dramatically different in the populations they serve, and that's why different companies have different levels of what is appropriate for capital and surplus.

CHAIRMAN MULLIN: Thank you.

MS. HENKIN: I have one more question. You were asked if you would amend your report based on that. Did we ask you to amend your report at any point

or to file a supplemental report after the hearing?

MR. DILLON: I don't believe we have. I believe we may have issued a correction maybe once before, but I don't believe we have ever amended our report based on this.

MS. HENKIN: And is anything you testified to today inconsistent with what's in your report?

MR. DILLON: No.

MS. HENKIN: Thanks.

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

ATTORNEY HUGHES: May I ask one question on recross, actually, two questions?

RECROSS-EXAMINATION BY ATTORNEY HUGHES

Q. So the RBC that Blue Cross has, that doesn't just support their QHP business; is that correct?

A. That is correct. RBC is at a corporate level, yes.

Q. And one thing that you did talk about is you're in seven states and you used to be in twelve states --

A. Yes.

Q. -- in terms of reviewing QHP filings. Can you give us a ball park of how many QHP filings in total L&E has done since the start of the QHP program?

A. I think 500 might be a reasonable estimate.

ATTORNEY HUGHES: Thank you.

MR. HOGAN: In those reviews is there a general average that enters your head as to what the RBC's have been in those other places?

MR. DILLON: So I will answer that primarily from the, the analysis we did on the Blue Cross that I alluded to earlier. Because, obviously, in the states that we reviewed, the Blue Cross plans are the dominant player as they are here. So I think that speaks, you know, is a pretty good reference point for that, and, as I mentioned earlier, when we did the benchmark analysis, Blue Cross of Vermont was in the bottom third across the varying measures. So about two-thirds of the, the Blue Cross plans have stronger positions.

MR. HOGAN: Thank you.

MR. HUDSON: Okay. Mr. Dillon, thank you very much.

MR. DILLON: Thank you.

MR. HUDSON: Is the HCA prepared to call its witness?

ATTORNEY KUIPER: Yes, we would like to call Peter Horman.

DIRECT EXAMINATION BY ATTORNEY KUIPER

Q. Could you please state your name?

A. Yes. My name is Peter Horman.

Q. And, Mr. Horman, have you been retained to reach an expert opinion in this case?
A. Yes, I have.
Q. Let me refer you to Tab 14.
A. Yeah.
Q. Does this contain your CV?
A. Yes, it does.
Q. Let's talk about your professional experience and education. What do you do for a living?
A. I'm an actuary.
Q. Do you have an area of specialty in your practice?
A. Yes, I do, mostly health care.
Q. How long have you been -- how long has health insurance been your specialty?
A. Health insurance has been my specialty since I started my career in 1999. I said my company mostly does health care. What I meant by that, I'm almost under the umbrella of health care, but sometimes I do technology projects within the health care range.
Q. I apologize. I didn't hear you. Could you bring the microphone a little closer?
A. Yes.
Q. Do you have any professional certifications?
A. Yes, I do.
Q. That's better. Could you, could you list them,

please?
A. Sure. I'm a fellow of the Society of Actuaries, and I'm a member of the American Academy of Actuaries.
Q. How long have you been certified as an actuary?
A. Since 2005.
Q. Do you have any actuarial training specific to health care?
A. Yes, I do.
Q. Could you explain that?
A. Certainly. The actuarial training sequence when you go from the entry level actuary of associates to the fellow is a sequence of all health care claims. It's a specialization track.
Q. Okay. Do you participate in any kind of continuing education?
A. Yes, I do.
Q. What is your educational background?
A. I have a bachelors degree in actuarial science from the University of Connecticut, and I have a masters degree in mathematics from Colorado State University.
Q. Do all actuaries have a masters degree?
A. No, they don't. It's not a requirement to become an actuary.
Q. Did you learn anything in your masters degree

program that you believe aids you in your work?
A. Yes, definitely, the appropriate application of probability and statistics to problems like we see in rate filings.
Q. What work have you done since becoming an actuary?
A. I, since becoming an actuary, I've done almost all the work I think the Board's exposed to, a lot of the different actuarial aspects, IBNR, trend, rate filing setting. In addition, I moved up to chief actuary and was responsible for some more of the financial accounting side of the actuary.
Q. Can you name the insurance companies where you've most recently worked?
A. Certainly. I worked for two nonprofit insurance companies in Massachusetts. One was Harvard Pilgrim Health Care, which is a New England based company, and then the other was Neighborhood Health Plan, which was a Medicaid and commercial company.
Q. And what, what's your current position?
A. My current position is I own my own company.
Q. And what, what does your company do?
A. I provide actuarial consulting services to mostly clients in the New England, New York area.
Q. And why you did you leave your last job to start your own company?

A. It's something I always wanted to do, to start my own company, but really so I could create better applications of math. Part of my company's name is Horman Mathematical and Actuarial Solutions. So, on top of noticing that, if I just called it Horman Actuarial Solutions, HAS isn't really the nicest acronym, I really like to bring that mathematical aspect to the review.
Q. Thank you. Now, can I direct you to Tab 13?
A. Certainly.
Q. Is this the expert witness report that you created for today's filings?
A. That's correct.
Q. Could you briefly summarize any recommendations that you, any conclusions that you came to on the filing?
A. Certainly. I found four recommendations. One of those recommendations dealt with four findings I found that significantly impacted rates.
Q. Okay. Just have a chart here. Does this chart represent the findings that, that you listed in your report?
A. That's correct. It's a summary of those four findings.
ATTORNEY HUGHES: I'm going to object. This

has not been shared with me or provided to me.
MR. HUDSON: Can you identify where in the report these numbers come from?
MR. HORMAN: Certainly. There's a summary of these on page --
ATTORNEY KUIPER: This exact chart is not in the report. This is just a summary of information used for demonstrative purposes at this hearing. I'm not going to try to admit it into evidence. I believe all of the important information is in the report. It's just to try to, to try to keep the testimony clear and everybody on the same page.
MR. HUDSON: And, just at a quick glance, these are some fairly basic figures from the report, correct?
ATTORNEY KUIPER: That's correct.
MR. HUDSON: I will allow it for illustrative purposes.
MR. HORMAN: Those numbers are on Page 12 of my report. It's 281 in the packet, and the numbers are a finding about aging trend, .5 percent reduction in the rates; finding about utilization trend, 1.9 percent reduction in rates; finding about CTR, 1.2 percent reduction in rates, and I identify three other areas of compounding conservatism which accumulate to

three-tenths to five-tenths of a percent, and the average ratio there is halfway in that range, which is reasonable.
BY ATTORNEY KUIPER:
Q. So you referred to compounding conservatism. How do you define conservatism?
A. Certainly, the definition that actuaries use of excessive rates is rates that don't cover claims costs, administrative costs, and some contingency adverse deviation in profit. What often happens is what that means is you're supposed to estimate best estimate factors and estimate your claims and then estimate your admin and then put on your contingency for reserve. What I found was items that had implicit conservatism you could call within these factors, which, when you add up those implicit conservatism within those factors, created more contingency than is reported in the document.
Q. So could you just one more time clarify the difference between the conservatism in the rates and RBC?
A. Certainly. The conservatism in the rates typically flows to a profit and loss, but RBC is designed to absorb losses. So conservatism in rates is designed to make it a lower probability that you would

experience a financial loss and need to use your RBC, but your RBC is intended to absorb financial issues or adverse deviation from the norm.
Q. Did you come to any conclusions that you included in your report that do not directly impact the rates?
A. That's right. I have three other recommendations. One was a refresh of data, another was a notice of that we've discussed here about some administrative reporting exhibits that there really seem to be a little bit misleading, and then one finding concerned with ways that Blue Cross could reduce costs without increasing rates.
Q. Could you briefly explain why you included this?
A. Very valid concern here about financial health of Blue Cross Vermont. It's an important. It's an important stakeholder in the health care system here, and so I recognized solvency is an important issue, so I wanted to include avenues they could use besides rate increase to improve their financial health.
Q. What was your general process while reaching your conclusions?
A. My general process for reaching my conclusions was a broad review of the rate filing I reviewed. Then I reviewed every detail of the detailed calculations, and on top of that I looked back to historic rate filings,

and I looked at their financial exhibits and also had access to the competitor filing which I could use as a benchmark.
Q. And what did you, what did you do with that information?
A. I used that information to develop my 14 findings. I tried to apply scientific, actuarial scientific rigor wherever possible to add value to the rates filed by the Blue Cross actuaries.
Q. How did you determine whether there was scientific rigor in what you reviewed?
A. So, typically, you, you can estimate the accuracy of an estimate based on the ability to test that estimate, see how well it holds up in practice, see if the application of statistics on it is appropriate or reasonable. In general, there's a whole actuarial toolbox of primarily mathematical or economic concepts which can be used to validate an assumption.
Q. When you do -- when you've developed rate filings in the past, have you used scientific rigor within every adjustment that you make?
A. No, that sometimes is impossible, and, again, that's not the standard I put on in this rate filing. What I did do is identify four areas where I felt there could be better rigor in the rate filing, and that's

what led to my findings. Findings that I had that I couldn't necessarily quantify, I didn't put a number as a change.
Q. Okay. Is your method for reviewing this file generally accepted by actuarial science?
A. Yes. I followed the actuarial standards of practices which are outlined in my report.
Q. So, in an effort to keep the testimony reasonably short, I'm going to now focus you on just the part of your recommendation that impacts rates.
A. Certainly.
Q. Can you explain your recommendation regarding the aging trends?
A. Yes. My recommendation on -- so I reviewed the Blue Cross filing, and Blue Cross made a series of demographic changes in rate filings which are reasonable, and they also identified an aging effect, which is the change in the average age factor as estimated by actuaries. They used base data in 2016, and they estimated as of March 2017 that age factor had changed about a half a percent. That, I did not have an issue with that. That's common. That's standard to reflect an age factor. It's an explicit measure. You could say it's a very scientific process from the standpoint of you have data, you have new data, and you

have factors that were developed to estimate.
The problem that I had issue with was they then, from March '17 to 2018, they assumed that the aging was going to go up again by half a percent, and that's where I didn't see any evidence for the aging increase in the paper. It struck me as they had a concern that aging would happen, but they didn't have data. At this hearing they've presented extra statistics that weren't in the rate filing of a quarter percent increase in aging in historic periods. That wasn't supplied in the rate filing. It's not evidence you would have to review it. All there was in the rate filing was an extrapolation of the same change from one data point last year to the future year.
Q. Your report states that, "It is not uncommon in this position for carriers to mitigate their rate increase to reflect demographics of the members they would like to bring back to the single risk pool". Could you explain that?
A. That's right. So, often, what you do as an insurance actuary is you're focused on broader market when you set your insurance rates, and that's one thing it didn't seem like Blue Cross reflected was really the market response to these big rate increases. And so what that means is we talked a little bit about people

dropping out of the market. Well, who are these people who can come back to the market if rates were lower, or, What's going to happen when you give a big rate increase? Is that going to push more people out? You know, likely, it could push them to the, to the lower cost carrier in the market.
If they lose membership, that would reduce their CTR requirement. So maybe you don't need as much profit margin. So there's a whole host of these economic responses people will have to the rate increases that there's no clear reflection of, Maybe we shouldn't be as conservative in these rates to reflect the way people respond to them.
Q. What would you recommend that Blue Cross Blue Shield do differently to predict aging?
A. What I would recommend is -- we asked some questions about what would happen, and aging is really a demographic modeling exercise. One of the ways you could do it would be to actually take your aging cohorts. For example, Blue Cross has stated one of our questions about this that the Vermont population is getting older. I'm personally getting older, and most people in this room are, but what they meant was that, on average, the average person in Vermont's getting older.

But it's an important point that, when people in this country pass 65, most of them go to Medicare. So that Medicare dynamic within the aging population really can change this age factor, and that's the type of modeling that really needs to be done to estimate if this population really is increasing or not. Some of this is a small group market and individuals. Sometimes Medicare is primary in this market so it lowers costs. So there are a lot of things to consider when you, when you're presenting this sort of demographic modeling and impact on aging.
Blue Cross really just relied on one data point they presented in the rate filing. To me, that expresses a concern. A concern is not what you build into rates. That's what your surplus is to reflect is your concern.
Q. Did you read Blue Cross Blue Shield's response memo that was in response to your expert witness report?
A. Yes, I did.
Q. And did they address your aging trend recommendation in that report?
A. I don't believe they addressed that one.
Q. And was anything -- did anything that was said in today's testimony change your opinion on that aging?

A. No, except to say they provided extra data that wasn't in the rate filing, and it's very difficult to review a rate filing. They easily could have presented that, that data of a quarter percent, whether it's right or wrong, but what that would have led to, if they had multiple years of a quarter or a half of a half of a percent and then showed a half a percent, maybe you'd say it's reasonable to add the quarter percent, but, for some reason, they just picked the data point that was half a percent. So it was a little concerning.

Q. Okay. Let's move on to the utilization trend. Could you explain your recommendation regarding the utilization trend?

A. That's right. I recommended a 1.9 percent reduction in utilization trend. It was based on the review of the Blue Cross Vermont analysis. They, they misused the statistics, or they applied the statistics appropriately. For some reason, they didn't explain the trend, but they left them in the report. So what I did was first I attempted to validate that the statistics they presented were reasonable. It turned out those statistics were not reasonable. They didn't predict the future.

And so those statistics they used from the

regression were all higher than 2 percent. So they had a 10 percent regression number, I think they had a 4 percent regression number, and they had a 3 percent regression number, and then in their report they say, But we're going to use 2 percent, and they say, Because 2 percent is less than those regression numbers, it's reasonable, and that appears to be the only justification for the 2 percent utilization trend.

The 2 percent was the most recent data point. Admittedly, in their development of that data point, it was reliant on them adjusting the 2015 data. You know, they mentioned presumably that would have increased the trend, and so I, I, I found that there's probably a better way to do this than the way Blue Cross of Vermont handles it.

Q. Could I refer you to Page 5 of L&E's report --

A. Certainly.

Q. -- at Tab 11?

A. Tab 11? Do you have the page in the workbook?

Q. Sure. 251.

A. 251? Thank you.

Q. So have you seen those two tables listed here before and -- have you seen these two tables before?

A. That's correct. I've seen these two tables before.

Q. What, what do you see when you look at these tables?

A. I see a table that shows a 10.6 percent trend. I don't know why it's in the record. It's clearly not predictive of any of the range of trends we've seen. It really just means Blue Cross took a statistical formula, applied it to data, and that data is not relevant to this report because it doesn't predict the future.

Q. So in your paper you discussed statistical regression methodologies. I'm going to ask you if you could demonstrate that for the Board. Is that okay for the Board? We have a -- I apologize if this isn't visible to everyone.

ATTORNEY HUGHES: So I'm assuming you're not trying to introduce this into evidence.

ATTORNEY KUIPER: No, I'm not. This is just for demonstrative purposes.

MR. HORMAN: This saves everybody from my drawing. Thank you. Statistical regression is, you know, it's exactly -- it's a time series. L&E discussed it, and what it's saying is that you have a factor you're estimating. In this case, Blue Cross is estimating utilization of severity trend, and you're saying that it's a function of time. So, what you can

clearly see from the dots here with the arrow is that, in this past, you have, you know, a clean line through these dots.

ATTORNEY HUGHES: And I'm going to interrupt. I cannot see what he's pointing to. So, unless you give me a copy, I would ask that you stand back so that I can actually see what you're doing. Thank you.

MR. HORMAN: You're welcome. So you have the dots that you draw a line through the dots. That's actually called fit. That's not a statistical regression. Fit means that those dots, that line fits well within those dots. The regression is then taking those dots and sort of forecasting them forward, and, as you imagine, if this line fits well for these dots, if it was predictive of the dots, you would see an increase in line on the dot.

In this example -- this is just a demonstration of what I did is that I tested L&E's statistics that they used to predict the future on past data to see if it predicted recent past, and what I saw was something the dots don't line up with the regression. And so, really, what it just shows is that the application they used in the rate filing really doesn't predict, doesn't predict the future rate, and this makes sense because it's really a residual estimation of the trend, after

unit cost, sorry, the residual trend after their unit cost.
BY ATTORNEY KUIPER:
Q. Thank you. Could you explain why you state that Blue Cross Blue Shield could be held to MVP's utilization trend?
A. Certainly. It was just, when you look at the development -- when Blue Cross presented their trend methodology here, they talked a lot about cost category movers. They talked about cancer drugs, for example, how that impacts a cost category. Blue Cross identified three areas that are going up. They, I assume they didn't identify any that are going down. The presumption is none of them are going down based on their examples.
But the way MVP did it was they did a projection more based on the actual cost category and the utilization within those cost categories, and so it's more of a construction of the trend as opposed to a measurement of this residual error like Blue Cross did. And what I've found in my career is the best way to predict the trend is that construction of trend. You know, I've done it -- at times, I've had to do it less complex than MVP, but I did have a more rigorous process where I went to every single level including

maternity saying, What's happening on maternity? We can look at the cost category of maternity. Is it going up, or is it going down?
Then I did fit statistical regressions to those categories, the utilization counts, the severity measures. Then I deemed whether the statistical regressions were predictive or not of those categories, and it makes a lot more sense when you're doing it at a little category because it really is this change over time.
And, as Blue Cross mentioned, the data they provided included a massive change after the ACA. That wasn't something I overlooked. That was something they decided to include in the data that most actuaries would have controlled for. You would have taken unrelevant data out of the data set before you present it to the public, and you would have used the statistics on that data set. So, so that that estimate at the category level is a better estimate. MVP did it at the category level, and I think it's a better estimate.
Q. Did Blue Cross Blue Shield's response memo to your report address your recommendations regarding utilization trend?
A. No, they didn't.

Q. Did anything that you've heard in testimony today change your opinion on that matter?
A. No, it didn't.
Q. Let's move on to your CTR. Could you explain your recommendation related to CTR?
A. Certainly. When I looked at CTR requirement, what I did was I took the Blue Cross exhibit, and Blue Cross mentioned that that exhibit is not -- they used the term it's just an example, but in the rate filing they provided an example that showed a 3.2 percent and then said how they selected a 2 percent. By the time it got to the hearing, that example shows a 1.9 percent. So maybe even they're admitting that their 2 percent is a little higher.
But what I did is I used their example. I made a correction to reflect the fact that their example was based on premium. The CTR should be based upon claims that brought down the CTR requirement. Blue Cross assumed 700 percent, and this is not 700 percent for the company. This is just the growth year over year on the size of the company they're assuming. So brought that down to 500 percent just on growth.
So that doesn't mean I'm bringing the whole company down 500 percent. It just means that the extra growth year over year is applied at the 500 percent.

And then also what I did was I reallocated their investment income, and, to the point of where we talk about these market forces and the importance of keeping low rates, you know, my review of Blue Cross's financial statements, it did look like they had other lines of business that were generating better profit, and what I've found is that it is common to have your higher profit lines tend to generate more of their own profit than your lower profit lines which rely more on the internal investment allocation.
Q. L&E pointed out that Blue Cross Blue Shield's RBC range is in the bottom half of actual RBC's for Blue Cross Blue Shield plans nationwide from 2012 to 2016. Does that change your recommendation on this point?
A. No. Many of the Blue Cross plans are, like Blue Cross Vermont, they're a local monopoly, and they tend to have more surplus than other plans, and maybe they do have a fair surplus, but they should have a fair example of companies. They should have all different types of companies and say, What's the appropriate surplus a company should have, not just a group of Blue Cross plans.
Q. You read Blue Cross Blue Shield's response memo on this point, did you?
A. Oh, I did read it, yes.

Q. And what was your reaction?
A. My reaction is it seemed like they updated it. You know, they said they didn't make a change in response to my calculation. It looked like they did make a change in response to my calculation. They changed the calculation to rely more on claims than premium, and the other thing in the -- you know, they say I misused the trend factor, but, in fact, I used a simple approximation and a simple formula as opposed to, as we see in the rate filing, they do have hundreds of demographic factors. They've got benefit factors that are moving down.

So I simply applied the trend. But then what they did with this calculation after they made the one correction is that they kept the size, the target RBC ratio at 700 percent and they didn't make any changes to the investment allocation.

Q. Thank you. So let's talk about your last three recommendations that were combined.
A. Certainly.
Q. So let's start with the dental trend. Could you briefly explain your recommendation on that point?
A. That's right. So taken in and of itself, Con used the term "noise", but what happens with this dental trend is it's a very small population, but it's just a

highlight of, Here's a small category. Here's a pretty conservative trend adjustment of 10 percent where the industry is saying dental trend's trending at 4 percent. It's an example of that that, Is it material on the rates in and of itself? No. But, five of those things, would they be material in and of themselves? Yes.

Q. Could you briefly explain your recommendation for the reduction of administrative costs?
A. That's correct. Another finding we had was the administrative costs. One of the reasons, you know, I, one of the reasons I brought it to the attention is that one of the presentations I saw was a little misleading by showing the percentage of premium going down for the admin was because it was almost established in this argument that Blue Cross is so efficient that their admin can't be challenged, and I don't think that's right.

What I did do was, reviewing their filing, Blue Cross said that they were giving a 3 percent merit increase to employees, and that's not what I'm opining on. We followed up with that because what happens with employees is employees move up the ladder and higher cost employees retire out. So the term "merit", some of that's inflationary, and some of that's really this

natural cycle as people progress through the organization. Upon, and, you know, they, they mentioned the statistics in here, but the real statistic was the per capita change in their employee cost, and that was 1.4 percent over the history, not 3 percent.

Now, Blue Cross, you know, they presented there were more statistics on that page. Their one was 7 percent, but that includes the number of employees they have. The rate filing is talking about the per capita change in their employee cost. That's what they used to justify the rate increase. A 7 percent increase because of the number of employees isn't relevant to the statistic they used in the rate filing. Those, those higher statistics really weren't relevant. Really, at the end of the day, the statistic they quoted in the rate filing was, came to 1.4 percent historically, and that's what I used.

Q. Could you briefly explain your recommendation on the reinsurance refunds?
A. That's right. I had a reinsurance recommendation, and reinsurance is needed by insurance companies to protect from high-cost claimants. Blue Cross added $1.65 to the rate filing. The $1.65 is for the cost of reinsurance beyond the claims that are coming in. This

is the one number in my report that has a range. There's obviously ranges around every number, but I tried to provide the best estimate.

And what most reinsurers do is they offer a premium refund if the reinsurance is well in excess of claims actually paid, and so with this estimate what I said is, There's $1.65 built into Blue Cross's premium, but the, the reinsurer or with, you know, a standard reinsurance contract would likely pay back a good chunk of that money.

Q. Did Blue Cross Blue Shield's response memo change your recommendation on any of these three issues?
A. No. Blue Cross identified in the reinsurance that they don't have a clause for return of premium, but I don't know if that response was relevant because you renew your reinsurance contract every year. So they have the ability to renew this contract in 2018, so, or at least most carriers. I can't speak to their contractual terms, except every other carrier, it's an annually renewed policy. So they could change the terms of this reinsurance contact.

Q. Did any of the testimony you heard today change your recommendations on this?
A. No.
Q. And did Blue Cross's memo or any testimony you

heard today change your recommendations on any of the points in your report?
A. No.
Q. A few minutes ago you described your recommendations that impact the rates. What is the combined impact of your recommendation on the requested rate?
A. The combined impact is about 4 percent, and my recommendation in the report is that L&E and Blue Cross go back to their own rating models and, because there's so much dependency for each product and, you know, adjustments that are functions of other adjustments. With that complication, though, it's about a 4 percent difference.
Q. In your review of the filing, did you find any issues that led you to believe that the rates should be increased?
A. I did not find any filings, but I did review a few topics to see if they were justified.
Q. And what did you find?
A. I found they're reasonable. I reviewed, one thing I reviewed was a leveraging factor which MVP uses in their rate filing. It reflects the -- if you think of Blue Cross as a company, a member has a $1,000 deductible today, and they have a $1,000 deductible

next year. Well, most of the trend is going to fall on the insurance company. So the leveraging factor reflects that, but upon further review, Blue Cross used a different methodology than MVP uses, and leveraging is reflected in their rate filing within their actuarial value factors.
Q. So let's move on to L&E's report and L&E's testimony.
A. Sure.
Q. Do you agree with the -- do you agree with L&E's recommendation regarding hospital budgets?
A. Yes.
Q. And do you agree with L&E's recommendation regarding the risk adjustment calculation?
A. Yes.
Q. Blue Cross lost money in 2016. Are you concerned that this will happen again?
A. Yeah. As an actuary in an insurance company, you're always concerned about losing money, and that's what the surplus is for. I, I'm not for a couple reasons. One is that Blue Cross lost money in '16, and a big piece of this rate increase is not recouping that money but correcting for those losses. And so the items I'm talking about here are just for increases over the cost we saw in '16.

Q. Blue Cross Blue Shield has testified that, if, for instance, with capitated payments, if you can't predict what the future decrease might be, then they will wait and see how it comes out in claims. Do you think they're applying this philosophy in a balanced way?
A. No, it doesn't seem like they provide that sort of consistency.
Q. What do you mean? Could you expand just a little bit?
A. It seems that, if they have a concern of something increasing, they'll reflect it in the rates, but if they have a concern of it decreasing, they'll hold it steady, and that's where we get into having this conservatism within each factor, not at the end in that CTR component.
ATTORNEY KUIPER: Thank you. I have no further questions.
MR. HUDSON: Attorney Hughes, do you have questions for this witness?
ATTORNEY HUGHES: I actually do. Thank you.
CROSS-EXAMINATION BY ATTORNEY HUGHES
Q. So can you turn to Exhibit 14?
A. Certainly.
Q. The HCA disclosed that you were paid just under $20,000 by July 6th of this year. How much of your

billable hours been since then?
A. It's been about another 12 to $15,000.
Q. And how much are you going to charge for your appearance here today?
A. My billing rate's on this document. Would you like me to read it?
Q. No. I'd like to you calculate how much you're going to charge for today.
A. I'm not going to do that. I don't know if I could do it accurately, and then I have books. Somebody maintains those books. I have records. I'm not looking at my records. So I've been in this room -- we all know how long we've been in this room. It's probably -- let's assume it ends up being 6 hours at roughly $300 an hour. That's $1,800.
Q. Okay. So you don't travel, charge for travel time?
A. No.
Q. Okay. How many reviews of rate filings have you performed on companies that you haven't been employed by or engaged by?
A. Could you repeat the question?
Q. How many reviews of rate filings have you performed on companies where you haven't been employed by them or engaged by them?

A. I, I don't know if I understand the question.
Q. So you did a review on Blue Cross's rate filing. You're not employed by Blue Cross. You're not contracted with Blue Cross.
A. I see. So, so you don't mean not engaged at all, but engaged by a third party?
Q. Engaged by a company, by the company.
A. By the company?
Q. Yes.
A. Okay. I don't I believe this -- so you're, you mean my role right now?
Q. Yes.
A. Yeah. I think this is unique.
Q. Okay. Did you serve as the chief actuary or acting chief actuary for Neighborhood Health Plan in Massachusetts from June 2013 through October 2016?
A. That's correct.
Q. Okay. And online records indicate that Neighborhood Health Plan had a capital and surplus position of just over $97 million as of December 31, sorry, 2013. Does that sound about right?
A. That's correct.
Q. And what was Neighborhood Health Plan's net income in 2014?
A. 2014 was -- I don't remember exactly. 2014, so

2014 there were a lot of losses.
Q. Okay. Could it have been a $101 million loss?
A. Oh, it was a lot. I lived through it.
Q. And records indicate that the December 31st 2014 capital and surplus position was just shy of $129 million due in part to a paid-in surplus of $146 million; is that correct?
A. That, those numbers sound reasonable. There was extreme -- you know, I came into a plan with extreme financial issues.
Q. And what was Neighborhood Health Plan's net income in 2015?
A. It, it's hard to estimate. If you did the numbers, right, we put up a big deficiency reserve, and so it really deals with the timing of the difference between the deficiency reserve and whether you correct for that. So but the answer is they were performing very, very poorly.
Q. So would a loss of $16 million sound about right?
A. No, I think it was much bigger. Like I said, because the accounting rules require you to put a premium deficiency reserve on the prior year, so a lot of the numbers you might be quoting deal with timing, and, you know, I, I will -- I didn't prepare the financial results, but, you know, I will speak to them.

Like I said, I came into a plan not very well capitalized. Fortunately, it had a large parent that went into ACA and grew exponentially and had a very, very difficult time, and they were, they were very committed to the community and working within it. Since I was there, we were working through the financial problems the whole time.
Q. So let's fast forward to 2016. What was their net income in 2016?
A. Their net income, again, I really -- we'd have to look at the balance sheet. Because I put up a big premium deficiency reserve that would have flown into '16. So it's not really reflective of the losses in '16. Accounting rules really require you to change timing of when these losses hit the financial statement.
Q. So does a loss of about $104 million sound right?
A. Yes. I mean, these losses were massive.
Q. Okay. And in 2016 did Neighborhood Health Plan implement a corrective action plan developed in conjunction with the Commonwealth of Massachusetts?
A. In 2016? I really can't speak to confidential communications I had within an organization, but, Neighborhood, we had a significant issue with the Medicaid plan. I think that's not, what -- you know,

one of the things we're not really talking about is that a lot of problems for Neighborhood dealt with Medicaid, and you have an organization that was incredibly committed to maintaining the benefits of a Medicaid population. You have a large provider system who was willing to fund them through those losses, and, yes, we were in constant, constant communication with the State of Massachusetts about the Medicaid rates.
Q. So what was Neighborhood Health Plan's average Massachusetts Connector -- that's Vermont's, I mean, Massachusetts's version of Vermont Health Connect. What was the increase that was approved for 2017 plan year?
A. It was high, and I'm not sitting here saying I've never given a high increase. I am saying I've been at incredibly financially challenged companies and given a high rate increase. Blue Cross is not incredibly financially challenged.
Q. So was it about 21 percent?
A. It may have been 21 percent, yes.
Q. So let's turn to Page 284 in the binder.
A. Which page was that?
Q. 284. So on this page, and I'll paraphrase slightly, you say that, if you use a certain methodology to conduct the backcast of 2016 and that

backcast fails to predict 2016 actual results, that the methodology is not reasonable to use in making projections to 2018.
A. Yes, I did say that in my report. A big theme of this was that the regression methodologies presented did not predict the trend.
Q. So then you proceed to go through three different methodologies that you think might work?
A. That's correct. So when, you know, when you apply actuarial science, you find a methodology that fails and say you can't use this, and so what I did is I said, What's the data and information available to me to estimate a different trend?
Q. So did you conduct a backcast of any of those three estimates?
A. Did I perform a backcast of any of those three estimates? No.
Q. So you don't know whether any of your methodologies would have predicted actual 2016 utilization trend?
A. That's correct.
Q. So, regarding, so you had the three methodologies, right? So, regarding the first methodology, did you review Blue Cross's 2017 filing so that you could opine on the methodology and conclusions found in there?

A. Yeah. As part of this review, I went back to 2017 and accumulated the statistics.
Q. And what did you find?
A. They've, I found there was a 1 percent utilization in severity trend.
Q. And was that reasonable?
A. It was -- was 1 percent reasonable? It was in a public rate filing, so I assume it was reasonable, yes, and I found it to be reasonable.
Q. So, regarding your second methodology, how did you adjust your data to reflect the large-scale population changes that took place from 2013 to 2014?
A. It, it wasn't my data. It was Blue Cross Vermont's data and supposed to be the best available data to estimate trend. That's why they put it in the public rate filing. That should be transparent. I used the data Blue Cross had. I don't know why they didn't adjust for the population change. I performed similar statistics that Blue Cross had and found they didn't work, and then what I was left with was the Blue Cross data set, which you pointed out wasn't an appropriate data set to be in the rate filing, and gleaned as much information as I could from it.
Q. So I'm sorry. I may have misunderstood one of your words. Could you repeat that?

A. Which word?
Q. I couldn't understand whether you were using a positive or a negative.
A. You'd have to repeat what I said. Could you just ask another question as to what you don't understand?
Q. No, I'm going to move on. So your third methodology is to use the trends from MVP's filing; is that correct?
A. That's correct.
Q. And did you review MVP's filing to determine this opinion?
A. Yes, I did.
Q. And did you provide any part of your analysis of MVP's trend, whether in draft or final form, to the HCA in writing or electronically?
ATTORNEY KUIPER: I'm going to object to this.
MR. HUDSON: On what grounds?
ATTORNEY KUIPER: That's confidential attorney information. It, we're talking about the MVP information he applied he has given to the HCA.
ATTORNEY HUGHES: So I would like to respond.
MR. HUDSON: If you want to rephrase to avoid the attorney-client privilege, it seems conceivable that --

ATTORNEY HUGHES: Well, two things. One, he's the one who said he relied on the MVP filing, and so I'm trying to get at that. But, Number 2, the HCA was under an order by the Board to produce data, and I have a quote here, "Copy of the expert opinion prepared and signed by the witness as well as the facts, opinion data, and documents relied on as a basis for the expert opinion". So, if he provided the HCA with an opinion, they were required to turn that over to us, especially in connection with our requests, because this is what he is relying on in part in his opinion, and so we are entitled to probe what that is.
MR. HUDSON: I can --
ATTORNEY KUIPER: Can I just speak? I'm, I perhaps misunderstood. If you were referring to information that, that on the MVP filing that relates to his opinion here, I don't object. If you're referring to all information, all of his analysis on the MVP filing in general, I just don't think it's relevant here.
ATTORNEY HUGHES: I asked analysis of MVP trends. That's what we're talking about.
MS. HENKIN: And there was a yes-or-no question, Did you produce any analysis on the MVP; is that correct?

MR. HUDSON: That's what I heard.
MS. HENKIN: Could you read back the question once more quickly?
ATTORNEY HUGHES: So the question was, Did you review MVP's filing to determine this option? He said yes. I said, Did you provide any part of your analysis of MVP's trend, whether in draft or final, to the HCA in writing or electronically?
MS. HENKIN: Thank you. I was asking the court reporter, but thank you.
ATTORNEY HUGHES: Yeah.
MR. HUDSON: All right. To resolve the issue, okay, whether -- okay. If you're fine with the question, then we've resolved the objection.
MR. HORMAN: Yeah, and just to reaffirm what I said earlier, I did review it, and I found that MVP's process was better. What they did --
BY ATTORNEY HUGHES:
Q. Excuse me. That's not responsive to the question.
A. Well, can you repeat it?
MS. HENKIN: It was a yes-or-no, Did you provide them something writing
MR. HORMAN: Oh, no. On trend? No. But I reviewed it as part of a review of this Blue Cross, and I, I, I had -- I don't know if I -- I had a draft memo,

but it, it didn't deal with any issues with the MVP utilization trend.
BY ATTORNEY HUGHES:
Q. So nothing in writing about MVP trend?
A. Besides what I wrote in the Blue Cross?
Q. No, altogether. Because you relied on the MVP, you were trying to drag the MVP trend into this, we need to probe what you did and why and where that leads us.
A. Well, I guess I have the L&E report which said it was reasonable.
Q. Reasonable for MVP?
A. That's correct.
Q. They didn't say it was reasonable for Blue Cross?
A. No. We were --
Q. As a matter of fact, I think they said the opposite, okay?
A. No. That's right.
Q. So can you describe MVP's trend methodology to the Board?
A. I, I did. I can repeat it if everybody wants to hear it again.
Q. Yeah, it would be helpful, thanks.
A. Certainly. MVP, instead of taking this residual error approach where they take the claims and identify

one factor which is unit cost and then measure the change, the difference between the trend and the unit cost, MVP broke it down more in the functional components of the trend. Not, as I mentioned, not as in detail, not as in detail as the question, Was it at the maternity level, but, certainly, it was at the inpatient, outpatient, and physician level where they measured the actual count of those services and the change over time.
Q. So what was their conclusion?
A. They came to a seven-tenths of a percent utilization trend.
Q. So you state on Page 6 of your opinion, which is Page 275 of the binder, that we should use statistical regressions that are predictive based on statistical best practices; is that right?
A. That's right.
Q. And did MVP measure the statistical validity of their regressions?
A. They presented the actual data point in the trend going through those data points. They did not perform the analysis which I performed on Blue Cross's to show that the statistical regressions they used did not predict the future, no.
Q. So their results did not predict -- MVP's results

did not predict the future, is that --
A. That's not what I said.
Q. Why don't you repeat what you said?
A. I said -- your question was, Did they, did I perform analysis similar to the analysis I performed on Blue Cross where I demonstrated that Blue Cross's statistics didn't perform the future? I said I did not perform that analysis on MVP, nor did they.
Q. So, if MVP had used the R-squared, what R-squared result would indicate to you that their methodology was sufficiently predictive?
A. R-squared's a measure of fit in statistics. It's not a measure of prediction. It only shows that, in our past example, the line fits, the data point fits between the data points very well. It's something people use to filter out statistical regression methodologies because, certainly, you'd need a statistical regression methodology with a good fit to be predictive, but it doesn't imply that that regression methodology is predictive.
Q. So, in Finding 6 of your opinion, you found that it would be appropriate to rely on the 2017 Segal Trend Survey to select a trend rate. Would that also be an appropriate way to select a medical utilization trend?
A. No. I mean, this is a small, this is a small

factor. You'd obviously -- you know, I think, if you take the medical utilization trend assumption that that's about 2 percent, the difference between what we're talking about, that's $8 million. So, to just that $8 million increase in rates, you would want to spend a lot more money to develop more appropriate systems. This dental trend has significantly less money. I don't want to even attempt to estimate it. So you want to spend the same amount of time to justify it.

Q. So you found that there was a national 4 percent dental trend?

A. There was a publicly available survey that showed most dental plans trending at 4 percent, and I, I found that statistic to be relevant because it says, you know, at some point, this pediatric dental population, once it's established at the level it should be, should trend roughly with everything else.

Q. So that national trend, was that specific to pediatric?

A. No.

Q. Okay. And, obviously, it wasn't specific to Vermont, right?

A. No.

Q. And did it measure dental as a new benefit?

A. No.

MR. HUDSON: Attorney Hughes, at this point, I do want to note the time, and I want to be sure that the Board has the chance to question the Witness before the public comment period starts.

ATTORNEY HUGHES: I'm nearly done.

MS. HENKIN: Let's go.

MR. HUDSON: Oh, that's terrific.

ATTORNEY HUGHES: But you just ruined my train of thought here.

MR. HUDSON: I apologize. Hopefully, I didn't add too much time to the proceeding.

BY ATTORNEY HUGHES:

Q. So, earlier, you said RBC is designed to absorb losses?

A. Well, it's designed to protect a company when they have losses.

Q. Okay. So it's not designed to absorb them?

A. No. And, if that were the case, you know, companies would go out of business if you just had a pool of money and, you know, you kept taking losses against that pool of money.

Q. So earlier you said that there were extra statistics presented today that was not in the Blue Cross filing. Could you turn to Page 29 in the binder?

Would you look at the bottom of the page? There's a chart there. Were those statistics that you were referring to actually in the binder?

A. That's correct. But it's in a different section than the section where they justify the age trend. You know, it --

Q. But they were still there?

A. That's correct. And maybe I should clarify. I said those statistics weren't in the aging section, and I reviewed this specialty section, but I didn't pick up on that they had some of those extra statistics because Blue Cross didn't use them to justify their aging statistic.

Q. But they're still there, right? Just --

A. You're 100 percent accurate.

Q. Okay.

A. I'm looking at Page 21, and I see a trend from '15 to '14 on age.

Q. Can you turn to Page 175?

A. That's right.

Q. If you look at Question 18, does that present the same factors again?

A. That's correct. That's there.

Q. You testified that, in your experience, companies would mitigate rate filings to get more business; is

that correct?

A. I don't think I said that.

Q. Okay. So, if an indicated rate is of a certain amount, are there reasons a company would mitigate their rate filing?

A. So I think what you're getting at is I explained the economic response customers have to price. It's well-established economic theory that, in a competitive market, people make a decision based on price, or, if they have another option like opting out of the market, they will make a decision on price. That's not something I came up with.

Q. Okay. But I believe you were talking specifically about companies mitigating their rate filings.

A. That's correct. Sometimes, as a company, you have to look at your overall price relative to your market, and you have to say, using those economic theories I cited, What's going to happen to my company if I present this rate to the street and my competitor has so much lower rate or those members, you know, have a penalty which is much less than the cost of the plan? For some people, I think the penalty is probably less than the increase in these rates.

Q. So was mitigating the rate filing ever a strategy at Neighborhood Health Plan?

A. Was mitigating the rate filing ever a strategy?
Q. Yeah.
A. I think that's a confidential strategy of a company. I don't think I could speak to it.
MR. HUDSON: Yeah, Attorney Hughes, again, I want to keep my eye on the clock and note that that prior company is not the subject of today's docket. We do need to keep things moving.
ATTORNEY HUGHES: Thank you.
MR. HUDSON: Thank you. Do any Board members have questions for this witness?
MS. LUNGE: I don't.
MR. HOGAN: No.
MR. HUDSON: Thank you, Mr. Horman.
MR. HORMAN: Thank you.
MR. HUDSON: So, at this time, we do have some witnesses remaining to be heard, and we --
MS. HENKIN: I think we should get done if we can.
MR. HUDSON: If we've got 15 minutes until 3:00, then we will hear our one remaining witness today, DFR.
ATTORNEY HUGHES: I would like to ask a question while Jesse walks to the witness chair. So will we have an opportunity for rebuttal? I know that

I asked for that. We can do it --
MR. HUDSON: Depending on --
ATTORNEY HUGHES: -- next Thursday or whatever, Wednesday, when you were planning on reconvening this.
MR. HUDSON: There will be time for closing statements. The request for rebuttal, to the extent that it's an issue, I want to consult the rule about whether, if that has to happen at the election of the Board or one of the parties, and, at this point, I'm concerned with more just time here.
ATTORNEY HUGHES: Okay. So you won't mind if we put it in a memo?
MR. HUDSON: Well, certainly, there's post-hearing memos coming, and we assume that. So respond to anything in that memo.
ATTORNEY HUGHES: Okay, thank you.
MR. HUDSON: All right. Good afternoon, gentlemen. So this is an appearance by the Department of Financial Regulation. They're not a party to this proceeding, but they are designated by statute as a witness. I will note that DFR's witness today is accompanied by DFR's general counsel, Mr. Scott Kline. Welcome, Attorney Kline. And so greetings, sir. Will you state your name for the record?

MR. LUSSIER: My name is Jesse Lussier.
MR. HUDSON: And will you provide a brief, a very brief description of your job?
MR. LUSSIER: I'm an insurance examiner at the Department of Financial Regulation. I'm involved in all aspects of the company, licensing, analysis, and examination.
MR. HUDSON: Welcome, and please proceed with your recitation.
MR. LUSSIER: I'm going to skip some of the background of what we do at DFR that we went over yesterday if that's okay to save time. One item I noted that has come up a couple times is RBC. I just wanted to briefly say that the RBC calculation is a measure of surplus adequacy. It is not a stand-alone measure of solvency. It works well in conjunction with other ratios, other methods, and other tools, but, again, it's not a stand-alone solvency measure.
We did file an opinion, and we amended our letter, and that's because we had, in the original filing, mentioned a CTR component that was later updated by Paul Schultz. We felt that it was necessary to reflect that change in our letter. It does not affect our overall opinion. With respect to the actual opinion of our letter, we have concluded that proposed rates will

not have a significant impact on our overall assessment of Blue Cross's solvency and that no downward adjustments should be made unless actuarially supported.
This is the Department's general philosophy, that rates should stand on their own, and, again, we relied on the Green Mountain Care Board's actuary to opine on the rates as both adequate and not excessive. I'll keep it brief. So thank you.
MR. HUDSON: Do we have any -- I hesitate to request attorney questions, but --
ATTORNEY HUGHES: I do have questions.
MR. HUDSON: If you have a question, we'll have it.
CROSS-EXAMINATION BY ATTORNEY HUGHES
Q. Okay. So DFR is the primary regulator of Blue Cross Blue Shield?
A. That's correct.
Q. Okay. Unlike MVP where you are relying on New York to do that for you?
A. That is correct.
Q. And how often are you in contact with staff at Blue Cross Blue Shield?
A. Normally, at least on a quarterly basis, I would say, on average. We receive financial statements on a

quarterly basis, and we normally have questions about those statements.
Q. Can you give us more detail about your quarterly analysis? Does that just involve the statements, or do you do more?
A. For any analysis we do, it depends on the company. Our analysis is confidential, so I'll keep it at high level. We receive quarterly financial statements. We look at those. Sometimes we review it for any kind of trends as well as just the stand-alone bottom line. Sometimes we will normally look at comparative numbers ratios and some other financial factors and go from there.
Q. Can you give us an example of one of the ratios that you might look at?
ATTORNEY KLINE: In general?
BY ATTORNEY HUGHES:
Q. Well, pick an items ratio.
A. We might look at the loss ratio, for instance. That would be the losses over the revenues.
Q. Okay. And were these ratios and other metrics that you talked about, were they all developed by DFR?
A. No. There's the National Association of Insurance Commissioners website which is I-site is a data aggregation tool that has all the filings over the last

ten years, and they have standardized ratios and reports that we have access to, and we would utilize on a quarterly basis.
Q. So do all health companies across the nation report to that site?
A. The majority of them. I'm sure there are some exceptions, but, generally, yes.
Q. And the analyses you do once you have those ratios in hand, are they all performed in-house by DFR staff?
A. Yes.
Q. Are any of them computer-driven?
A. Are any of the analysis -- parts of them are. Some of the standard ratios will come out so that we don't have to calculate them manually in that sense.
Q. So the Department developed those, or are they also NAIC?
A. NAIC.
Q. And do you consider any independent reports or other sources of information in your quarterly reviews?
A. Anything that is deemed relevant, sure.
Q. And how about your year-end review; what do you look at in addition to the quarterly statements?
A. The year-end reports are a little bit more robust just on the annual statement level. An insurance company will also submit an audited financial

statement, actuarial opinions, the RBC report, some supplemental filings such as the supplemental health care exhibit, there are some other various reporting items that are dependent on which company it is.
Q. And I believe you testified yesterday that companies are examined once every three to five years. Is that about right?
A. That is correct, unless there's -- we can go in earlier than that if deemed necessary.
Q. Okay. And have you recently examined Blue Cross?
A. They're, they're, the most recent examination was as of the five-year period ending in 12/31/2015.
Q. And when did you start the exam of that five-year period?
A. I don't know that off the top of my head.
Q. How long did the exam last?
A. We had the overall examination from the very beginning meetings to when the final report was issued, several months.
Q. Any estimate of how much an exam like that costs?
A. I don't know off the top of my head. I don't have those numbers in front of me.
Q. Can you give us a ball park?
A. The cost of the examinations can run from tens of thousands to a few hundred thousand, possibly,

depending on the company and the complexity of the company.
Q. And what areas of the books and records of the company do you review? Do you focus on any particular thing, or do you look at all of them?
A. During the course of an examination?
Q. Yes.
A. Could you repeat the question so I'm clear?
Q. What areas of the books and records do you look at? Do you look at just some directed, or do you look at all of them?
A. We don't normally look at all of them. Part of the examination process is it's taking more of a risk-based focus, which means we identify risks associated with the entity, and then we will test those specific risks.
MR. HUDSON: Attorney Hughes, do you have any specific questions that are specific to the DFR's solvency opinion and its contents? If we could move on to those, that would be great.
ATTORNEY HUGHES: Well, there's been a lot of questions about what people can look at as opposed to just using RBC, and so I'm trying to develop that it's not a one-dimensional RBC and how much money do you have in the bank. DFR engages in a rigorous review of

the company, its books and records. They do financial exams every five years. Those exams are extensive. They also do RBC. I'm going to get into RBC.

MS. HENKIN: I'm going to object to you, because, as you know, we're a little short on time, and, if that's what you want to ask, I would ask for the Board that you ask those questions more specifically instead of going through if they look at this type and that type. If you want to ask about a rigorous exam, I don't have an objection, but, other than that, I don't think the Board has to hear step-by-step on this.

BY ATTORNEY HUGHES:

Q. Okay. So what is the function of RBC?

A. RBC is a tool to help monitor surplus adequacy.

Q. And, in RBC terminology, there is something called an authorized company level. Can you describe what that is?

A. Essentially, it's, it's a number that the RBC report spits out. It's, it's a benchmark of surplus adequacy.

Q. So it's not just a line on a financial statement? Blue Cross calculates, they put things into a formula, and out comes an RB, or the ACL result; is that right?

A. The ACL comes from the RBC report calculation.

Q. And can you give us just a few factors that go into the RBC calculation?

A. I'll give one quick factor that's, I think, relatively easy to understand, membership levels. If you have more members, you'll need more surplus to cover those members, and, likewise, if you have less members, you'll need less surplus to cover those members. That would impact the RBC ratio calculation.

Q. So do you have your amended letter in front of you?

A. Yes.

Q. And can you go to Page 2 of that letter?

A. Okay.

Q. And can you tell us about the threats to solvency that are outlined in your letter?

A. The four threats that are listed?

Q. Yes.

A. Would you like me to read them?

Q. No. You can just give us the heading for each.

A. Adverse medical cost trends, adverse utilization, premium adequacy, and membership.

Q. And are these four threats the only ones that exist in the universe?

A. No.

Q. Does your report provide two instances of these

type of events occurring with respect to Blue Cross?

A. Yes.

Q. Okay. Can you just briefly describe those?

A. The first is adverse utilization. If Blue Cross experienced a higher than, higher claims expenses than they originally projected, and the second is premium inadequacy. Paul had discussed that briefly during his testimony.

Q. And is premium inadequacy the same thing as a loss?

A. Not necessarily.

Q. Okay. So has Blue Cross had any losses since you joined the Department?

A. Yes, they have.

Q. Okay. And did they have one in 2016?

A. Yes, they did.

Q. And how much was that?

A. The net loss was approximately $9 million.

MR. HOGAN: 9.5.

ATTORNEY HUGHES: Not 39.

MR. LUSSIER: Thank you, Mr. Hogan.

BY ATTORNEY HUGHES:

Q. How would you characterize the trend of Blue Cross's RBC without using actual RBC results?

A. RBC has declined year over year since 2014.

Q. Is it the Department's opinion that a 2 percent CTR that Blue Cross is requesting is reasonable?

A. The Department's opinion is that the range that Blue Cross has targeted is reasonable, and actuaries agree with that, and, also, when it comes to the rate components, we normally defer to the actuaries as well, and L&E, I believe, used the term "definitely reasonable" on 2 percent contributions to reserve.

Q. So can you read the last paragraph of the Commissioner's opinion?

A. The last paragraph?

Q. Yes.

A. "DFR does not suspect the proposed rate will have a significant impact on our overall solvency assessment of Blue Cross Blue Shield of Vermont. However, any downward adjustments to the filing's rate components that are not actuarially reported will reduce Blue Cross's surplus over time and could negatively impact its solvency, thus impacting access to health insurance in Vermont."

Q. So, if the Board were to reduce Blue Cross's rates contrary to the opinion of the Board's actuary, would the Department have a concern?

A. We would probably want to revisit our analysis. We'd rely on the actuaries to give us an opinion on

rates as filed, and that we believe the rates as filed have been deemed reasonable by the actuaries.
Q. And were you here yesterday when Jacquie Lee provided the definition of adequate, an adequate rate?
A. I was. I'm not sure I remember.
Q. I believe she said that the term adequate as a rate is one that provides for the payment of claims, administrative expenses, taxes, regulatory fees, and has a reasonable contingency or profit margin. Does that sound about right to you?
A. That sounds good.
Q. And does the party have any opinion whether the rates approved by the Board should be adequate within the meaning as used by the actuaries reviewing this file?
A. Yes. We believe the rates as filed should be adequate and not excessive.
ATTORNEY HUGHES: Thank you.
MR. HUDSON: Okay, thank you. Attorney Kuiper, did you have any questions?
ATTORNEY KUIPER: I don't believe I have any questions today.
MS. LUNGE: I have one question. Okay. So thank you for your, for your opinion. So the, the standard of review that the Green Mountain Care Board

has to look at which is in Tab 11 Page 2 of the L&E report includes protects against insurer solvency, and that's primarily what your opinion is targeted towards; is that right?
MR. LUSSIER: Yes.
MS. LUNGE: Okay. And then, as L&E testified earlier, they look at excessive, inadequate, or unfairly discriminatory which are actuarial standards; is that right?
MR. LUSSIER: Yes.
MS. LUNGE: However, the standard of review for the Board also includes affordability, quality of care, promoting access to health care, as well as those other standards; is that correct?
MR. LUSSIER: Yeah. For the Board?
MS. LUNGE: Yeah, for the Board.
MR. LUSSIER: I believe that's correct.
MS. LUNGE: Okay. Thank you.
MR. LUSSIER: I'll take your word for that.
MR. HOGAN: Just a quick thought on RBC. What happens under the law if RBC hits 500?
MR. LUSSIER: Under the law?
MR. HOGAN: Yeah.
MR. LUSSIER: There are no regulatory thresholds at 500.

MR. HOGAN: Okay how about at 400?
MR. LUSSIER: There are no regulatory thresholds at 400.
MR. HOGAN: Okay.
MS. USIFER: Okay. You talked about the rate components that need to be actuarially supported, and we've had three actuaries present today with different ranges. So one was down 1.2 percent, two were at 2 percent, and within the L&E they talked about 1 percent would still, you know, not put Blue Cross Blue Shield below the threshold level. So how do we consider, you know, the different ranges?
MR. LUSSIER: I'm not sure that's an area that I could speak to. That will be above my pay grade.
MS. HENKIN: I have a question. Jesse, I know you have not been working on these opinions for a long time, but you've seen these before over the last few years, correct?
MR. LUSSIER: Correct.
MS. HENKIN: Has the Department ever said anything different than pretty much, Don't change anything that is not actuarially supported?
MR. LUSSIER: In, generally, no.
MS. HENKIN: So this last sentence, I'll read

it to you again: "However, any downward adjustments to the filings rate components that are not actuarially supported will reduce the carrier surplus and, over time, could negatively impact its solvency". Do you know what a truism is?
MR. LUSSIER: Would you like to explain it to me?
MS. HENKIN: Well, I'm just looking. It says the statement that is obviously true or nothing new or interesting. But is that a truism that we could put on any of these reviews on solvency?
MR. LUSSIER: Pardon me. I'm sorry. Could you repeat that?
MS. HENKIN: Could we put that on every review that we do for solvency?
MR. LUSSIER: Could we put that --
MS. HENKIN: As the State, as DFR. I'm sorry. I'm lumping myself with you. I don't mean to. I worked there one time. I clerked there in 1991.
MR. LUSSIER: I think, as we, the range was discussed previously, and, certainly, if the RBC were, were above the targeted range, I, I believe our opinion would be worded differently.
MS. HENKIN: Thank you.
MR. HUDSON: Hearing no further questions,

thank you for coming in today. So I do have a broad-based request from the Board that we do proceed to closing statements at this time.

ATTORNEY HUGHES: And I think the Board will be very pleased. I really thank you for your attention, your completely undivided attention here today, and I know that this has probably been the driest hearing you've ever sat through, and I thank you for your time, and we will put all of our comments and arguments of substance as well as our follow-up for rebuttal in our post-hearing memorandum.

MS. LUNGE: Thank you.

MR. HUDSON: Thank you, Attorney Hughes.

ATTORNEY KUIPER: I'm happy to allow more time for public comment. We thank the Board as well.

MR. HUDSON: Thank you.

MS. HENKIN: If we're going to close the hearing except for the public comment, is there a list of available or are people signed up? Because I would be happy to do that once we close down.

MR. HUDSON: So, since we have all the closing statements that we're going to have, we should note that the evidence of the hearing is now closed. I do have a request from the Board for a quick bathroom break as the public comment section is getting

organized. So we'll grant that, and we'll start again.

(A recess was taken from 3:06 p.m. to 3:10 p.m.)

MR. BENNINGTON: I just want to let you all know my name is William Bennington. I live in Plainfield. I'm a farm worker. I currently am blessed to have Medicaid, but the farm I've worked on for five years is becoming increasingly successful, which, thankfully, is resulting slowly in wage increases for myself and the possibility of beyond seasonal work, which obviously means me making more money which means me facing this sort of benefits cliff of no longer qualifying for Medicaid but not having an employer-offered plan.

So I'm looking at maybe in the next year or so being on the Exchange and getting a plan from Blue Cross Blue Shield, and the conversation going on here today about a 12 percent increase this year, over the past four years, almost a 40 percent increase in rates is terrifying to me. I can't imagine having to sign up for one of these plans right now just because I'm making a little bit more than I currently make, and, especially, you know, I'm almost 30. I'm starting to think about having a family. Thinking about insurance for them it's pretty terrifying.

And so I just really want to tell you all that I

think that health care is a human right. I think the State of Vermont has a law to the effect that health care is a human right, and we should have a publicly financed universal health care system that you are actually, are part of that law as this Board, and I think, as members of the Green Mountain Care Board, you absolutely have a responsibility to Vermonters to reject these rate hikes and to reject all future rate hikes and to do everything you can in your jurisdiction to move this state towards a publicly financed universal health care system to provide health care as a public good.

MS. HENKIN: Thank you.

MS. KIENDL: Hi. My name is Beth Kiendl. I live in Brattleboro. I'm a nurse, and I, I really thank you. This has been really interesting for us as nurses because, as you know, we don't look at money; we look at people. And it's, you know, there's a lot of energy and a lot of agencies and a lot of people who go into working on figuring out what, which is really a very small amount when you're talking about that you can even move in this system. As nurses, we would call it constipated. I mean, seriously, and we have pharmaceuticals to fix that. You don't. You have this and us, hopefully.

Our, our commitment as nurses, the oath we take is about ensuring the health of, not only of our patients of, but of our societies. We take it very seriously. Fortunately for us and for the State, many of us are now semi-retired and have a lot of time to give. We're here. We're not going away, and we're only going to grow. We, our understanding from the statute that, you know, from Green Mountain Care Board from Act 48 is that you're coming with us, looking at accessible, equitable -- let's leave affordable to the end -- but, seriously, quality health care.

So, just for one minute, not even a whole minute, I want you to kind of be where we are. We take care of you and your families and your friends and your neighbors. We work in hospitals. I work in an admission department where I watch the number of people who we have to turn away. We work on inpatient units where we let people out early. They come back. The system is hugely flawed. We all understand that. My concern, our concern, not even concern, our confusion is that, when a bridge in the state is broken and it risks people's health, risks people's lives, the commitment is to fix the bridge, and then the money is found.

We fully believe that, if the commitment were to

the health care -- I understand there have been financial groups that worked on Shumlin's plan, blah, blah, blah, but we really believe that, if, for a minute, the health care were the issue and it was decided that X, Y, and Z was going to happen, the money would be found.

MS. HENKIN: Thank you.

MS. KIENDL: The only other thing I want to say is, We are around to help. Please utilize us.

MS. HENKIN: Ann Zimmerman, please. The next person up will be Alison Gravel.

MS. ZIMMERMAN: Hi. I'm Ann Zimmerman. I live in Guilford, and I'm using notes because I have a hard time speaking in public sometimes, but thank you for the opportunity. I'll try to be quick, and I want it say, in fairness, that I am enrolled in MVP, not Blue Cross Blue Shield. You know, scrolling down back and forth between plans, I don't know if it looked a little bit cheaper. I wasn't able to make that hearing, so I'm here. You know, and it's not easy to get out of work for to come and, you know, do this. Basically, I share a ride with, a car with my daughter right now. She needs it for work, and this is when I could get up here.

And so I don't think you hear from folks like us

all the time, so I just want to make sure that you do. I'm a single head of household. I've got two dependents. I work in retail, as many Vermonters, you know, in our service, largely service economy. I really like my job working a well-loved community book store in Brattleboro, and there's a lot of great things about it, including wonderful employers who treat their employees well. You know, they're very understanding about my status as a single parent in terms of being very flexible and understanding, and so I've kept my job for a long time, but when push comes to shove, it's still a retail job without great benefits, and a book store is a pretty marginal business at best. Employee health insurance is just simply out of the question.

You know, when the Affordable Care Act first went into effect, I was thrilled to be included in the Medicaid expansion. It was great coverage. But, you know, a 50-cent raise here and a 50-cent raise there, and, suddenly, I don't qualify anymore, and I need to purchase insurance on the Exchange, and, luckily, some of the big glitches in that were worked out by the time I had to go into that, and it's decent coverage, and I'm grateful that I actually get a pretty large subsidy through the ACA being pretty low income, and Vermont kicks in even more, which is great.

So it could certainly be worse, but given recent statements coming from the White House where the plan seems to be to let Obamacare fail, no one really knows what's going to happen with those subsidies, and it's possible that, you know, they are going to use that as a way to speed along the demise of the Affordable Care Act, which is pretty scary, and, of course, I could never afford our plan's premium without that, not even close, and I doubt that I could afford any plan's premium without that.

So I feel lucky that we've been pretty healthy overall. I don't have a really, you know, traumatic health care story to share, and my heart goes out to the people who do because I know a lot of them, but I'm 52, and I'm assuming that I'm going to need more health care as time goes on and not less.

But here's my main point, and it sounds like a no-brainer, but I think it just needs to be said. For low-income people like myself, any rate increase is a problem. I regularly have to bring the balance in my checking account down to close to zero to make ends meet, and occasionally something happens, and it goes below zero, you know, hopefully not too often. So making sure that I have that amount in there every month when the policy due date comes around is just one

more stress, and I only mention this because I'm hardly unique. It's stressful for a lot of people who are low income who are just trying to keep their little ships afloat from month to month. So if --

MS. HENKIN: I'm going to have to cut you off. I'm sorry. Just one sentence.

AUDIENCE MEMBER: She's not finished.

MS. ZIMMERMAN: Stress is bad for people's health, and any governing body who's in the business, you know, of health should be, you know -- I'm sorry. I lost my place. But, basically, a rate increase adds to people's stress, and a governing body should be in the business of helping, you know, not to make things worse, and, you know, we sat here for a lot of day waiting our turn to speak, and we talked a lot about the health of insurance providers and --

MS. HENKIN: I also welcome you to leave your notes with us if you like, and then we have that as a written comment.

MS. ZIMMERMAN: Okay. We just haven't talked a lot about the health of Vermonters. We've talked about the health of companies, and, you know, I've learned a lot, actually, and I don't speak corporatese, and, in fact, it's hard to sit through all that, you know, but I just wanted to say, like, I guess, my most

important thing was that I, that I, that what the best thing you could do was see our single-payer law fully realized and implemented. That would take away the stress of a lot of people.

MS. HENKIN: Alison Gravel and Kevin Wagner if Alison is not here.

AUDIENCE MEMBER: Alison Gravel left her videotaped testimony, which I'm going to play just now for you. It's one minute long, and here it is. She came at 9:00, so she waited as long as she could. I'm sorry. It's on the other phone.

MS. HENKIN: Put that right up to the mic so we can hear, and Kevin Wagner is after that.

(Video recording playing.)

MS. GRAVEL: I'm Alison Gravel, and I have a very good friend who had cancer and she was on Medicaid and she survived and then she got a job. Good thing to get a job, except she couldn't have Medicaid anymore. So now but she can't afford health insurance now because of she doesn't get paid very much. So it's just myself. I'm very lucky. I'm an attorney. I'm a member of the Bar Association. I get group health insurance, so I'm doing fine, but there's so many people who are on the edge. They get -- they're working. They can't get Medicaid, and they're working.

They don't make enough to get health insurance. I just think something has to be done about this.

MS. HENKIN: Thank you. Kevin Wagner followed by Matt Marshal? Someone had a request, because they have a baby, to go next. If no one has an objection, I will let her go next. And you're Bekah?

MS. MANDELL: I am Bekah, yes. I have also a toddler, so I have to do a lot of nursing while I'm doing other things. The other day I was nursing and I was making pancakes, and I thought, This is not safe. Hot stove, a baby, and a toddler, but, anyway. So hi, everyone. My name is Bekah Mandell. I grew up down the road here in Middlesex. My husband and I just recently bought the house that I grew up in from my parents and moved back here to central Vermont.

Two years ago, some of you might remember that I was here with another baby. That was my son who had just been born, and I had him and also $10,000 in medical debt from his birth on top of the premiums that we were paying through Blue Cross Blue Shield Silver plan of about $1,000 a month. So today I'm here with a daughter who's three months old, and this time we owe just over $2,000 in medical debt for her birth.

Why so little this time? Little, right? Yeah. Because we are paying nearly $2,000 a month for health

insurance premiums through Blue Cross Blue Shield. Last fall when we found out that we were going to be parents again, we were really excited. It was something we were really looking forward to. My husband and I got out the calculator, and we crunched the numbers over and over again, How could we avoid having $10,000 in medical debt after the birth of our second child? Because that was really hard for us the first time around, so we wanted to avoid that, especially if our second child ends up in the NICU like our son did, and she did actually end up in the NICU.

We decided the best course of action would be to go on one of the higher premium plans so we could be protected from the potential of a catastrophe and we didn't have to worry about high medical bills if our daughter was in the NICU, and I'm really glad we made the decision that we did, but it has resulted in us paying $2,000 a month in premiums.

I'm self-employed, and my husband owns a small business. Our health care premium is the single largest line item in our budget, significantly larger than the mortgage on our house, and every month, you know, we have to juggle to make a payment. We, you know, it's like, All right, do we set aside money for childcare? Do we pull from that because that bill

isn't due until later in the month? What if we can't? What if one of the clients doesn't pay may husband in time to put the money back in the pot that's for the for the childcare?

So there's a juggling act every single month. Can we take out a loan to the business, what have you, and I'm constantly worrying about how we're going to pay the health insurance bill. And so, last year when we weren't expecting a baby, we decided to go on the Bronze plan to try to save money. Instead of paying $2,000 a month in premiums, we paid a little bit less than $1,000, right around what our mortgage is, and that was also stressful because then we had high copays, and I found myself thinking when my son was sick, like, Are you really sick? You know, is this really something that I should be taking you to the doctor about, or is this something that is going to work itself out?

You know, children's immune systems are supposed to be exposed to lots of things. I was like, Maybe this is a good experience. You're going to build up your immune system. But that doesn't feel good as a parent, right? Like, actually deciding whether your kid's sick enough to go to the doctor makes you feel like a really bad mom, and I didn't like that

experience at all.

And so, you know, this dance that my husband and I are doing about trying to figure out different insurance plans, trying to figure out the money, the premiums each month, waiving the cost of the copay, and it's our children's health, it feels like frankly rearranging deck chairs on the Titanic. It's time for it to end. It is a losing proposition. It's not sustainable for our family or for the State of Vermont.

As new parents, we shouldn't be spending all of our energy on health insurance dance. We should be focusing on our kids, our careers, our community. As many of you know, being new parents is hard enough without the added worry of financial stress on affordable health insurance premiums. Health care is a human right. As members of the Green Mountain Care Board, you have the responsibility to put the best --

MS. HENKIN: Sorry.

MS. MANDELL: No. You have the responsibility to put the best interests of Vermonters above all, above all of us. I urge you to reject these unaffordable rates and do everything possible to move our state towards a system that treats health care as a right for all.

MS. HENKIN: Thank you. Scott Earisman and

is next and then Keith Brunner.

MR. EARISMAN: Good afternoon. My name is Scott Earisman. I am from Essex, Vermont. I have a written statement that I'll turn in, but I'll read you parts of it. I'm a father, household provider. I do balance medical expenses with things like college tuition, property tax payments, all the costs of daily life that haven't gone down with the income that's partly based on Blue Cross reimbursement rates for providers that hasn't gone up. It's gone up 2 percent in the last five years. So, if you're asking for more money, it's not paying the providers of the state more money.

If all the people of Vermont pooled our resources, we have plenty to cover everyone, but in the private insurance model, the pool gets split and segregated, rewarding to some, burdensome to others. Asking 70,000 Vermonters to pay a 12.7 increase is, in its essence, a new tax on lower income Vermonters but ignores those working part-time jobs and jobs that do not offer health insurance benefits.

Our governor stipulated that we cannot afford any new taxes. So it could not afford to help families of small children afford child care. We could not help our mentally ill in crisis with sufficient beds so that

they do not wait weeks in emergency rooms. We put a band-aid on the needs of mental health workers to earn a living wage, and we offered no help for our college-aged kids buried under the cost of an education.

We at the Vermont Workers' Center believe that health care is a human right and that, instead of asking more of Vermonters in this divided and inefficient system that Blue Cross is an instrument in developing and maintaining, we ask that Blue Cross should be responsible for their own financial decisions and their own financial health instead of putting that on the backs of Vermont while the Green Mountain Care Board works to make health care accessible to all in an equitable and universal manner. Thank you.

MS. HENKIN: Keith Brunner, please, and then Crystal Anderson.

MR. BRUNNER: Hello. My name is Keith Brunner. I live in Burlington. I have a Blue Cross Silver plan on the Exchange. I don't have a ton to say. I'm like most people. I'm working different jobs trying to make ends meet renting from friends who own homes because they give us discounted rent. The prospect of paying more health insurance would definitely impact my life next year, and I'm beginning

to consider this idea of, What would it look like to have a child and raise a family in Vermont? What would that mean for health insurance having friends like Bekah and her family and the experience they've had?

And these are the things that I'm grappling with as a young person, and based on my experience and the experience of all the other people who spoke, I'm here to urge you all to reject the rate increase and do whatever in your, like, whatever's in your realm of possibility to move us towards having health care as a public good. This was supposed to be the year that we were celebrating Act 48, and yet we're here dealing with a, like, another rate increase. So it's in your hands. Thank you for your work.

MS. HENKIN: Thank you. Crystal Anderson?

MS. ANDERSON: Hi, my name is Crystal. I am fortunate enough to be on my father's plan until the age of 26, but when that happens, I am -- I was also fortunate enough to secure a job above minimum wage, but I'm not at that benefit cliff year, and when it comes time to have to pay for my own health care, I have a number of medical things that I need to pay for. I am a transgender woman, and, as such, I need to pay for hormones. I have mental health things I need to pay for, and these are things that, like, I can't just,

like, ignore.

Like, I need to these, like, to survive. I need to deal, need hormones to deal with my gender dysphoria, and these are crucial to my survival, and, when I turn 26, these are all things I'm going to have to pay for, and I'm going to have to pay for these for the rest of my life, and I don't think it's fair to those of us who have these things that we can't control be it, you know, something related to gender dysphoria, something related to mental health, something related to a physical disabilities, whatever it is that they're dealing with, I don't think it's fair that we should be forced to stay behind, and some of us are slowly dying because we can't afford these things that we can't control.

Again, I'm fortunate that I don't have to worry about that, but it is something that is very soon in my future, and it's terrifying because I don't know how I'm going to survive if I have the same job the same income and can't afford the things that I literally need to stay alive. So I would urge the Board to not raise rates any more than they already are because they're impossible for so many of us, and health care is human right, and you should reject the increases in rates.

MS. HENKIN: Thank you, Crystal.

AUDIENCE MEMBER: If it's okay with you, I've got some other testimony of people who were not able to --

MS. HENKIN: I would like to go through list first.

AUDIENCE MEMBER: So I'd like to give up my spot to Manny who you asked for before, and here's Manny.

(Inaudible video begins playing.)

MS. HENKIN: So can I just comment? Those are kind of marginally able to hear. So, if you could get some of those in writing to submit to us, we still are going to be back here next week also. We're not going to be in this building. We'll be taking public comment. But they're very hard to hear and understand. So, if we can maybe get that transcribed or something and you could send those to us, I would appreciate it.

AUDIENCE MEMBER: Sure. And maybe, in the future, could we make it easier to the public to be at the public hearing? Because these people waited all day to be here.

MR. KELMAN: My name is Peter Kelman. My wife and I are both retired and live if Montpelier. She is a Blue Cross member. I'm not, because I'm 74

and eligible for Medicare, and having sat here for much of the day just simply underscores that, indeed, discussing rate increases in the kind of way that you have been really does seem like talking about what silverware to put on the captain's table on the Titanic as the ship is going down. It's it's absurd and, I think, irresponsible.

Instead, what we should all be doing, especially you, the Board, is acting to avoid the icebergs which, in this case, are the so-called health insurance companies who clearly are draining billions of dollars away from the actual health care of tens of millions of Americans, not to provide these companies with the ever-increasing profits which were not mentioned in that list of things that are counted. Profits, how about profits which are, profits which are demanded by the stock market?

So allow me to just provide one egregious example of the diversion of taxpayer dollars to the insurance based on my own experience as a Medicare-eligible senior for the past eighth years during which my health care has been covered by an AARP-branded, United Health Care run, Medicare complete policy. What complete means here, I'm sorry, is really quite extraordinary. I have been covered for all parts of Medicare including

drug prescription and Medigap, plus benefits unavailable through basic Medicare with coverage in and out of network almost anywhere I travel all for little or no charge above and beyond my monthly Medicare payments.

And who pays for this generous policy? Not me, the American taxpayer. The giant insurers like United Health Company and Blue Cross in other states are paid by Medicare to offer these and other plans at a substantial profit to them while costing the government more money than it would have cost them to pay general, basic Medicare.

As public servants, you, as a Board, need to recognize that Blue Cross Blue Shield of Vermont is no different from these or any other for-profit entities. Their rate increases will just keep coming as yet another aspect of the massive transfer of wealth from the American taxpayer to the stockholder and executives of these giant corporations. I urge you to stop the charade now. The icebergs that threaten to catastrophically damage the health care of Americans are the giant health care insurance companies. It is past time to get them out of the way and use the money saved to provide true, truly affordable health insurance, a government-run single-payer system

starting right here in Vermont where we already have a law on the books to do so.

MS. HENKIN: Thank you. Eliza Hale is next.

MS. HALE: I'm going to give up my position to the next person.

MS. HENKIN: Eliza Hale, thank you.

MS. SHEPARD: My name is Amanda Shepard. I'm a home care provider from Addison county. I'm a mother of two wonderful children ages twelve and two. I provide care to several people, couple of people. I've taken care of vets who have served our country, and, as I take care of people, I'm not just taking care of those people. I'm talking care of people who cannot afford to get care because they find them when I'm at the neighbor's house looking for my people and they're borrowing money from each other. And so, when I go to the pharmacy, I'm not going for myself. I'm paying for people who are on Blue Cross and Blue Shield.

I'm on Medicaid, and I make $17,000 a year. I have not gotten an increase in my salary. I am paying for people who are on Blue Cross Blue Shield's prescriptions because they cannot afford them. They're already taking money out of their Social Security to pay for the parts. They use to get coverage that covered all of it, and now, because they have

insurance, they have to have money that comes out.

So, for me, if I can't drive them to the hospital, if I can't get there to help them in other ways, I have to be afraid for their life, and, as a home care provider, I have went around the state talking to thousands of other home care providers, organizing a union. I became president of that union after speaking to so many home care providers, and in that journey as I spoke to people and their clients, I found that men are not going back to work for nine years because of hernias that they could have been back to work in three months. I'm finding women are not being able to stay alive for their children and for their grandchildren because they're not having access to pay for the prescriptions that could keep their hearts going longer.

We're living in a stressful day. I'm watching youngsters commit suicide because they're scared of their parents' medical bills. They don't want to tell them that they're having mental issues because it's not covered. I'm watching people around me in my community borrow from one another because Blue Cross and Blue Shield keeps increasing their rates, and these folks are going to other sources of low income to meet those needs.

So, if people are keeping these policies, which many of the people I speak to, they hide behind a curtain, and they pay a penalty at the end of year or avoid taxes or live in fear because they have not picked up a health care program that's supposed to cover what they need because they don't want to bring the rest of their family down. 55-year-old men who have major medical conditions would go to work and hide it every day because they know that, if they go out and pay for the insurance, that could make it so their wife who has cervical cancer cannot get the treatment that she needs.

So I'm looking at people every single day who their needs are not being met, and today what I listened to is, How do we meet the needs of an insurance company? How do we make sure an insurance company can have profit? How do we make sure that insurance company can survive? And I think we need to ask ourselves, How does the Vermonter survive? How do we keep our Vermonters in work? How will we keep our Vermonters safe? How do we take care of them? Because we don't need to take care of an insurance company. We need to take care of Vermonters.

MS. HENKIN: Not here. Griffin Shumway. After this it's Diane Champion.

MR. SHUMWAY: So I have three testimonies to read today, my own, and one person who couldn't be here today or had to leave early because the Blue Cross Blue Shield got five hours of our time, and one person who just wanted me to speak for them. I'm going to begin with June Baffle from Barre Town. She says, "I'm a Blue Cross Blue Shield insured retiree. Blue Cross Blue Shield is my supplemental insurance. I feel that a 12 percent increase is not a fair increase for retired people or single payers or families. Please take this information into consideration."

Next is Keegan Harris who had to leave at 2:00 o'clock, even though he was here at 11:00. "This year my partner spent several weeks between jobs, several months between jobs that meant a significant financial matter, state for our family as she struggled to decide whether to gamble on high copays or high deductibles. Gambling on one's own or one's own family's health is already inhumane, and the financial stakes are already higher than many of us can afford. Raising rates will make it worse. Health care is a human right. As members of the Green Mountain Care Board, you have a responsibility to the people of Vermont to reject those unaffordable rate hikes and do everything possible to make sure Vermont moves forward towards providing

health care as a public good for all."

And my own: "My name is Griffin Shumway. I live in Wilder, Vermont. I'm a member of the Vermont Workers' Center. These rate hikes will negatively impact the community. It will hurt poor and working families already struggling to afford life's expenses, and an approval of these increases is a tacit approval that the State supports a Vermont where people are struggling to live. I believe health care is a human right and that the Board has a responsibility to reject these rate hikes and move towards the State providing health care as a public good."

"We've heard today from the -- we've heard today for five hours from the perspective of a profitable and profit-driven corporation where, while everyday Vermonters were thoroughly pushed back in their ability to testify. Their testimony has largely been about -- Blue Cross's testimony has largely been about maintaining a rate of profit rather than maintaining a state of health. If, the Board's goal is to provide for a healthy population, it has a responsibility to reject these rate hikes and move towards health care as a public good."

"My partner has struggled to afford health care for the two years since she turned 26 and lost her

parents' health care. When she has health care, she is urgent in visiting all the normal checkups, all the normal things that she needs specifically related to sinus and joint issues that she has."

MS. HENKIN: Would you like to leave those with us also today?

MR. SHUMWAY: I'd love to. "And, when she does that, she racks up large amounts of debt that we're largely unable to afford because of her high-deductible health plans. We're trying to buy a house, and these debts are putting an unneeded burden on us to struggle and to live and survive."

"I take the other tack. I have a high-deductible health plan. I don't see a doctor because I can't afford to go see a doctor. Sure, I can go to see a primary care doctor, but, as soon as I have anything wrong, I am able to afford to go there, and I would be racking up large amounts of medical debt. This past fall when I hurt my arm, I had to pay $175 essentially to get my temperature taken."

"These are just two anecdotes, but it, in my community, this is why I believe that, in my community, people are going to struggle to afford these rate increases. This is why I believe that health care is a human right, and, as members of the Green Mountain Care

Board, you have a responsibility to reject these unaffordable rate hikes and to do everything possible to move our state toward a public health care system for a public good for all, just like you've been tasked to do in Act 48. Thank you."

MS. HENKIN: Thank you. Diane champion? Keegan Harris, and then Kevin Wagner, has he spoken yet? Okay. So let's go to Maggie Belensk.

MS. BELENSK: Hello. My name is Maggie Belensk, and I'm a member of the Vermont Workers' Center and a registered nurse and a member of the Nurses Union here in Vermont. Every day I see the direct implications that the current health care crisis is having on the people of Vermont. I've had patients who've been forced to leave against medical advice while in the hospital because of the resulting financial burden and debt that health care billings will be having on them. It's not unusual to have patients readmitted after having to leave as their health worsens, resulting in them coming back time and time again.

I had at patient the other day who had brought all of her medications from home organized into a pill sorter for each day because of how much her own medications alone cost her when going through the

hospital pharmacy during her last admission. She told me about how the health care bill has changed her quality of life and that she had to go without in order to pay it off. It was frustrating to have to explain to her that we have to go through our pharmacy as is hospital policy while she sat there thinking about how she was going to float her next grocery bill when she was discharged.

Privatized insurance coverage is not working for her and is not working for the people here in Vermont. I'm concerned for my patients, coworkers, family, and friends looking forward at the system we have in place today. The excessive amount of money that goes into the health care system continues to go into the business that is insurance companies and is continuing to fill up the pockets of those higher up rather than going towards what really matters, which is the human right to health care.

Year after year, the Green Mountain Care Board approves rate increases for private insurance companies making health care less and less affordable, while the money to improve the quality of care in the system is still severely lacking. Health care dollars should be going toward better wages for nurses and LNA's, education, and job opportunities to chip away at the

remarkable staff shortage.

It was just this past Sunday at work when we were so tragically understaffed on our unit that nurses were filling in for the duties of the LNA's because there just wasn't enough people. On a floor with every bed filled, we had to call for resources travel nurses in to assist us, and even then there was not a single LNA on the floor to answer bed alarms, call bells, take vital signs, and turn patients. This is not an uncommon occurrence, and this is not safe. This chronic understaffing trend leads to unsafe conditions for both patients and workers along with burnout of health care professionals.

We need to take action towards abolishing the current privatized insurance system. Instead of lining the pockets of insurance companies, finances need to be directed into a universal system for all where everyday working class people will see the benefits. No matter your background, we are all patients, you, your family, your friends, the person that delivers your paper each morning. Let us focus on that and join together in this fight, a universal system for all people. I believe that health care is a human right, and, as members of the Green Mountain Care Board, you have the responsibility to reject these unaffordable rate hikes

and do everything possible to move our state forward providing health care as a public good for all.

MS. HENKIN: Thank you. Lily Naha.

MS. NAHA: Hello. My name is Lily. I've been living in Brattleboro for the past several years. Last year I graduated college here in Vermont, and for the past school year I have been tutoring at the Massachusetts Literacy Project down in Greenfield, and right now I'm enrolled on Medicaid, which fortunately is working all right for me right now, but it's quite likely that, if I were to try to stay and continue a career here, my income were to go up and I would, I mean, in the probable near future be unable to afford health insurance, and that makes it much less likely that I, like many other recent college graduates, much less likely that I, that I and many others of us will stay here in Vermont and much more likely that we will relocate to a state or country where we can continue our careers while also having consistent access to basic medicine.

Something you might want to consider, but, also, everyone, regardless of their of their job or level of education, has a right to health care, and if this kind of -- if this, as it seems to be, if this kind of continued steep raise in health insurance prices is the

inevitable result of letting insurance companies continue to dominate the state health care system, then you do have the responsibility to move away from that, and you already -- the State already has passed a law saying that it would move away from that into single-payer, and if passing such a law does not actually compel you to move towards that and instead to allow this kind of racketeering to continue, then one is tempted to ask, What even are laws? But that is all. Thank you.

MS. HENKIN: Thank you. Genevieve?

MS. MERTENS: My name is Genevieve. I'm a member of the Vermont Workers' Center and Nurses Union. I'm a registered nurse in Vermont. In my job I see patients denied certain treatments because their insurance doesn't cover it. I see patients waiting to seek treatment until they're close to death because they can't afford to go sooner. I see patients choose to stop treatment because they have to choose between buying groceries for their family or continue buying their medications.

I had a patient last month who has diabetes, which is a manageable and preventable disease. She could not afford her medications, could not afford to come to doctor's appointments. Her unmanaged diabetes led to

ulcers on her feet that got infected, and she had to have both her legs amputated just below the knees. This devastating surgery could have been prevented. Medications could have managed her diabetes. Doctors could have caught the infection sooner before it spread, and educating her about her diabetes could have helped prevent the severity of her condition.

Lack of access to affordable health care is a systemic issue. I believe that health care is a human right and, as members of the Green Mountain Care Board, you have a responsibility to reject those unaffordable rate hikes and do everything possible to move our state towards providing health care as a public good for all. We should be discussing how to take care of Vermonters and not how to take care of insurance companies. Thank you.

MS. HENKIN: Thank you very much. Ellen Schwartz?

MS. SCHWARTZ: Hi. My name is Ellen Schwartz. I'm a member of the Vermont Workers' Center. Everything I've heard here today has been based on the assumptions that the insurance-based system is the only way to provide us in Vermont with health care access. If I had my doubts about it, listening to this hearing today shows me that our system doesn't work for Vermont

residents because everything I heard in the first five hours was based on the economic viability of the insurance industry and not one word about the people on the other end of those policies.

I'm personally on Medicare, so I benefit from a publicly funded system that recognizes that people in my age range and people with disabilities should be able to access health care, something everyone should be able to access. Medicare isn't perfect, especially if you can't afford a supplement, or, if as I do, you need expensive dental care which isn't covered, but it's not perfect, but it's something.

I'm concerned about the effect of proposed rate increases on people who have no choice but to buy individual insurance on the marketplace or to do without. I still remember 45 years later what it was like to end up in the ER delirious with fever because I had pneumonia and no health insurance. It was a Saturday night, and I got lost in the shuffle of a busy and understaffed Boston emergency room. I wouldn't wish that experience on anyone or any of the other myriad ways that people cope with lack of access to health care.

The promise of Act 48 was that Vermont would have a universal, publicly funded health care system this

year. Every year I come to these hearings, and I listen to people who are struggling to meet their fundamental need for health care. Some navigate a complex web of systems, others do without care, and still others patch together some of what they need. This is frankly immoral, especially in a country as rich as ours. We don't need to be subsidizing six-figure salaries for insurance company executives while on the other end of the spectrum people are foregoing care and going into medical debt.

I implore you to recommit yourselves to Act 48, the law that created the board on which you sit. If you haven't recently read the law, please do. It sets forth a vision of health care in Vermont that is both humane and achievable.

Among other things, it states the State of Vermont must ensure universal access and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers such as cost must not prevent people from accessing necessary health care, and it states the health care system must be transparent in design, efficient in operation, and accountable to the people it serves, and all Vermont residents should be eligible for Green Mountain Care, a universal health care program that would provide health

benefits through a single payment system.

I'm still waiting for Green Mountain care to be implemented. That, rather than annual premium hikes and a marketplace with high-deductible plans that provide insurance but limit health care is a solution to the spiraling health care crisis that's eroding the health of people in our communities. Please reject the rate increases and instead, work on a full implementation of Act 48 and our human right to health care. Thank you.

MS. HENKIN: I want to announce right now that we're on time and every name has been crossed off the list that either did not answer or asked to speak. So we are right on time to get out of this room. I want to thank everyone. If anyone wants to leave their written statements, please, you could leave them with us over at the corner over there or right up here at the Board table. We'll take those. There will be another public comment period. It's at the Green Mountain Care Board. It's next Thursday night from 5:00 to 7:00. So some people who maybe had to work and would not be able to be here could come to that one, and we will take public comment on that time also. Thank you, everyone.

(Whereupon at 3:57 p.m. 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 Rate Review Hearing Re: Docket Number GMCB-008-17rr, at the Vermont State House, Room 11, 115 State Street, Montpelier, Vermont, on July 20, 2017, beginning at 9:00 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 271 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 27th day of July, 2017.

// Sunnie E. Donath