

STATE OF VERMONT  
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER 9-18-rr

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

July 23, 2018

9 a.m.

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115 State Street  
Montpelier, Vermont

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

P R E S E N T

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

18 MS. KESSLER: No we don't.

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

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

1 designation from the Board Chair as you just heard.  
2 It is July 23rd, 2018. This the docket number GMCB  
3 9-18-rate review. If you have a cell phone, can you  
4 please turn off the sound now so I don't have to look  
5 at you with -- glare at you later.

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

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

1 expedited transcription of this. So that will be  
2 done and it will be posted to the web site after it's  
3 done. The Board has jurisdiction over this matter  
4 under Title 18 Section 9375(B)(6), Title 8 Section  
5 4062(A) that deals with rate review, and Title 8  
6 Section 4512 that's specific for Blue Cross. I want  
7 to welcome everyone. It's going to be a little warm  
8 in here and it's a little bit of an intimate setting  
9 for this hearing, but welcome. If you are here to  
10 comment, there is a sign-up sheet. We will be taking  
11 comment at whatever time the hearing evidence is  
12 concluded. So I don't have a time certain for that,  
13 and tomorrow night there is also public hearing from  
14 -- beginning at 4:30. I believe we have a 6:30 stop.  
15 We will try to get everyone accommodated. I know  
16 that's been pretty widely disseminated for that  
17 public comment to be heard and it's at City Hall  
18 tomorrow night. Written public comments are also  
19 being accepted to I believe the 28th.

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

24 MR. ANGOFF: Angoff.

25 MS. HENKIN: Is that misspelled?

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

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

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

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

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

7 (All witnesses were duly sworn.)

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



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

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

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

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

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

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

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

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

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

6 MS. HUGHES: Yes.

7 MS. HENKIN: Mr. Angoff.

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

25 In addition, the statute expressly gives

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

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

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

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

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

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

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

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

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

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

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

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

16 MS. HUGHES: Yes we will.

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

19 MS. HUGHES: We have copies.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 The rates are designed to allow us to

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

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

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

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

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

22 MS. HENKIN: Mr. Angoff.

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

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

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

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

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

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

19 That's what I think the Board should really focus on.

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



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

7 I know that the Board, I think quite  
8 correctly, has put in previous orders that we expect  
9 -- we reasonably expect Blue Cross to be tougher with  
10 the hospitals. The Board's absolutely right about  
11 that, but I think the Board should consider at least  
12 doing a little more than just saying we expect and  
13 actually reducing the rate, not a lot, but reducing  
14 the rate some in order to really give Blue Cross an  
15 incentive to get tough with the hospitals. It's a  
16 cost plus percentage of cost business. It's really  
17 in Blue Cross's economic interest, as ironic as that  
18 might seem, to have costs be a little higher because  
19 2 percent of a hundred dollars is less than 2 percent  
20 of 101 dollars. So the higher the underlying costs  
21 are the more Blue Cross makes. They need a real  
22 incentive to cut those -- to get -- to negotiate more  
23 stringently with the hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

25 PAUL SCHULTZ,

1 RUTH GREENE,  
2 JOSHUA PLAVIN, M.D.,  
3 ANDREW GARLAND,

4 Having been duly sworn, testified  
5 as follows:

6 DIRECT EXAMINATION

7 BY MS. HUGHES:

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

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

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

22 Q. And is your curriculum vitae part of exhibit  
23 15 pages 318 and 319?

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

25 Q. Can you tell us what your professional

1 credentials are?

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

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

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

11 Q. And is that exhibit 1 of the binder?

12 A. (Mr. Schultz) That is.

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

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

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

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

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

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

25 Q. And does that contribution to reserve include

1 profit?

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

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

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

10 Q. And why did Blue Cross do that?

11 A. (Mr. Schultz) There were a number of changes.  
12 There were two statutory changes in Vermont that affected  
13 2019 -- or will affect 2019 benefits and, therefore,  
14 rates. There was also regulation that was promulgated by  
15 the federal government after the date of the filing  
16 regarding association health plans. The Vermont  
17 Department of Financial Regulation is expected to  
18 promulgate emergency guidance also with respect to AHPs.  
19 Because of these changes we needed to make an amendment to  
20 our rate filing.

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

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

25 Q. And would you describe the contents of the



1 amendment?

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

10 We then layered on top of that a factor for  
11 association health plans. We do expect there to be a  
12 pretty significant migration of small groups from  
13 qualified health plans to association health plans in 2019  
14 because of these recently released federal and expected  
15 state rules. Those changes increased the rate by about  
16 2.1 percent on average.

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

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

1 amendment for that.

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

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

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

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

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

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

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

18 MS. HENKIN: Mr. Angoff?

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

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

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

15 MS. HUGHES: Thank you.

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

18 BY MS. HUGHES:

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

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

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

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

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

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

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

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

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

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

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

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

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

20 Additionally the federal government also had a  
21 couple other things I mentioned. AHPs that's part of our  
22 amendment. For association health plans as of 2014  
23 Vermont decided -- I'm sorry. Vermont decided that as of  
24 2014 associations would no longer be able to offer health  
25 plans to small groups. Small groups could only purchase

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

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

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

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

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



1 Vermont has recently passed a law with an  
2 individual mandate specific to Vermont that starts in  
3 2020. It will have a yet to be defined penalty associated  
4 with it. We do not believe that this will impact anyone's  
5 decision in 2019 because members can drop their coverage  
6 in 2019 and then reenroll in 2020 with no penalty. I also  
7 want to point out that the assumptions that we made are in  
8 line with best estimate assumptions that were developed by  
9 an actuarial study that was published by the Board.

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

12 A. (Mr. Schultz) We do. So there were a few  
13 other assumptions that went into the filing. Risk  
14 transfers are one of them. At the time of filing we had  
15 an assumption based on the information we had available at  
16 the time. After the filing more -- knew more about the  
17 2017 risk adjustment. This was part of our amendment and  
18 part of the L&E recommendations. So it was included in  
19 the amendment. We also had to make some assumptions as to  
20 administrative costs, how are those going to trend forward  
21 over time. We included a 3 percent assumption for wage  
22 increases and a zero percent assumption for all other  
23 items.

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

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

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

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

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

10           So pharmaceuticals dispensed in a medical  
11 setting have increased by about 15 percent from 2016 to  
12 2017. So it's a pretty huge jump. These are similar to  
13 specialty drugs on the retail pharmacy side that we know  
14 are also increasing at a very fast pace. Some of these  
15 are life saving medications, but they are very expensive.  
16 So these include things like cancer drugs, rheumatoid  
17 arthritis drugs, immuno deficiency drugs. All these are  
18 wonderful things for our members. They in some cases cure  
19 diseases or increase quality of life, but they are  
20 expensive and they are driving up the utilization trend.

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

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

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

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

25           We also have other providers with whom Blue

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

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

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

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

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

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

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

1 directs care more appropriately to primary care providers.  
2 This initiative is expected to have an impact on trend, if  
3 you include it within trend, of about 1.1 percent. So it  
4 will reduce our trend from 2 percent utilization trend for  
5 2018 to 0.9 percent utilization trend for 2019. That in  
6 turn has an impact of about 0.8 percent on premiums.

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

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

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

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

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

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

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

22 Similarly on pharmacy trend I noted that the  
23 13.3 percent trend which L&E agrees is best estimate is  
24 before Blue Cross contracting efforts. Those contracting  
25 efforts will have the impact of moving that trend down to



1 9.9 percent which is far below L&E's best estimate.

2 Q. What contribution to members reserve was  
3 requested?

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

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

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

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

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

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

14           In 2016 within the large group line of  
15 business we covered premature twins who were born in late  
16 2016 and required several months of intensive care. They  
17 were eventually discharged and we paid a medical bill of  
18 about a million dollars for those twins. Obviously we  
19 can't include that sort of thing into rates. So that  
20 million dollars essentially comes out of surplus.

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

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

10           The final one I want to point out, if we go to  
11 2014, because of issues with the rollout of Vermont Health  
12 Connect in early 2014 we had a number of members who did  
13 not yet have their ID cards. So what Blue Cross did is if  
14 members showed up at the pharmacy they didn't have an ID  
15 card but they said that they had tried to enroll through  
16 Vermont Health Connect and into a Blue Cross plan, we  
17 covered their medications free of charge. So that program  
18 was about \$200,000, which is not the largest number that I  
19 mentioned, but we can only implement those sorts of  
20 programs to help see Vermonters through difficult changes  
21 in their health care if we have an adequate level of  
22 reserves.

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

25           A.       (Mr. Schultz) Our average requested rate

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

2 Q. 6.9.

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

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

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

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

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

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

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

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

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

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

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

10          Q.       And what do you conclude about those results?

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

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

20          A.       (Mr. Schultz) Yes. So as with any projection  
21 or any assessment of how rates change from year-to-year we  
22 need to start with actual experience. So if we look at  
23 2017 experience and compare it to the 2017 experience,  
24 implicit in last year's rate filing we find that they are  
25 almost exactly equivalent which is good news. We also

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

5 Far and away the biggest driver of the  
6 increase in rates is trend. Trend increases rates from  
7 '18 to '19 by about 7.3 percent. That consists of all the  
8 different components I talked about earlier. So for  
9 utilization trend, as you recall the Board last year  
10 reduced utilization trend from 2 percent to 1 percent. We  
11 reexamined that this year. We continue to see evidence of  
12 a 2 percent utilization trend. So in restoring that to a  
13 2 percent level and projecting it forward another year  
14 that impacts premiums by about 2.3 percent for utilization  
15 trend.

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

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

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

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

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

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

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

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

24           A.       (Mr. Schultz) I do.

25           Q.       And can you please identify that for the



1 record?

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

8 Q. And is it a summary?

9 A. (Mr. Schultz) It is.

10 Q. And what is it a summary of?

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

15 MS. HUGHES: So I would ask that exhibit  
16 18 be admitted into the record.

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

19 MR. ANGOFF: No objection.

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

22 BY MS. HUGHES:

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

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

1 average premium in dollars per member per month. The  
2 horizontal axis is time. Each of our three years that we  
3 observed. The various areas within the graph, at the  
4 bottom the blue area represents administrative expense and  
5 contribution to member reserves that we filed in each of  
6 these three years. The green area above that is  
7 representative of claim costs for each of the three years.  
8 At the very top we have a red area. That shows the taxes  
9 and fees that were inherent in each filing. You will  
10 notice that kind of varies from year-to-year. The big  
11 difference being the federal insurer fee was in place in  
12 2018. It was not in place in 2017 or 2019, and, finally,  
13 there's this yellow triangle at the top. This shows the  
14 impact on 2019 rates of various federal regulation that  
15 has come out over the past year. So that's not -- that's  
16 association health plans. That's also the removal of the  
17 penalty for the individual mandate. That also shows CSR  
18 defunding. This is prepared -- while I talked about the  
19 impact held by Vermonters in my previous testimony, this  
20 is the overall average increase. So it does include  
21 that's the silver load. So that's what's in the yellow  
22 triangle.

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

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

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

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

7 A. (Mr. Schultz) Yes I am.

8 Q. And is that exhibit 13 of the binder?

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

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

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

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

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

19 Q. And do you oppose any of those  
20 recommendations?

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

24 Q. And what about the fifth recommendation?

25 A. (Mr. Schultz) The fifth recommendation was

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

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

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

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

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

22 Q. And what about UVMHC?

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

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

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

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

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

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

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

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

21 Q. So turning again to the binder that's been  
22 provided to the Board and contains the exhibits that have  
23 been admitted into evidence are you familiar with exhibits  
24 2 through 12?

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

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

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

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

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

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

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

16 A. (Mr. Schultz) Yes I am.

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

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

1 not inadequate.

2 Q. And are they excessive?

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

8 Q. Are they unfairly discriminatory?

9 A. (Mr. Schultz) They are not.

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

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

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

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

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

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

24 Q. And are the rates affordable?

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

1 So to address that I would like to first turn to exhibit  
2 18 again. I want to address some lines on this exhibit  
3 that I did not address earlier. There are three dotted  
4 lines on the page and I'll start from the bottom and work  
5 my way up.

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

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

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



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

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

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

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

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

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

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

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

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

1 affordable for individuals who are nearing retirement.

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

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

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

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

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

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

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

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

1 that right.

2 MS. HENKIN: See how our time is going.

3 We should have time to do that.

4 MS. HUGHES: Thank you.

5 BY MS. HUGHES:

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

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

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

18 BY MS. HUGHES:

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

21 A. (Ms. Greene) Yes it is.

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

24 A. (Ms. Greene) Yes I have.

25 Q. And is that tab 14 of the binder?

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

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

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

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

25                       The third point that I'll draw out is the

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

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

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



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

5 Further, the Board has consistently cut our  
6 rates believing they are incentivizing us to be more  
7 efficient and to negotiate better rates with our  
8 providers. The truth is that we do everyday focus on  
9 efficiency and everyday negotiate and bring our market  
10 share to bear on our provider negotiations. However, it  
11 is clear that our rates have been inadequate over the last  
12 several years. From the period 2014 to 2017 we have lost  
13 16 million dollars in this market segment.

14 Second, it was part of the prehearing Q&A on  
15 tab 12 page 282. One of the questions that was asked of  
16 us is to provide a calculation of what the RBC would be  
17 for the QHP business only. The illustration that we  
18 provided is just that, it's an illustration, because RBC  
19 is not a tool that's used for a particular stand alone  
20 line of business it's used for the whole company.  
21 However, it was instructive in that illustration that the  
22 approximate RBC for the QHP business only decreases from  
23 2014 -- 2013 -- sorry -- to 2017 the QHP business RBC  
24 would have declined 239 percentage points. So clearly the  
25 rates have not been adequate to sustain the reserves that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Q. So what is Blue Cross's contribution to

1 reserve philosophy?

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

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

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

1 level of RBC risk based capital?

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

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

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

1 believe in serving.

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

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

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



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

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

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

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

7 Q. Perhaps backfill some of the other changes?

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

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

18 A. (Ms. Greene) Blue Cross Blue Shield's goal is  
19 clearly to have funded premium rates. As I mentioned, in  
20 observing the Commissioner's solvency opinion the  
21 fundamental tenet of maintaining our solvency is to have  
22 consistently funded premium rates, and so we're here today  
23 to outline that is for 2019 a rate increase proposal of  
24 6.9 percent. That's what we need.

25 Q. Thank you. My next questions will be directed

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

5 MS. HENKIN: Go ahead, please.

6 BY MS. HUGHES:

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

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

10 Q. And what is your position there?

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

13 Q. And how long have you held that position?

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

15 Q. And before that position where were you?

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

19 Q. And before that?

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

22 Q. And did you start your career in insurance in  
23 2002?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

25           There is one other lever that we could pull

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

16           So I imagine what it would be like to exercise  
17 the nuclear option and I would encourage you to think  
18 about that as well. It starts with a letter to 30, 40,  
19 50,000 people saying effective x date your provider is no  
20 longer in our network. Let's help you find care somewhere  
21 else. To me that is a scenario that is likely to cause a  
22 tremendous amount of damage and waste. Whether we look at  
23 the amount of money we would spend on public relations and  
24 legal fees, the damage we would do to our provider  
25 relationships, the number of members that we would

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 that was for prior approval alone across our different  
2 initiatives.

3 In our other initiatives our estimate is about  
4 1.9 million in development. We achieved 18.1 million  
5 savings for this population -- individual and small group  
6 population in 2017. This cost avoidance is reflected in  
7 the claims experience that Paul has provided and,  
8 therefore, made our premiums lower than they would have  
9 been without those efforts.

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

14 A. (Dr. Plavin) I'll finish up quickly. I  
15 apologize. I tend to talk. Just a comment about the  
16 pharmacy opioid epidemic. Through instituting guidelines  
17 and standards we have seen a decrease in actually close to  
18 40 percent in opiate abuse in our population, which is  
19 really good, and the prior approval process is streamlined  
20 and evolving, and so now over 50 percent of our prior  
21 approvals are automated reducing burden, providing  
22 realtime approvals in an automated fashion. We constantly  
23 evolve them and we retire policies and we have new  
24 policies and we work with our providers.

25 So one of the examples is the institution of a

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

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

12           MS. HUGHES: Thank you.

13           MS. HENKIN: As it's just about 11:30.

14           I am going to give a very short break and I think  
15 it's for the benefit of the witnesses and those who  
16 are looking at me anxiously out there. 10 minutes  
17 and we'll be back in the room at 20 until, and we  
18 will proceed with these witnesses and the questioning  
19 from the HCA. So 10 minutes.

20           (Recess.)

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

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

1 microphone.

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

5 CROSS EXAMINATION

6 BY MR. ANGOFF:

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

9 A. (Mr. Schultz) Good morning.

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

12 A. (Mr. Schultz) Yes.

13 Q. Then another 7.9 million in 2020, right?

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

16 Q. And 3.6 million in 2021?

17 A. (Mr. Schultz) Yes.

18 Q. And another 2.8 million in 2022?

19 A. (Mr. Schultz) Right.

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

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

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

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

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

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

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

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

15 Q. To reflect that 16.6 million?

16 A. (Mr. Schultz) Well it does not reflect the  
17 16.6 million because we haven't received it yet.

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

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

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

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

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

9           A.       (Mr. Schultz) Yes.

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

12          A.       (Mr. Schultz) Yes.

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

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

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

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

23          Q.       Say again?

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

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

1 the URRT, correct?

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

3 Q. And so that profit and risk load equals the  
4 1.5 that you characterize contribution to reserves plus .1  
5 for bad debt, right?

6 A. (Mr. Schultz) Correct.

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

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

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

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

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

22 A. (Mr. Schultz) Let me be specific. We're  
23 reducing our contribution from reserves to 2 percent to  
24 1.5 percent to reflect the fact that moving forward the  
25 AMT has been abolished and we will no longer pay 20



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

6           The 16 million dollars that we'll receive in  
7 2019 Ms. Greene testified that when that money comes in we  
8 will use it for a number of things including  
9 reestablishing our reserves for the defunding of CSR. We  
10 will take a look at where our reserves are at that time  
11 and if they are adequately within our targeted range, we  
12 will provide additional rate relief to Vermonters at that  
13 point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 would be interested in hearing that.

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

10 The AMT credit, should it come to us in  
11 late 2019, it's projected at this point in time to be  
12 16 million dollars. Our guidance to Paul was to  
13 include -- stick with our long term CTR assumption of  
14 1.5 percent given that there are a lot of -- there's  
15 a lot of uncertainty and volatility in the federal  
16 environment right now, some of which are reducing our  
17 reserves in the AMT which when it gets to us will  
18 increase reserves.

19 So in light of all of that we  
20 recommended a 1.5 percent consistent with our long  
21 term assumption. We didn't increase when we lost the  
22 CSR defunding and we didn't decrease because of the  
23 estimated 16 million that we might receive in late  
24 2019.

25 BY MR. ANGOFF:

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

4 A. (Ms. Greene) Right.

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

9 A. (Mr. Schultz) Yes.

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

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

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

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

1 the AMT law.

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

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

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

16 A. (Ms. Greene) Correct.

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

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

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

1 federal income tax in 2019?

2 A. (Ms. Greene) Right.

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

6 A. (Ms. Greene) More tax refunds?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 A. Yes I do.

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

19 A. (Mr. Schultz) Yes.

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

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

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



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

5 A. (Mr. Schultz) I'd rephrase that a little bit.  
6 The people we continue to insure will continue to use the  
7 same amount of services we would have projected in the  
8 absence of this. What's happening is that we project that  
9 some healthy members will choose to forego insurance in  
10 2019 due to the lack of a penalty. So when you're  
11 removing members from the denominator and you're keeping  
12 the claims more or less constant in the numerator when you  
13 divide that out you get an answer that's 2 percent higher.

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

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

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

22 A. (Mr. Schultz) Yes.

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

25 A. (Mr. Schultz) Yes.

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

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

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

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

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

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

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

3 Q. So there was a little double counting there?

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

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

9 A. (Mr. Schultz) Yes.

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

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

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

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

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

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

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

23 (Recess)

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

1           you, Jackie.

2                           MS. HENKIN: You may proceed.

3 BY MR. ANGOFF:

4           Q.           Then under trend factors there's cost  
5 utilization trend. You also raise rates, don't you, by  
6 3.2 percent for utilization trend because people are going  
7 to use more services, right?

8           A.           (Mr. Schultz) Yes.

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

11          A.           (Mr. Schultz) No. Those are completely  
12 separate factors. Once we adjust for population  
13 adjustments that gets us to the projected population for  
14 2019. Now trend is going to continue. Medical cost trend  
15 is not going to stop just because we've identified the  
16 population that will be enrolled. So for that population  
17 that will be enrolled we expect their costs to be higher  
18 not because of the change, but once we have identified  
19 that population we've settled on a population we're  
20 looking at their 2017 claims, we're projecting 2019  
21 claims, we expect those claims to be higher because of  
22 medical utilization trend.

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

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

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

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

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

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

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

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

11 A. (Mr. Schultz) Yes.

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

14 A. (Mr. Schultz) Correct.

15 Q. Aren't both of those assumptions unrealistic?

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

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

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

3 A. (Mr. Schultz) Yes.

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

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

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

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

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



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

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

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

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

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

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

16 A. (Mr. Schultz) Correct.

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

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

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

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

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

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

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

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

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

1 it's a reasonable assumption.

2 Q. It's an educated guess?

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

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

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

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

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

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

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

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

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

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

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

25 Secondly, my opinion is within the statutory

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

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

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

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

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

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

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

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

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

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

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

20 Q. What is a possibility?

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

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

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

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

3 Q. What are you saying?

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

8 Q. What things will land at different places?

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

14 Q. Okay.

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

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

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

25 Q. I know Blue Cross Blue Shield has made

1 tremendous contributions. Do you have another definition  
2 of affordable?

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

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

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

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

19 A. (Mr. Garland) Yes.

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

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

23 Q. You both need each other?

24 A. (Mr. Garland) Correct.

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

1 consumer just cannot keep paying these increases, correct?

2 A. (Mr. Garland) Presumably.

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

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

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

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

25 That being said, I also can't clearly assert



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

12 Q. You agree you need each other?

13 A. (Mr. Garland) Yes.

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

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

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

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

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

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

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

15 A. (Mr. Schultz) Yes we can.

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

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

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

1 discussion of administrative costs is on pages 30 to 32.

2 A. (Mr. Schultz) Okay.

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

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

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

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

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

22 A. (Mr. Schultz) No. No.

23 Q. Okay. Explain that then.

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

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

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

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

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

19 A. (Mr. Schultz) Yes.

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

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

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

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

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

13 A. (Mr. Schultz) Sure.

14 Q. Are you there?

15 A. (Mr. Schultz) Yes.

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

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

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

23 BY MR. ANGOFF:

24 Q. Do you see note 25 there?

25 A. (Mr. Schultz) Yes I do.

1 Q. Change in incurred claims and adjustments?

2 A. (Mr. Schultz) Yes.

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

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

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

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

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

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

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

7 A. (Mr. Schultz) Yes.

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

12 A. (Mr. Schultz) Yes I do.

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

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

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

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

4 A. (Mr. Schultz) I do.

5 Q. Okay. You see Blue Cross's net income then in  
6 2017 was 7.6 million as opposed to 2016 where it was --  
7 where you lost money, okay, and my question is does that  
8 7.6 million in net income affect your rate filing in any  
9 way?

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

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



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

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

8           A.       (Mr. Schultz) Yes.

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

11          A.       (Mr. Schultz) Yes.

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

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

18          Q.       That's fine. Ms. Greene.

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

1 coming into the RBC.

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

5 A. (Mr. Schultz) Yes.

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

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

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

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

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

24 A. (Mr. Schultz) Yes.

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

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

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

4 Q. Can I ask the question?

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

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

12 A. (Mr. Schultz) Yes.

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

19 A. (Mr. Schultz) Correct.

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

23 A. (Mr. Schultz) Yes.

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

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

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

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

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

9 Q. Whether they use actuarial terms or not?

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

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

16 A. (Mr. Schultz) Yes I am.

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

19 A. (Mr. Schultz) There is not.

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

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

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

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

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

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

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

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

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

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

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

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

5 MR. ANGOFF: No further questions.

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

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

13 MR. SCHULTZ: Yes.

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

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

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

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

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

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

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

3 MR. SCHULTZ: Yes.

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

9 MR. SCHULTZ: Yes.

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

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

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



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

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

9 MR. SCHULTZ: Multiple associations.

10 MR. MULLIN: Okay, and the company has  
11 in the filing stated they believe it's going to be  
12 8,000 lives, correct?

13 MR. SCHULTZ: Correct.

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

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

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

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

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

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

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

20 MR. MULLIN: What number is that  
21 assumption?

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

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

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

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

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

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

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

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

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

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

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

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

25 MR. SCHULTZ: Yes.

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

25 MS. GREENE: I suppose someone could

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

1 the fact that you are now administering fewer lives?

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

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

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

25 MS. GREENE: We started the year with

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

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

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

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

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

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

25                      MR. MULLIN:  That would have been the

1 short answer.

2 MS. GREENE: Sorry. I got there.

3 Sorry.

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

11 MR. GARLAND: I cannot.

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

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

20 MR. MULLIN: Both.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

1 phrase. Was it about contracting?

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

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

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

21 MR. GARLAND: No.

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

24 MS. HENKIN: Member Holmes.

25 MS. HOLMES: Thank you. So actually

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

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

1 you know, for the Green Mountain Care Board regulated  
2 entities, 2.3 percent last year, 2.9 percent for the  
3 other facilities and providers, and this year it  
4 looks like for those entities regulated by the Green  
5 Mountain Care Board is going down to 2.1 percent from  
6 2.3 and it's actually going up for the other  
7 facilities that are not regulated. So I'm going to  
8 2.9 to 3.5 percent. One thing -- one question I have  
9 is why. So the entities that we're regulating is --  
10 actually were to some degree -- maybe we can take  
11 some credit -- holding down some of the cross trend.  
12 What are you doing for the entities that we're not  
13 regulating to try and keep it in line with what we're  
14 doing here?

15 MR. SCHULTZ: So the numbers -- I just  
16 want to repeat my testimony from earlier. So if we  
17 look at what we currently know about contracts  
18 elsewhere and what goes under your umbrella, that 3.2  
19 becomes 2.8 percent. I apologize. I don't have the  
20 correlating numbers for the 2.9 and 3.5, but we have  
21 pushed harder on those contracts and what we know now  
22 is that those are 2.8 percent. If we look at the  
23 hospital budget submissions, those rather than being  
24 2.2 percent are at 3.2 percent, and the one other  
25 element I want to add to that before I turn it over

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

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

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

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

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

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

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

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

1 consumers to stay within the network?

2 MR. GARLAND: Consumers to stay within  
3 the network?

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

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

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

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

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



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

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

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

16                 MS. HOLMES: Is there any expectation in  
17                 2019 that will lower utilization as well? Has that  
18                 been manifested in your rate request?

19                 MR. GARLAND: Given the project plan I  
20                 think the goal for 2019 is to get the tool up and  
21                 running and to raise awareness just so we can get  
22                 people to begin interacting with it. I think broad  
23                 based incentive campaigns and savings from them are  
24                 much more likely to be something we're looking at in  
25                 2020, although even there I wonder if we'll have

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

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

16 MR. SCHULTZ: It will eventually have an  
17 impact on pharmacy trend and we applaud that sort of  
18 thing. We certainly hope it happens. I do want to  
19 point out, you can see it in the L&E account, the  
20 pharmacy trend for first few months of 2018 has been  
21 20 percent. We did not change our pharmacy trend in  
22 the amendment even though the trend is clearly  
23 significantly higher than what we filed. So we're  
24 glad to see that activity. We hope it does mitigate  
25 costs in the future. If you ask me my professional

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

3 MS. HOLMES: One point in one of the --  
4 whether it was in the question I cannot remember, but  
5 you stated Blue Cross -- stated in general Blue Cross  
6 is motivated to reduce access to unnecessary care,  
7 and there was a frequent citation of -- multiple  
8 citations of this National Academy of Medicine  
9 assumption that about 25 percent of all expenditures  
10 -- this is probably you -- have no impact on health  
11 outcomes. 25 percent of all health care expenditures  
12 have no impact on health outcomes. So if we look at  
13 just roughly the allowed claims, we're talking about  
14 546 million dollars of allowed claims, 25 percent of  
15 that would be about 114 million dollars of  
16 expenditures that probably have no impact on people's  
17 health, right. A lot of money. Maybe that's a big  
18 broad estimate, but just doing a little back of the  
19 envelope.

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

1 effort of reducing readmissions and reducing ER  
2 visits amounts to about a four million dollar  
3 savings, these two initiatives. So I'm wondering  
4 what are more significant efforts that could be done  
5 beyond, you know, these two efforts to really reign  
6 in this unnecessary and wasteful expenditures that  
7 that will have a big impact on rates if we could cut  
8 25 percent of our expenditures that are having no  
9 impact on people's health. How do we do that?

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

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

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

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

11 DR. PLAVIN: Yes.

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

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

21 MS. HOLMES: Time is of the essence.

22 DR. PLAVIN: I know.

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

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

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

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

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

25 MS. HOLMES: Are you optimistic by next



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

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

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

1 morale and creating retention/recruitment in Vermont  
2 issues.

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

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

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

20           Actually to the pharmacy question maybe  
21 I can talk about economy for a second which is that a  
22 \$253,000 medication for cystic fibrosis may prevent  
23 one or two admissions a year. So you're spending  
24 \$253,000 to improve the quality of life of a kid most  
25 of the time. You're maybe avoiding two admissions

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

7 MS. HOLMES: I think I just have two  
8 more questions I believe. Several of the components  
9 of the rate reflect care management costs, right? So  
10 there's money going out to OneCare Vermont. There's  
11 money -- there's money allocated towards per member  
12 per month to OneCare Vermont. There is per member  
13 per month allocation to ESI, the Express Scripts for  
14 clinical management. There's Blueprint money  
15 allocated, and then 14 percent of your administrative  
16 costs are related to medical management and quality  
17 and wellness. So there's a lot of money largely kind  
18 of being allocated towards care management, clinical  
19 management, and some of it's now being -- some of the  
20 care management Blue Cross Blue Shield used to do  
21 internally is now I would imagine somewhat being  
22 outsourced, right?

23 So OneCare Vermont is doing some  
24 clinical management, care management. Blueprint  
25 community is doing some. How do we ensure there's

1 not a duplication of services along the care  
2 management spectrum such that we are -- you know  
3 there's money embedded in the rate and there's  
4 internal Blue Cross Blue Shield staff doing that kind  
5 of work, there's OneCare Vermont doing that kind of  
6 work, there's Blueprint people doing that kind of  
7 work. How do we know there's not an area where  
8 there's too much overhead throughout the system?

9 DR. PLAVIN: So we are working closely  
10 with OneCare. In fact, they have a technology called  
11 Care Navigator which is a community care plan and so  
12 all the care managers that might be involved with the  
13 case can actually share information back and forth  
14 and they have different purviews. So here a mental  
15 health designated agency you're going to focus on the  
16 care management around that piece. We might actually  
17 spend more time on navigation of benefits per se or  
18 out of network care that happened in Boston for an  
19 example, OneCare, and so what we certainly don't want  
20 to do is duplicate costs, and over time you're right  
21 we probably will change what we do. Maybe what we do  
22 as some of that function becomes that of OneCare and  
23 the Blueprint. OneCare doesn't really provide direct  
24 care management. They rely on the Blueprint, but  
25 that's an evolution as you know.

1           We're at the table. We meet with them  
2 regularly. We're on the committees and we certainly  
3 don't duplicate and we certainly refer to them. We  
4 will likely, as you had suggested, have to reenvision  
5 how we do things as our relationship with the ACO  
6 OneCare evolves. I think it's pretty nascent right  
7 now and so we're still doing a lot of utilization  
8 management. That utilization management ideally  
9 could be done in a different way, but it requires the  
10 ACO to take that over. The cost of that overhead  
11 might transfer from us to them ultimately, but it  
12 will still be a cost. I don't know how efficient --  
13 how much more efficient we can make it.

14           MS. HOLMES: With respect with the  
15 assumption about the two percent rate increase linked  
16 to the elimination of the individual mandate, I think  
17 this is brought up a couple of times, but the  
18 individual -- that assumption assumed that all  
19 members without premium assistance will reduce and/or  
20 preventative care will drop coverage, about a  
21 thousand people, and I think, like the Health Care  
22 Advocate, this strikes me as high. I think there are  
23 surely many people out there who may never see a  
24 doctor for a year. I might be one of those that  
25 would never drop my insurance because I'm risk

1 adverse, and I think -- as I was thinking about it I  
2 would think a better way to identify those people who  
3 see no value or very little value of insurance but  
4 for the mandate would buy catastrophic and bronze  
5 plans because they don't anticipate being users of  
6 the plan, but they feel like there's a federal  
7 mandate I've got to buy this insurance plan, but 25  
8 percent of the population that you have identified as  
9 dropping coverage when the individual mandate penalty  
10 is eliminated are in gold and platinum plans. So  
11 they have chosen to be in the most expensive most  
12 generous plans, but your assumption is that they  
13 don't really want need them and they would drop it.

14 So if you look at that, that's about --  
15 you know if you only look at say the bronze plan  
16 enrollers, forget -- you didn't give a number in your  
17 testimony here of how much -- what percentage of  
18 those at one thousand are in catastrophic plans, but  
19 you broke down bronze, silver, gold, and platinum  
20 there's only about 400 people in bronze plans. So  
21 wouldn't a better assumption be maybe those roughly  
22 400 people drop because they don't probably value  
23 insurance as much and those people who have chosen to  
24 be in silver or definitely gold and platinum value  
25 insurance for its risk and are probably not going to

1 drop it.

2 MR. SCHULTZ: I thought you were done.

3 MS. HOLMES: I probably wasn't.

4 MR. SCHULTZ: I think that would be  
5 another interesting way to look at it. I want to  
6 reiterate when we looked at this we did not have as  
7 much information or high quality information as the  
8 actuaries that you jointly with DFR hired to take a  
9 look at this. I didn't have information about  
10 income. I didn't have information about what MVP  
11 charges or what their membership looks like. So I  
12 did try to model this in such a way that I will admit  
13 it is a relatively simplistic way to look at it.

14 So again do I think that these are  
15 precisely the people who will leave? No. Do I  
16 believe there will be people who leave who have more  
17 than just the preventive visit or no care at all?  
18 Yes absolutely, and in fact if you compare the  
19 membership assumptions from the study you  
20 commissioned, they are assuming a far greater number  
21 of individuals leaving the market. They are still  
22 coming back to that 2 percent, and perhaps if we had  
23 -- if I had an infinite amount of staff and an  
24 infinite amount of time to look at this and I had  
25 access to the same information, I would have been



1 able to do a much more detailed indepth study instead  
2 of choosing a relatively simplistic model. I noted  
3 that model led to a result that is right in the  
4 middle of the range that the actuary you hired came  
5 up with using their better data, probably more  
6 resources frankly, and I was satisfied with that  
7 result was actuarially reasonable.

8 L&E in their opinion on the matter came  
9 to the same conclusion this estimate we had was a  
10 reasonable actuarial estimate. So do I think it's a  
11 perfect reflection of reality? No I don't, but I do  
12 think it's a reasonable answer, and I'll also say we  
13 assumed a greater proportion of people had left that  
14 would have had a higher impact on premiums because of  
15 the decreased scale would have increased our costs  
16 and things like that. So I think by doing this this  
17 way we actually handled it in a slightly lower  
18 premium impact than we may have otherwise done.

19 MS. HOLMES: Okay and I guess my last  
20 and final question talks about efforts that you had  
21 to reduce fraud, waste, and abuse. So from 2014 to  
22 2017 the percentage of claims recovered grow from .09  
23 to 1 percent, but there were no expectations of any  
24 further reductions in fraudulent claims. So sort of  
25 held constant at about 1 percent is the expectation.

1 It just sparked me as curious. I did a little  
2 research to find out what is typical in the  
3 percentage of fraudulent claims -- what do people  
4 estimate the fraudulent claims percentage to be.

5 So the National Health Care Anti-Fraud  
6 Association estimates about 3 percent of all health  
7 care spending is lost to fraud and the FBI estimates  
8 it at 3 to 10 percent. So I'm just wondering if you  
9 increase the percentage of fraudulent claims  
10 recovered to say that 3 percent, what impact would  
11 that have on rates?

12 MR. SCHULTZ: That would have a pretty  
13 direct impact on rates. I do want -- I'm not an  
14 expert on fraud, but I do want a comment a little bit  
15 on the statistics. I know from my previous  
16 experience as a Medicare actuary that a very large  
17 proportion of the fraud that's committed in this  
18 country is on the Medicare side. I can go into more  
19 detail on that if you're interested, but given the  
20 time maybe I shouldn't.

21 So we think that -- we continue to  
22 implement additional programs. You can see that in  
23 one of our responses over time. So as providers --  
24 providers aren't doing this out of ill will for the  
25 most part. These are things we're finding that are

1 claims that are not submitted the way they should  
2 have been and providers learn from that and they  
3 start submitting claims in a more appropriate way.  
4 So as we move through time that one percent that we  
5 identified last year, if we're going to find one  
6 percent again that's a different one percent. That's  
7 not just the same providers doing the same things  
8 because they kind of learn from that experience.

9 So we do continue to enhance our efforts  
10 here and come up with new and different programs and  
11 kind of try to stay in pace with some of the billing  
12 and practices that we see. So we do think we're  
13 going to be able to maintain that one percent. I  
14 would like to think, and I think there's good  
15 evidence, that in Vermont that the fraudulent  
16 practices are not as high as they may be elsewhere  
17 like they may be for Medicare. So I think that one  
18 percent is actually a pretty good result.

19 MS. HOLMES: But is there room to  
20 increase that?

21 MR. SCHULTZ: There may be and we  
22 implement programs all the time in an effort to try  
23 to do so.

24 MS. HENKIN: At this time we're going to  
25 take a 15-minute break for lunch and we're going to

1 be starting again at 5 minutes to the hour. We are  
2 about an hour and 20 minutes behind where I  
3 anticipated and we're not through the Board's  
4 questioning. So please take a very quick break and  
5 we will see you back at 5 minutes to 2.

6 (Recess)

7 MS. HENKIN: Okay. We are now going to  
8 continue with questioning from the Board and I'll go  
9 to the board member at the end.

10 MS. USIFER: I just want to go back a  
11 little to something that Jess was talking about. On  
12 page 223 when you talk about the members who are  
13 going to lose the 2 percent that we're taking for  
14 those members who are not going to join the plan, I  
15 wanted to ask have you considered any changes in bad  
16 debt as well when you made your assumptions?

17 MR. SCHULTZ: We did not. No.

18 MS. USIFER: So you kept that debt  
19 whole?

20 MR. SCHULTZ: Yes.

21 MS. USIFER: And I know the fact Vermont  
22 is going to reinstate a penalty in 2020 came after  
23 the fact of you coming up with your 2 percent. Don't  
24 you think that would have some impact on some of the  
25 members? I'm not saying a large percent, but to

1 assume everyone doesn't have a thorough understanding  
2 of we're off on the federal as far as receiving a  
3 penalty but it will come back on that future time for  
4 Vermont?

5 MR. SCHULTZ: I don't think it will have  
6 any impact. As L&E stated in their report, we have  
7 guaranteed issues in place. So there's nothing  
8 preventing these members from leaving in 2019 and  
9 coming back in 2020. So no. I would like to give  
10 you a different answer, but I don't think the Vermont  
11 mandate effective in 2020 will have an impact on  
12 2019.

13 MS. USIFER: Okay. Can you look at page  
14 12, and part of the reason for the rate increase 1.3  
15 percent was looking at the 2017 to '18 medical  
16 utilization that was reduced to 1 percent from 2  
17 percent by GMCB last year, and now you have  
18 reexamined these and you're restating that again for  
19 this filing, and I just want to understand do you  
20 have data -- any new data that's supporting that  
21 actually what's coming in is closer to the 2 percent  
22 versus the 1 percent or you're saying that was your  
23 original assumption. We adjusted that last year and  
24 now we're readjusting that.

25 MR. SCHULTZ: Is your question in terms

1 of new 2018 experience?

2 MS. USIFER: Yes. The specific part  
3 where you added 1.3 percent for the 2017 to '18 trend  
4 component because of the adjustments that Green  
5 Mountain Care Board did last year.

6 MR. SCHULTZ: I'll answer that in two  
7 ways. So we did have an additional year of  
8 experience that we were able to examine to take a  
9 look at what that utilization trend run rate is and  
10 again reconfirm the 2 percent.

11 I'll also answer it in terms of the  
12 question is there additional new data as soon as --  
13 since the time of the filing, and I'll give you the  
14 same answer to that I usually give to Ruth to my  
15 right. It's still pretty early to be able to fully  
16 assess what the 2018 experience would be like. So we  
17 did include the additional year of experience we had  
18 from '17. We did not include any experience from  
19 '18. Very early return shows there is some  
20 additional pressure on 2018 rates over and above what  
21 we had anticipated, but I did not factor that into  
22 the filing and I did not factor that into the trend  
23 calculation.

24 MS. USIFER: And is that over and above  
25 what you had anticipated or what was filed?

1 MR. SCHULTZ: It's over and above what  
2 we had anticipated. We did file our anticipation of  
3 the 2 percent utilization trend and what we're seeing  
4 so far is that experience -- emerging experience is  
5 slightly behind that. I can't put a number on it  
6 because again it's very early in the year to look at  
7 medical claims. We can look more concretely at  
8 pharmacy claims which is part of the 1.3 percent as  
9 well, it's about half of it, and as L&E documented in  
10 their report and we documented in one of our  
11 questions in the Q & A pharmacy trend is running much  
12 closer to 20 percent for the early part of the year.  
13 It's easy for us to look at pharmacy claims. They  
14 are electronically submitted so those are almost  
15 realtime in today's world. So we're able to assess  
16 some 2018 pharmacy claims. Again we did not change  
17 our trend. We did not increase it for that  
18 increasing pharmacy trend we're observing thus far in  
19 2018.

20 MS. USIFER: And then on the association  
21 health plans where you guys have not originally  
22 submitted that in your submission and now you think  
23 there's more certainty that will happen and that was  
24 bringing in the potential of 2.2 percent for rates  
25 which is probably 8.4 million or so dollars that

1 would be contributing, and just wanted to know if you  
2 thought about offsetting that from the AMT tax which  
3 I understand is also a federal plan and it's not  
4 necessarily definite but is assumed to be happening  
5 in the later part of the year, and if we did that and  
6 did not roll through that 2 percent and assumed we  
7 could offset that with the AMT and there would be  
8 time to look at the actuals next year, and then  
9 understand did you really get the AMT of 16 million  
10 rather than put this into the filing now at this late  
11 time, and I understand also put some moderate point 1  
12 percent change for the chiropractic and things like  
13 that, but I'm just looking at it as they are both  
14 federal programs -- federal things that are running.  
15 We're not necessarily sure of either yet. We don't  
16 have a hundred percent surety that the association  
17 plans will run in. We certainly will know down the  
18 road whether you got 16 million from the AMT and  
19 whether it occurred, but one way to capture that  
20 would be to offset.

21 MR. SCHULTZ: I think there are two  
22 parts to that response and I'll return it to Ruth to  
23 the second part. In terms of the actuarial work when  
24 these association health plans come into being my  
25 team and I are going to have to price those as well,



1 and I'm going to have to meet the same standards of  
2 making sure they reflect the population that I expect  
3 and the benefits that those plans are going to offer.  
4 So I think that's an important consideration because  
5 if you completely ignore any impact it might have on  
6 QHP when we go to price AHP, I can't make an  
7 assumption that 8 million dollars is just going to  
8 disappear from the system altogether. It's the same  
9 people. Whether they have them here or over here I'm  
10 still going to charge them or we need to still charge  
11 them rates that are adequate.

12 So, therefore, whether they are a member  
13 of the qualified health plans or a member of an  
14 association health plan that's the same bucket of  
15 money. So we've got to balance both things. If we  
16 just decide to pay that -- if we essentially decide  
17 to decrease rates to pay that out of the AMT, to me  
18 that speaks to a solvency decision in terms of the  
19 CTR that senior management instructed me to file. So  
20 for that piece of the response I'll turn to Ruth.

21 MS. GREENE: My response to that is much  
22 like the HCA's question sort of what would happen if.  
23 I think I'll go back to the Commissioner's solvency  
24 opinion which clearly states that one of the  
25 fundamental aspects of protecting solvency is to

1 submit rates that are fully funded, and with the  
2 knowledge that we have here sitting here today about  
3 the association plans for 2019 we believe there will  
4 be an impact. So that's why we believe we need to  
5 file the amendment.

6 If for whatever reason there's a cut in  
7 the rate or there's some new event that happens, that  
8 will all come into our surplus, and when we review  
9 that and look at what's required to sustain our RBC  
10 level when those events occur we're constantly  
11 looking at it. So I think to the extent that  
12 something were to happen, mainly there's another rule  
13 on AHPs that will come out between now and the end of  
14 the year that's from the federal government, we will  
15 be, as I said, navigating these waters, and the 16  
16 million will come into surplus and whatever our  
17 situation is at that time it will be a positive thing  
18 because it will help us navigate, but there's already  
19 so much pressure and financial risk on us in terms of  
20 the lower end of our range that it would not be  
21 consistent with our need to submit fully funded rate  
22 proposals to not file the amendment at this point.

23 MS. USIFER: The only challenge to that  
24 might be if you have the knowledge today, we assume  
25 we will get the AMT money back today with the

1 knowledge that we have, right? There's nothing  
2 saying that we won't get it back. So it's just  
3 sometimes we're putting things in when we have the  
4 knowledge on the association plans. We also do right  
5 now have the knowledge on the AMT. We're just not  
6 putting it in because it could change.

7 MS. GREENE: It could change and we know  
8 that the federal government has changed its payment  
9 policy. So we believe it's appropriate to reflect  
10 that when it's received not when we're estimating  
11 that we'll get it.

12 MR. SCHULTZ: Can I elaborate on that  
13 for a second? So even if we do receive the entirety  
14 of that 16 million dollars, that is not going to push  
15 us outside of our solvency range. So we've testified  
16 in the past that if we fall outside that range we  
17 will amend our CTR and file something that is  
18 different from our long term assumption. If we fall  
19 below our range, we'll have to increase the CTR to  
20 try to get back there. If we've above our range,  
21 we'll decrease CTR to again back -- back within the  
22 range.

23 I want to make it clear that 16 million  
24 dollars is not going to push us outside of our  
25 solvency range all else being equal in terms of how

1 claims are coming in, et cetera, et cetera.

2 MS. USIFER: I guess the last question  
3 is I definitely followed the cost containment  
4 programs you have rolled through here. Are there  
5 anything you can talk about on the horizon that maybe  
6 can be accelerated into 2019? I mean we're still  
7 just midyear in 2018. Are there things you guys were  
8 looking at that you may reap benefits from in 2019?

9 MS. GREENE: I think the example  
10 possibly, Andrew, that you gave earlier is one that  
11 we're working on and it's on the horizon. You  
12 mentioned that our goal is to implement it in 2019,  
13 see what the results are, and then we'll have to  
14 decide if that's something that we can incorporate  
15 into the rate filing. I don't know if there's any  
16 others in the hopper. That's a relatively large one  
17 in terms of interacting with members realtime I think  
18 was the example that Andrew had given earlier so that  
19 we can get them to good quality care, but -- for  
20 possibly improvement, but there is a lot of focus on  
21 that one because it's so important to our members.

22 DR. PLAVIN: Lab management is going to  
23 take longer. So there's very few independent labs in  
24 this state like other states. So it will take a bit  
25 longer to kind of realize benefits.

1 MS. GREENE: Again another example I can  
2 just offer up as a way to show you there is a  
3 pipeline. There's a project that we're in the  
4 beginnings of assessing the ROI and that relates to  
5 whether or not there's new data and technologies to  
6 apply to automatically checking claims as they are  
7 submitted and throughput. We have mechanisms now for  
8 that, but our understanding is there's some  
9 technology out there in the marketplace and we're  
10 going to look at that. So that's just an example of  
11 something that we're constantly on the lookout for,  
12 those sorts of things.

13 MS. USIFER: Thank you.

14 MS. HENKIN: Member Pelham.

15 MR. PELHAM: I was waiting for Robin to  
16 start to talk. So I have some questions having to do  
17 with this premium filing, the relationship of these  
18 premiums to Vermont Health Connect and their  
19 calculator, a little bit on the cost shift, and a  
20 little bit on the other language that was in the  
21 special session budget bill that affects Vermont  
22 Health Connect just to see about your understanding  
23 of it.

24 So I'm new on the board and this process  
25 of asking questions is a little different for me

1 because usually I used to sit there and have to  
2 answer questions. So I'm sympathetic to your  
3 position. The -- to get a sense of scale on your  
4 filing cover sheet it says this is worth about 26  
5 million dollars. So in terms of the rate increases  
6 people can talk per member per month, things of that  
7 sort, but the amount is 26 million dollars which is  
8 helpful in terms of a sense of scale and these  
9 premiums when approved before subsidies. They are  
10 before running them through Vermont Health Connect  
11 where most people will engage their policies.

12 So I'm wondering have you -- do you have  
13 information or have you done analysis that shows what  
14 these premiums alone independent of advanced premium  
15 tax credits and cost sharing reductions what the  
16 percentage of these -- what the relationship is? Are  
17 these premiums to percent of the federal poverty  
18 level?

19 MR. SCHULTZ: We have not done that  
20 analysis. No.

21 MR. PELHAM: So would it surprise you --  
22 I just did a couple. Actually what I did do was went  
23 to the 2018 because those are approved rates and  
24 there is a calculator for those rates and I could  
25 absolutely tie it out between the calculator and the

1 premiums, and so I'm looking at a couple at 250  
2 percent of poverty that the premium before the Health  
3 Connect would be 28 percent of their income and for  
4 an adult with child the premium would be 32 percent.  
5 These are bronze plans, 32.3 percent and across all  
6 four plans. So if you do a matrix of individual,  
7 couple, adult to child, and family, and then the six  
8 income levels across the top of the federal poverty  
9 level chart, that those cumulatively the average  
10 premium is 27 percent of income, and so I know that  
11 we have a second next stop on the train which  
12 thankfully we do have that, but would you consider  
13 rates in this arena as being affordable or  
14 unaffordable as a percent of income?

15 MR. SCHULTZ: I think the Vermont  
16 Legislature saw that they would be unaffordable above  
17 300 percent, thus, the existence of those programs  
18 you talked about provided by the state subsidies  
19 already. Also federal subsidies for those  
20 individuals.

21 MR. PELHAM: Well that's exactly what I  
22 want to get to in a minute. So I went down through  
23 these and just to tell you where my numbers were that  
24 across all the silvers the average is 33.3 percent if  
25 you did that matrix. Across all golds it was 36.6

1 percent, and across all platinums it was over 41  
2 percent. So then when you go to the Vermont Health  
3 Connect calculator and you start running your  
4 premiums through that system it makes a big  
5 difference and affordability is really affected by  
6 the almost hundred million dollars of subsidies that  
7 exist that we talk about today. So the bronze plans  
8 -- and there is no standard of affordability. I  
9 believe your answer to the Health Care Advocate that  
10 there is no -- we don't have a standard and we're all  
11 using our best judgment and trying the best we can.

12 I think there is one standard in the  
13 Affordable Care Act of about 9.5 percent for an  
14 individual without help from an employer. So that's  
15 just kind of a rough measure. Looking at the bronze  
16 plans most of them seem to be affordable and meet  
17 that criteria, but as you start kind of scaling up to  
18 silver plans they become kind of by that standard  
19 unaffordable at around 400 percent of poverty, and  
20 you go to the gold plans at around 250 percent of  
21 poverty and the platinum plan is around 150 percent  
22 of poverty. So as your incomes come down it's a  
23 relationship this makes sense. So it's clear to me  
24 that these subsidies are key to affordability. So  
25 let me just kind of leave that alone and go to the



1 next area which is you mentioned the cost shift.

2 The cost shift is you have it 393  
3 million in 2014 up to 491 million in 2017 and the  
4 Medicaid cost shift at 209 million is the actual  
5 number we have.

6 MS. GREENE: For the total.

7 MR. PELHAM: That's right, and you talk  
8 about collaborating with the state to provide  
9 seamless enrollment and management of the products  
10 offered through Vermont Health Connect. So have you  
11 had discussions with the state relative to the filing  
12 for 2019 as to how the subsidies that the state might  
13 make available would make these plans more  
14 affordable?

15 MS. GREENE: So the process as we've  
16 come to understand it over the years is that once the  
17 rates are approved the Department of Vermont Health  
18 Access will take those rates and run it through the  
19 technology that matches that up to the calculator and  
20 they will update the calculator. We have not run the  
21 2019 rates through that view if that is your  
22 question. Once those rates are up and running we do  
23 coordinate very closely -- I think the seamlessly  
24 reference is getting at we work very closely with the  
25 Department of Vermont Health Access on the outreach

1 and communications making it really clear what the  
2 changes are and how folks can navigate the new plans,  
3 if there's any new plans or any -- in this case this  
4 year we have the silver solution which we're working  
5 very closely to make sure the communication is  
6 proactive.

7 MR. PELHAM: My understanding is the  
8 Vermont premium assistance is an entitlement. So  
9 from a state appropriation point of view it's not a  
10 fixed amount that has to be managed to. It's an  
11 entitlement in addition to the advanced premium  
12 credit at the federal level.

13 MS. GREENE: That's how it worked in the  
14 past. It's actually a separate plan design so if  
15 someone is eligible for the Vermont premium  
16 assistance, their plan accounts for that, right, in  
17 what they see for premiums.

18 MR. PELHAM: Now do you -- do you know,  
19 because I don't, whether or not the cost sharing  
20 reductions sponsored by the state, not the federal  
21 level which are gone now, are the state cost sharing  
22 reductions an entitlement or is that an amount of  
23 money that the calculator has to manage to?

24 MS. GREENE: The way cost share  
25 reductions work is that it's based on the claims that

1 are paid. So my understanding is that the state  
2 estimates what they think they will pay for the  
3 Vermont piece of the cost share reduction and then  
4 they pay that based on enrollment, but at the end of  
5 the year we settle up what was actually paid for  
6 claims and what sort of cost share reduction was  
7 required to have that person experience of the  
8 appropriate cost share. So I'm not clear if in your  
9 nomenclature that's an entitlement or not, but that's  
10 how it works.

11 MR. PELHAM: If it gets trued up, it's  
12 not just an open ended entitlement. So here are the  
13 numbers. For 2018 the Vermont premium assistance was  
14 6.6 million and the CSRs were 2.6 million. That's  
15 from the JFO documents. You can go online and do the  
16 budget tracking documents that's what you will find.

17 For 2019 the Legislature has  
18 appropriated 7.1 million for Vermont premium  
19 assistance but only 1.4 million for cost sharing  
20 reductions. So that's a decrease of '18 from 5.6  
21 million to 4.7 and that's just the general fund  
22 share. Do you have any sense as to why the  
23 Legislature and the Governor would have decreased the  
24 cost sharing reduction appropriation?

25 MR. SCHULTZ: I can take that one if you

1 want.

2 MS. GREENE: Sure.

3 MR. SCHULTZ: Actually fairly limited  
4 understanding is that the Legislature for whatever  
5 reason didn't decide to fully subsidize CSRs. That  
6 was not to say that the benefit is going to change.  
7 They do expect the benefit to remain. They do expect  
8 that the total outlay is going to be 2.8 million  
9 dollars and they are going to have to find that money  
10 somewhere, but my understanding of the negotiations  
11 that went on they only included the 1.4.

12 MR. PELHAM: So let me -- I don't have  
13 much more here. I just want to go to the special  
14 session which you talked about where there were two  
15 pieces of legislation that affected you, the cost  
16 sharing related to chiropractic and breast cancer.  
17 Did you have any discussions with the state as to  
18 them passing a law at the end of the session and then  
19 -- but not appropriating any money for it?

20 MR. SCHULTZ: That's an interesting  
21 question. So my understanding is that if there are  
22 new mandated benefits, the state is required to pay  
23 for those. The way the state has approached these  
24 types of changes in the past is that it is not a new  
25 benefit, but rather it is a benefit change in cost

1 sharing and as a result that needs to go into premium  
2 rates as opposed to having a state appropriation.

3 MR. PELHAM: Okay. So I'm trying to  
4 make the connection between the actual appropriation  
5 going down and the legislative approach you're going  
6 up for services and benefits. Did you testify to  
7 either of those two bills having to do with those two  
8 changes to benefit?

9 MR. SCHULTZ: Sarah is saying we did.

10 MR. PELHAM: Then you did. So just to  
11 kind of close the loop here there -- in the  
12 appropriations bill there was change to the language  
13 to a reserve called the case load management reserve.  
14 Are you familiar with that at all?

15 MS. GREENE: I personally am not.

16 MR. SCHULTZ: No.

17 MR. PELHAM: So in '19 -- and here again  
18 you can go to the Joint Fiscal Office and find these  
19 -- that is in the general fund and for fiscal '18  
20 they had 22 million dollars in that fund. For fiscal  
21 '19 it is up to 100 million dollars. It's a huge  
22 increase and I know something about that from when I  
23 was Finance Commissioner. We created it in the Dean  
24 Administration. We used it to stash cash that we  
25 knew the Legislature wouldn't touch to be frank with

1 you because they wouldn't want to take it away from  
2 human services programs, but this is a huge increase,  
3 and I'm told, I don't know for that fact, that that  
4 increase was driven by the kind of true-up and settle  
5 up of Vermont Health Connect, and that is money that  
6 can be used to -- I'll read it to you -- a  
7 sub-account for Medicaid related pressures related to  
8 case load, utilization, changes in federal  
9 participation, existing human service programs, and  
10 settlement costs associated with the management of  
11 the global commitment.

12 That's new language and what the  
13 Legislature did is kind of assign it to two areas.  
14 One is the incurred but not reported associated with  
15 local commitment, and the other was for this language  
16 and assigned that 14 million dollars; and, finally,  
17 and this is the question, you don't need -- the law  
18 is structured such that you don't need the  
19 Legislature to appropriate the money. It can be  
20 appropriated by the emergency board and the emergency  
21 board is combined of the Governor and the chairs of  
22 the finance committees, money committees in the House  
23 and Senate, and so when we get to an issue like the  
24 individual mandate which is an upward pressure on  
25 ratepayers, and L&E has estimated for us that the

1 amount associated with just the individuals who in my  
2 opinion are under the most pressure because they  
3 don't have an employer helping them, et cetera, that  
4 the cost of an individual mandate to them is -- the 2  
5 percent increase would be a little over three million  
6 dollars and to MVP about one million dollars.

7 So would you consider going to the  
8 emergency board and asking them for -- because this  
9 individual mandate is a one year event, it's an  
10 anomaly, and rather than lose those people in the  
11 system and hope you get them back a year down the  
12 road just to try to find some incentive to keep them  
13 in the mix would you be willing to consider -- I'm  
14 not saying to -- but consider going to the emergency  
15 board given that there's a hundred million dollars in  
16 human services case load reserve now to help mitigate  
17 the burden on ratepayers of your premium filing?

18 MS. GREENE: So I'll invite my  
19 colleagues to comment as well. I wouldn't rule any  
20 idea out at this point. We're dealing with the curve  
21 balls frankly that are coming from the federal level.  
22 There is a federal -- the Board has actually  
23 organized the federal issues working group which is a  
24 very collaborative stakeholder group to look at  
25 ideas, and my suggestion would be to have that group

1 look at whether or not that might be an option in the  
2 case of current or future.

3 MR. PELHAM: So if that was a good idea  
4 --

5 MS. GREENE: And I don't know what would  
6 be involved. I don't even know who has to move it or  
7 what the --

8 MR. PELHAM: You go to the emergency  
9 board and ask.

10 MS. HUGHES: I'm sorry to interrupt, but  
11 we're not a government agency so I'm not sure how we  
12 could get in under that tent.

13 MR. PELHAM: I do understand that, but  
14 your premiums are directly related to Vermont Health  
15 Connect and what people buy. So they get filtered  
16 through that system, and I'm making the point that  
17 there's new statutory language that is specifically  
18 directed at Vermont Health Connect with a reserve  
19 that has -- now has a hundred million dollars in it  
20 and it shouldn't be off your screen. That's all.

21 MS. HENKIN: Thanks, Tom. Robin.

22 MS. LUNGE: Have you conducted a market  
23 analysis about the competitiveness of your premium  
24 rates?

25 MS. GREENE: Competitiveness in Vermont



1 of our premium rates?

2 MS. LUNGE: Yes.

3 MS. GREENE: For qualified health plans?

4 MS. LUNGE: Yes.

5 MS. GREENE: When the rates are filed we  
6 look across all of the plan rates by metal level and  
7 have a look at how different or similar the rates  
8 are. It's a market analysis.

9 MS. LUNGE: That would be something you  
10 do internally?

11 MS. GREENE: Yes.

12 MR. GARLAND: Actually this year we took  
13 an additional step. We did hire a small research  
14 firm, a boutique firm, to do a little external  
15 research for us on our current position in 2018, our  
16 anticipated position in 2019, and to get a little  
17 more insight into purchasing drivers, what were  
18 causing people to think about or how people were  
19 thinking about the premiums and what kind of choices  
20 they would make as they go ahead. We have only seen  
21 the preliminary results of that. The detailed  
22 analysis is due to us exactly next week.

23 MS. LUNGE: So any information from  
24 those preliminary results were not available for  
25 integration into your filing?

1 MR. GARLAND: No. We received the  
2 preliminary stuff on the 18th or 19th. It was just  
3 last week and it tells us more about how people are  
4 thinking about the purchasing decision than I think  
5 -- a level of detail that probably wouldn't be  
6 helpful to actuarial science.

7 MS. LUNGE: Thank you. Related to the  
8 case management initiatives in your filing you  
9 indicated that you're working through some new work  
10 flows related to identification of individuals before  
11 they become high cost and complex cases quote  
12 unquote. How are you integrating these work flows  
13 with the work of OneCare Vermont?

14 DR. PLAVIN: So that we actually meet  
15 with them regularly. So we have a team that meets  
16 with OneCare and talks about -- this is using the CRG  
17 grouper to identify emerging risk, and people jump to  
18 new risk levels within those groupers. So we have a  
19 shared pool of patients that were identified for case  
20 management and so then those patients kind of float  
21 to the top of the queue, if you will, for outreach  
22 either on our side or in collaboration with the ACO.

23 MS. LUNGE: You also indicated that --  
24 I'm sorry I don't have the case number of your  
25 filing, but that some of the technology costs that

1 would be additional related to new case or care  
2 management would be about \$150,000.

3 DR. PLAVIN: Yes.

4 MS. LUNGE: Do you have different care  
5 or case management processes for ACO members versus  
6 your general population?

7 DR. PLAVIN: So we are developing those  
8 right now. So again we have a case management group  
9 that is doing exactly that work at this moment.

10 MS. LUNGE: What, if any, are you  
11 considering in terms of reduction of prior  
12 authorizations in a future ACO program?

13 DR. PLAVIN: So that is kind of a  
14 question of how they would implement utilization  
15 monitoring so that they can -- so we can kind of move  
16 that. It's becoming shared risk, a partnership which  
17 is good, but for 2019 I think it's more of a 2020  
18 initiative, but I think that definitely is in the  
19 future.

20 MS. LUNGE: Have you looked at what  
21 Medicaid has done?

22 DR. PLAVIN: Sure, but the results are  
23 not final yet is my understanding. So yeah we have  
24 looked at what they have done and we're anticipating  
25 learning from that.

1 MS. LUNGE: For your 2019 ACO program  
2 for the qualified health plans are you moving to a  
3 fixed payment model?

4 MR. GARLAND: For 2019?

5 MS. LUNGE: Yes.

6 MR. GARLAND: No.

7 MS. LUNGE: Why not?

8 MR. GARLAND: Well there's a lot of good  
9 things we did in the contract. We got RX in, but we  
10 said it was important and I think what it's important  
11 for a commercial market to have some opportunity for  
12 the clients to share in the initial upside. I think  
13 it builds a lot of credibility and it will absolutely  
14 help us as we turn to the group market. There are  
15 technical challenges that are not insignificant that  
16 also made 2018 or 2019 -- 2017 for 2018 I guess  
17 significantly less attractive. We will revisit this  
18 with OneCare at the first quarter of 2019 to ask as  
19 we move into that year when attribution is settled  
20 are we at a point when we can at least move some of  
21 the back end payments so it mimics the fixed payment  
22 system, but then there's the final hurdle we'll have  
23 to work through, and this is a commercial only  
24 challenge which is of course to map to benefits.  
25 Even within the QHPs we have a very wide disparity in

1 cost share, and if we move to a place where we're  
2 moving a global budget, then we have to figure out a  
3 way to fairly charge member y with a bronze plan  
4 their \$3,000 deductible versus the member with the  
5 platinum plan and their \$500 deductible.

6 We're going to have -- it's going to  
7 take time to work through the mechanics of that  
8 particularly because we do have folks that are using  
9 health savings accounts. So for some folks there can  
10 be real tax implications to the way we manage that  
11 and have to go cautiously.

12 MS. LUNGE: How will your attribution  
13 numbers shift if your predictions around the  
14 association health plans come through?

15 MR. GARLAND: I think it is not likely  
16 that they shift at all. There's a lot of caveats  
17 there. The association health plans themselves are  
18 still waiting for final rules and so the associations  
19 have given us a strong sense of what they are  
20 interested in and what they think they want to do. I  
21 suspect that the ACO will be a pretty natural fit for  
22 them and that we've already taken that first step  
23 with individual and small group is likely to lead  
24 most of them to continue to participate in the ACO.  
25 I think we're very likely to see any association to

1 say ACO is not for us we want you to rethink this  
2 decision.

3 That being said, we don't know the whole  
4 universe of folks who are interested in association  
5 health plans, only those who have spoken to us, and  
6 we could have a third party show up tomorrow and  
7 propose something different than anticipated, but I  
8 don't see it being a major disruption to what we're  
9 working on with OneCare.

10 MS. LUNGE: Isn't the ACO program part  
11 of what you file in your forms?

12 MR. GARLAND: I don't know if it is a  
13 form filing.

14 MS. GREENE: No.

15 MS. LUNGE: I can ask DFR. They are  
16 here too. So you don't see any issues with offering  
17 the ACO program to an association health plan  
18 regardless of what plans the associations potentially  
19 have?

20 MR. GARLAND: For now it looks like the  
21 majority of interest in the association health plans  
22 is on the fully insured side and in that case it's  
23 our risk. So our default position would be when it's  
24 our risk we're doing the ACO for individuals and  
25 small group. So an association would have to push

1 back on us very hard and say we have a reason why  
2 we're not there with you, but I don't see any  
3 evidence of that.

4 MS. LUNGE: Okay. Thank you. Most of  
5 my questions have been answered. In your filing you  
6 described at a high level some of the outreach that  
7 you would be doing related to both the silver loading  
8 quote unquote and the individual mandates, but could  
9 you more specifically talk about your member outreach  
10 that you will do related to those two issues?

11 MR. GARLAND: Yes. I think, as you  
12 mentioned, we have described this in some detail in a  
13 couple of places and I can find the references for  
14 you.

15 MS. LUNGE: I actually did not think it  
16 was in some detail. I thought it was in a very small  
17 amount of detail to tell you the truth.

18 MR. GARLAND: Unfortunately I'm not  
19 directly involved in this work group, but what I know  
20 is that always proactive and reactive customer  
21 communication is extremely important to us. So on  
22 the proactive side we're a part of the  
23 multi-stakeholder working -- I think we've referenced  
24 this before. The Health Care Advocate are on that  
25 group, DVHA participates in that, and together we'll

1 be working on what are the messages, what are the  
2 themes, what are the media that we can all tap into  
3 to get the message out, and we'll develop with that  
4 work a broad based communications strategy that will  
5 include written communication postings on our web  
6 sites. We leverage our social media tools to get the  
7 word out. I'm sure we'll have a broad canvass of  
8 tools and we know it's particularly important this  
9 year because of the silver solution.

10 Inside the organization we have already  
11 begun training the dedicated team that works with the  
12 individuals and small groups as they are trying to  
13 make purchasing or product decisions. So there is a  
14 small group of highly trained individuals who just  
15 work on this problem. They will be fully trained on  
16 silver solution and be able to field questions, and  
17 where they hit their limits regarding the calculator  
18 and things move people to the right resources so they  
19 can get those questions answered, and I'm sure our  
20 larger customer service team who doesn't specialize  
21 in those services they will also be cross trained so  
22 if they identify people struggling with those issues  
23 they can move those customers to the dedicated team  
24 that does them.

25 MS. LUNGE: Are there any plans around



1 auto enrollment or auto mapping to new plans related  
2 to either individuals who are switching plans or  
3 small businesses, for example, who should be  
4 switching from the silver exchange plan to the off  
5 exchange plan?

6 MS. GREENE: So I don't know the  
7 specific answer, but I do know that one of the areas  
8 of improvement at Vermont Health Connect is with  
9 respect to preparing for the upcoming renewal, and  
10 they put together a passive file of all the enrollees  
11 that are coming over and it's that file that would  
12 control what plan the membership is selecting or  
13 being renewed into for '19. So I can take that  
14 question back to the folks who are working on that  
15 and see what the answer is.

16 MS. LUNGE: And that makes sense for  
17 those who enrolled through Vermont Health Connect,  
18 but what about the individuals directly enrolled  
19 through you and small businesses directly enrolled  
20 through you?

21 MS. GREENE: It's very much what Andrew  
22 just described. We would be targeting individuals  
23 that we feel need to or are affected by the changes  
24 in such a way that they need to be real clear what  
25 they would like to do and that we've got their

1 renewal wishes understood correctly, and to the  
2 extent that it's the service or the outreach in  
3 collaboration with DVHA and to the extent that  
4 there's any communication that's required we will be  
5 doing that very directly and in person. There is no  
6 plan to auto place people. That was sort of a thing  
7 of the past when things were crazier than they are  
8 now.

9 MS. LUNGE: Thank you. So I believe  
10 that Blue Cross's position on the state and  
11 individual mandate would support it. Is that your  
12 understanding?

13 MR. SCHULTZ: Yes.

14 MS. LUNGE: And could you tell me what  
15 testimony was provided to the Legislature regarding  
16 the impact of not doing a penalty for 2019 by Blue  
17 Cross?

18 MS. GREENE: I cannot.

19 MR. SCHULTZ: I can't speak to that.

20 MS. GREENE: We can dig that out for  
21 you.

22 MS. LUNGE: Thank you. Related to the  
23 association health plans what was the date the  
24 federal final rule was released?

25 MR. SCHULTZ: I believe it was June

1 22nd. If that's not the date, real close to that.

2 MR. GARLAND: That's right.

3 MS. LUNGE: June 2018.

4 MR. SCHULTZ: Yes.

5 MS. LUNGE: And the state rule is not  
6 yet released?

7 MR. SCHULTZ: Correct.

8 MS. LUNGE: And then as discussed  
9 earlier there are a lot of enrollment and population  
10 shift assumptions in the current rate filing  
11 including those related to the individual mandate,  
12 those relating to the association health plan, those  
13 relating to the shift in business last year. I might  
14 have missed one in there. Is it fair to say that  
15 enrollment assumptions are one of the more  
16 challenging aspects of actuarial science?

17 MR. SCHULTZ: Yes that's fair.

18 MS. LUNGE: In your assumptions related  
19 to the association health plan did you make any  
20 assumptions about sole proprietors?

21 MR. SCHULTZ: No we did not. We did not  
22 for a few reasons. There have been studies that have  
23 been published on the impact on sole proprietors in  
24 other markets. Vermont's a little unique for many  
25 reasons. One of them is we don't do age rating as we

1 discussed earlier. So in other markets it would be  
2 very easy for a sole proprietor to take a look at a  
3 rate for a 42-year-old on a qualified health plan and  
4 compare it to a rate in a 42-year-old in a  
5 association plan and make a decision they can live  
6 with. That is not going to be the case in this  
7 market because of the lack of age rating. So sole  
8 proprietors will have to make some choices not really  
9 knowing or understanding what the rate difference is  
10 likely to mean to them.

11 The evidence in other markets are the  
12 rates will increase because of sole proprietors  
13 leaving the individual risk pool moving to AHPs. We  
14 didn't think that was appropriate to include in our  
15 filing both for the reasons it's going to be harder  
16 for them to compare plans because many sole  
17 proprietors are going to be receiving subsidies and  
18 therefore will be incentivized to stay with Vermont  
19 Health Connect. Those are really the main reasons we  
20 didn't include them. I think it would have been a  
21 reasonable assumption to include something for the  
22 sole props in here too. That would have increased  
23 rates further, but we decided not to go down that  
24 path.

25 MS. LUNGE: Thank you. To your

1 knowledge did the federal association health plan  
2 change the federal preemption rules related to state  
3 law? And if you don't know, that's fine.

4 MR. SCHULTZ: I don't know.

5 MS. GREENE: I don't know.

6 MS. LUNGE: Related to the Vermont  
7 vaccine fee have you received any final guidance from  
8 the Department of Health about the cost of that fee  
9 or tax? Whatever you call it.

10 MS. GREENE: Final guidance might be a  
11 strong statement.

12 MS. LUNGE: Final number.

13 MS. GREENE: So we were provided updates  
14 to how they were going to roll surpluses in that  
15 program forward and I'll let Paul speak to it, but I  
16 believe we have the latest information that is  
17 available.

18 MR. SCHULTZ: It's in rates. We  
19 basically assumed they would waive the fee for a  
20 number of months. It was more or less equal to the  
21 amount of time they would need to get the funding  
22 back down to its reasonable level. Based on  
23 information I've seen since then I'm not entirely  
24 sure that the premium holiday will last as long as we  
25 assumed, but it's a really small amount in the

1 filing. So if the latest and greatest information is  
2 a little bit different, there won't be much of an  
3 impact one way or another.

4 MS. LUNGE: Other than the \$150,000  
5 investment in technology related to care management  
6 are there any other health care reform investments  
7 that you have included in your filing?

8 MR. SCHULTZ: I want to make it clear  
9 the \$150,000 that you're referring to that's not  
10 included explicitly in this filing. That's money  
11 that we -- that was not incurred in 2017 so it was  
12 not part of our roll forward and so that 150 is not  
13 in here.

14 Beyond that, again, our process is to  
15 start with what we spend in 2017 and as much as that  
16 includes some initiatives to move forward with these  
17 cost containment strategies that already existed that  
18 will find its way into the 2019 projection as well,  
19 but we did not increase the projection in any way for  
20 any of this future activity beyond that trending  
21 forward that we always do.

22 MR. GARLAND: I can just add our base  
23 budget includes a number of resources that are  
24 dedicated up to one with full time and several who  
25 have up to 10 to 50 percent of their time allocated

1 to work on the interface with the ACO, and that's  
2 both on the legal side, on the payment -- provider  
3 payment side, on the medical services side, to work  
4 on the other programs that have gone on in Vermont.  
5 Some nurses sit on the community health teams. We  
6 have quite a broad base of engagement built into the  
7 base admin budget and we could easily draw an outline  
8 around it and tell you what those are.

9 MS. LUNGE: Thank you. I'll take a  
10 minute to look at my notes and I think I should be  
11 pretty much done. Am I remembering correctly that  
12 you have filed a lawsuit against the federal  
13 government to recoup the cost sharing reductions that  
14 would be funded?

15 MS. GREENE: I can speak to that. The  
16 both situations with the federal government defunding  
17 of the CSR and then the risk corridor program which  
18 is one of the original three R's of the ACA we worked  
19 with two different law firms to retain them to  
20 provide a lawsuit to see if we could recoup those  
21 monies. It's -- they will share in any recovery that  
22 we get. It's somewhat of a long shot, but we figured  
23 on behalf of our members in Vermont we would leave no  
24 stone unturned.

25 MS. LUNGE: And what's the status?

1 MS. GREENE: The risk corridor one is  
2 running into trouble. That's one where we're pretty  
3 much in the same situation as health plans  
4 nationwide, and to the extent that there's a lot of  
5 similar lawsuits there was a ruling that made it  
6 sound like that wasn't to go our way on the risk  
7 corridor one.

8 On the cost share reduction we're still  
9 in the process of getting a ruling on the first step  
10 in the process and we remain optimistic that  
11 Vermont's in a unique situation because a lot of the  
12 other states and regulatory frameworks have  
13 contingency plans for 2018 in terms of rate changes,  
14 and Vermont is unique in the sense that we and one  
15 other jurisdiction do not have that option. So we  
16 may -- we are optimistic that the CSR one will  
17 possibly yield some results, but it's way too early  
18 to tell.

19 MS. LUNGE: Great. I just have one last  
20 question. You have mentioned the speculative nature  
21 of federal payments and I just wanted to clarify a  
22 couple of things. The cost sharing reduction and  
23 risk adjustment were both programs that were  
24 established in the Affordable Care Act, isn't that  
25 right?



1 MS. GREENE: That's true.

2 MS. LUNGE: The alternative minimum tax  
3 change is a different piece of legislation that was  
4 passed in December of last year I believe?

5 MS. GREENE: That's right. December  
6 2017.

7 MS. LUNGE: Thank you.

8 MS. HENKIN: We would like to move on  
9 now to our next witness. I want to just say that I'm  
10 not sure how long the Department of Financial  
11 Regulation will go, but we do have witnesses here  
12 from Dallas who will not be returning and I would  
13 like to get them done. So I would like to finish up  
14 questioning and if they are not finished up by about  
15 -- it will be 3:30, we are going to go right to DFR  
16 -- right from DFR to the actuaries and come back to  
17 DFR on another date. It looks like we're going to  
18 have to take some evidence and some questions coming  
19 in and we may have to open up for more testimony. So  
20 I will let DFR proceed, but we may be interrupting  
21 you in about a half hour or so depending on how this  
22 is looking. Are you just going to testify or is your  
23 attorney --

24 COMMISSIONER PIECIAK: I was planning to  
25 testify and take any questions from the Board and

1 from the other parties here as well. So good  
2 afternoon. I'm Mike Pieciak. I'm the Commissioner  
3 of the Department of Financial Regulation. First and  
4 foremost I want to thank the team from DFR that's  
5 here that helped review this filing. Like always  
6 they did great work and I just want to thank them and  
7 recognize them for that work; and then, secondly, I  
8 want to also just recognize all of us in the room for  
9 a second because I just came back from a National  
10 Association of Insurance Commissioners meeting and  
11 this was the Commissioners only meeting, and I look  
12 at some of the other rate filings that are occurring  
13 across the country. I think the average this year is  
14 double digits. Maybe even high double digits. I  
15 know the Maryland Commissioner the rates went up by  
16 about 30 percent. That's at least what's filed. In  
17 California I think they approved a 8.7 percent rate  
18 increase, and it was reported on that was back to  
19 more modest rate increases.

20 So as you can see from across the  
21 country people are really dealing with this issue of  
22 rate increases in a much more dramatic way than  
23 fortunately we are in Vermont. Many of those states  
24 are also dealing with coverage as well. So carriers  
25 pulling out of their market and not their entire

1 state being covered. So again we don't have that  
2 issue here in Vermont. So I think everybody to some  
3 degree has to take credit for that; the Green  
4 Mountain Care Board, the Health Care Advocate, and  
5 also the carriers as well.

6 So I was just going to talk a little bit  
7 about DFR and our role in this process, an overview  
8 of DFR so that the board members that might be new  
9 have some familiarity with that. I'll talk a little  
10 bit about solvency, talk a little bit about risk  
11 based capital, RBC, that you heard today about.  
12 Generally overview our oversight of Blue Cross Blue  
13 Shield. Talk generally about some impacts to  
14 solvency that we watch out for, and then turn to our  
15 opinion letter that we issued this year and talk  
16 specifically about the issues that we highlighted,  
17 and then of course take any questions that you might  
18 have.

19 So that those that might not be familiar  
20 the Department supervises the securities industry,  
21 the banking industry, the captive insurance industry,  
22 and then also the traditional insurance industry here  
23 in Vermont. I consider ourselves first and foremost  
24 a consumer organization. We protect consumers. We  
25 protect them from fraud. We protect them from

1 products that are not good products for them. We  
2 handled in the last five years about 1800 inquiries  
3 from consumers returning to them about 11.4 million  
4 dollars in restitution. On top of that we have had  
5 about 1.3 million dollars in penalties against  
6 regulated entities in the state.

7 So I think first and foremost we think  
8 of ourselves as a consumer organization. Certainly  
9 when we're talking about solvency, solvency is the  
10 primary number one consumer protection in the  
11 insurance arena. That's something we take very  
12 seriously. We also have a mandate to make sure that  
13 our markets are robust, there's availability of  
14 products, and those products work well for  
15 Vermonters.

16 So by numbers we have about 1400  
17 licensees that do business in Vermont. Those are  
18 carriers that are doing business here in Vermont. A  
19 dozen or so of those are domestic insurance  
20 companies. When they are domestic insurance  
21 companies we obviously take a much greater interest  
22 in their solvency. We're the primary solvency  
23 regulator so when we're talking about solvency you  
24 know I mention it being a primary number one goal of  
25 the Department because we need an insurer to be

1 around to make good on the promises that they have  
2 made to consumers, whether that's a life insurance  
3 company, a P & C company or a health insurer as well.  
4 So solvency is really what we do as the greatest  
5 consumer protection. It's something we hold in the  
6 highest regard.

7 To help us reduce solvency and  
8 understand solvency and look at those 1400 different  
9 carriers that may be operating in Vermont and other  
10 states the NAIC has developed what's called risk  
11 based capital. It's a ratio for us that uniformly  
12 and objectively looks at the surplus adequacy for  
13 carriers across the country, compare them to one  
14 another, and then determine sort of where they are in  
15 the trajectory in terms of how close they may be to  
16 insolvency.

17 The RBC was developed in the 1990's as a  
18 result of some insolvencies that occurred in the  
19 1980's. Prior to that there was basically a fixed  
20 capital requirement. So if you can put 5 million  
21 dollars away, you can operate in our state. That  
22 turned out not to be sufficient because obviously  
23 there was great risk beyond just being able to put  
24 down that 5 million dollars. So RBC is something  
25 that's developed. It's specific for industry types.

1 There's a health care RBC, a P & C RBC, and life  
2 insurance RBC. So they are specifically by the type  
3 of insurance that's being provided.

4 I will mention that has been talked  
5 about that the RBC ratio for Blue Cross Blue Shield  
6 has been approved for a range between 500 and 700 RBC  
7 points. I'll also mention that on average all of the  
8 health insurers in the country together their average  
9 RBC based on any NAIC data from 2016 is 925. So even  
10 the average RBC of all of the health cares in the  
11 country RBC our range is below that, but we still  
12 think our range is reasonable and provides a level of  
13 solvency to Vermonters and to the Blue Cross Blue  
14 Shield organization as well.

15 So again the general oversight. Much of  
16 the Blue Cross RBC is one factor. One of the  
17 downsides of RBC is it looks historically. It  
18 doesn't look into the future. It's looking at past  
19 results, and obviously when we're looking at solvency  
20 we want to know what's happened, where the trends  
21 are, but also what's on the horizon and how that's  
22 going to impact the company.

23 So when we're reviewing Blue Cross Blue  
24 Shield, we have quarterly financial statement  
25 reviews, we look at all the financial statements on

1 their face and also do certain analyses on those,  
2 provide tools from the NAIC that it allows us to look  
3 at certain ratios. We also have an annual review  
4 that we conduct that looks more in depth at the  
5 company's financials, claims analysis, investment  
6 analysis, RBC analysis, and that is obviously a much  
7 greater in-depth review.

8 We also do examinations at least every  
9 five years. We completed one in 2015 so there's  
10 another examination in the not too distant future  
11 that we will conduct. Those are very long intensive  
12 reviews, 9 to 12 months. They are on site. They are  
13 looking at almost everything, but we certainly focus  
14 our attention on things that we think have greater  
15 risk exposure for consumers, and then we also have  
16 what I just call sort of intermittent meetings when  
17 things come up, when we need to get certain data from  
18 Blue Cross Blue Shield, when we need to talk to their  
19 executives or their experts. We do that on a  
20 somewhat frequent basis.

21 So if I can talk generally about some of  
22 the impacts on solvency that we've mentioned in our  
23 solvency opinion, these aren't necessarily specific  
24 to Blue Cross Blue Shield this year, but these are  
25 threats to solvency that can happen in any given

1 year.

2 One is certainly adverse medical trend.  
3 So medical trend cost of service ends up being higher  
4 than the amount Blue Cross Blue Shield anticipates it  
5 being. That obviously will go down to the bottom  
6 line decrease surplus and decrease RBC. Adverse  
7 utilization. So this would be a situation where  
8 people are using more health care than was  
9 anticipated whether it's the economy is better,  
10 whether there's a flu outbreak or some other sort of  
11 issue on the medical side that could certainly cause  
12 adverse utilization.

13 There's premium inadequacy. So premium  
14 inadequacy could mean, for example, the Board -- the  
15 Blue Cross Blue Shield doesn't get the rate they need  
16 from the Board certainly, but it also means  
17 administrative expenses could be more than were  
18 anticipated. There could be issues related to  
19 federal health care. We thought that was so  
20 significant that we broke it out into a separate risk  
21 factor this year, but there could be a number of  
22 issues that impact premium inadequacy.

23 Membership growth is another one. I  
24 think of that sort of increased risk and I can talk  
25 about it when we get to our specific opinion, but



1 when the growth in membership occurs and there's not  
2 a corresponding growth in surplus that increases the  
3 risk and reduces the RBC and has a greater impact on  
4 solvency, and then finally we thought it was so  
5 significant that we pointed it out this year federal  
6 health care policy. There's been so many changes in  
7 the last two years around health care policy. At  
8 least those that were intentional decisions have all  
9 in some ways seemed to have undermined the ACA or  
10 that was their intent. We'll also talk about a  
11 federal change to taxes that was somewhat  
12 unintentional as far as we can tell in terms of its  
13 impact on health insurers, but certainly will benefit  
14 potentially health insurers, but certainly the trend  
15 out of Washington, D.C. has been health care policy  
16 that's been unpredictable and that has looked to  
17 undermine in some respects the ACA.

18 So with that I think I will turn it over  
19 to our specific opinion this year. I think you have  
20 that filed and it is probably listed as an exhibit  
21 number. I don't have it in front of me, but there  
22 are a few things I wanted to point out a little bit  
23 different this year than in past years. Certainly  
24 primary is the drop that we've seen in the risk based  
25 capital ratio. The RBC has trended backward since

1 2014. That is a trend -- the trend is one of the  
2 things that we look at. We look at what the number  
3 is at, but we also look at where things are trending.  
4 The trend has been unfavorable to a pretty  
5 significant degree in the last three or four years.

6 Also the current status of the RBC. Not  
7 only has the trend been negative, but it sits now  
8 toward the bottom of the RBC range. So that's  
9 something that is of concern to us. Again, as I  
10 mentioned, RBC is one metric that we look at. I  
11 included another one in the solvency opinion this  
12 year that I thought helps illustrate the point.

13 If you look at the 2017 numbers from  
14 Blue Cross Blue Shield and compare them to the 2013  
15 numbers, in 2013 they had 420 million dollars of  
16 earned premium and they had a surplus of 132 million  
17 dollars. Fast forward that to 2017. The premiums  
18 earned have increased to 578 million dollars. That's  
19 for all covered lives. That's not just for the  
20 exchange, but the entire population. That's an  
21 increase of about 37.4 percent, but if you look at  
22 the surplus during that same time period, it's gone  
23 from 132 to 134 million dollars. So 1.2 percent  
24 increase. So basically what that's telling us the  
25 risk exposure has increased pretty significantly, at

1 least 37 percent, but the population -- the amount of  
2 money that they have to offset swings like adverse  
3 utilization, medical trend, all those other solvency  
4 issues has remained somewhat stagnant only going up  
5 1.2 percent.

6 We compared that to some of our other  
7 companies we regulate. The increase in premiums  
8 written was somewhat similar. The other companies we  
9 took a sampling. They had gone up about 36 percent,  
10 but their corresponding surplus had gone up about 38  
11 percent during that same time period. So again  
12 comparing them -- comparing Blue Cross Blue Shield to  
13 itself that's certainly something that was giving us  
14 cause for concern. When looking at some of their  
15 contemporaries also highlights that concern for us.

16 Then, lastly, again I think the solvency  
17 opinion touches on this well, but we see a wide  
18 variety of federal health care changes that have been  
19 impacting, potentially will impact, and also unknown  
20 impact into the future. So CSR defunding is  
21 certainly something that had been talked about for a  
22 while, but when it happened it happened very quickly.  
23 Certainly impacted Blue Cross Blue Shield during 2017  
24 for the three months it didn't receive payment.  
25 Obviously impacting Blue Cross Blue Shield during

1 this current year. Fortunately there was the silver  
2 loading solution that we implemented. However, I  
3 will just caution and mention this in the opinion  
4 that Secretary Azar, who is the head of Health and  
5 Human Services, indicated that they could not do  
6 rulemaking to prevent the silver loading solution for  
7 the current plan year 2019, but it wasn't off the  
8 table in future years. So even the solution that  
9 we've come up with is somewhat tenuous and something  
10 that we again looking out into the future highlight  
11 as a risk factor.

12 Association health plans. This is again  
13 a federal policy. The Department is working to  
14 implement a robust regulatory regime around  
15 association health plans. We think if we don't do  
16 that then it leaves us susceptible to out of state  
17 plans coming in that maybe are not offering as high  
18 quality or robust benefits. So that's something  
19 we're working quickly to implement emergency rules,  
20 but certainly it will have an impact on the  
21 association market.

22 We also touched upon the individual  
23 mandate, limited or short term duration plans.  
24 Legislative fixes have mitigated those impacts to  
25 some degree, but again those are things that their

1 primary effort in my opinion was to try to undermine  
2 the ACA. We've mitigated those impacts, but yet to  
3 see what the true impact will be in 2019 and going  
4 forward. Also at the time of the opinion the risk  
5 adjustment program was put on hold and I think this  
6 just demonstrates again the uncertainty of federal  
7 health policy.

8           So I think our overall message with our  
9 solvency opinion this year was that things are  
10 trending down. They are at a very low point in their  
11 RBC compared to previous years, and with the current  
12 federal environment it is not a good time to be  
13 trending down at the bottom of your range.  
14 Uncertainty in Washington, D.C. makes it very  
15 difficult to predict what will happen in a given  
16 month let alone a given year or a couple years out.  
17 So that's why I think you see some increased urgency  
18 in our opinion letter this year.

19           So I do want to mention one thing before  
20 opening up to questions because there was a benefit  
21 in the federal changes relating to the alternative  
22 minimum tax and the elimination of the corporate  
23 alternative minimum tax. So as you know Blue Cross  
24 Blue Shield is scheduled to get payments over the  
25 next let's call it five years. The first one being

1 at the end of 2019 at the earliest. Maybe in 2020.  
2 We issued a permitted practice this winter that told  
3 Blue Cross Blue Shield that they could fully  
4 non-admit their deferred tax assets. So basically  
5 they are going to get 16 million dollars in  
6 2019/2020. We said those dollars, since they are so  
7 far out to the future, should not be reflected in  
8 their financial statement because otherwise it would  
9 be misleading and overstated. Those are monies that  
10 cannot be used right now today. If they needed 16  
11 million dollars today, they couldn't go to their bank  
12 account and grab it. They probably couldn't do that  
13 for all or most of next year. 2020, the end of 2019,  
14 is the earliest they can access those funds, and  
15 obviously the same is true for all the following  
16 years after 2020. So that's why we issued that  
17 permitted practice and I just wanted to make that  
18 clear to the Board. So again that is to say again it  
19 is scheduled. Whether or not those payments come to  
20 fruition is something else we put in our solvency  
21 opinion and just caution the Board. We hope they do,  
22 but with the changes that we've seen in federal  
23 health care policy the last few years it is certainly  
24 not a certainty and we want to reflect that in our  
25 opinion.

1 MS. HENKIN: Thank you. I'll let  
2 questions from the carrier. Do you have any  
3 questions?

4 MS. HUGHES: I have no questions of this  
5 witness.

6 MR. MULLIN: HCA.

7 MR. ANGOFF: Thank you, Commissioner.

8 CROSS EXAMINATION

9 BY MR. ANGOFF:

10 Q. Good afternoon.

11 A. Good afternoon.

12 Q. Let me just make sure that I understand -- I  
13 think I do -- the various RBC levels. Under 70 percent is  
14 the mandatory control level?

15 A. That's correct.

16 Q. Under a hundred -- between 70 and 100 is  
17 authorized control?

18 A. Authorized, yup.

19 Q. What's between 100 and 150?

20 A. So at 150 to 100 there's mandatory regulatory  
21 reporting and controls. Basically we have to set some  
22 sort of regulatory regime that's going to be in place and  
23 mandate that the company do certain things such as raise  
24 capital. In this case because Blue Cross Blue Shield is a  
25 non-profit it's hard for them to do that, if not

1 impossible. We might have to say you have to have a  
2 mandatory rate increase of x percent on certain segments  
3 of business or we could I guess potentially require a  
4 merger or some other sort of serious situation.

5 Q. And then between 150 and 200 what's that?

6 A. So around 200 -- between 300 and 200,  
7 depending both on the -- basically how quickly they are  
8 going down and then also at some point when the RBC ratio  
9 hits a certain point, that 200 percent, we also require  
10 company -- the company to issue certain -- issue to us  
11 reporting about how they are going to fix the problem  
12 that's going on. So this isn't us telling, but the  
13 company coming up with its own solutions. So all of those  
14 things I just mentioned could be solutions. Raise  
15 capital. Again they can't do that readily because they  
16 are non-profit. Could be a merger. Could be cutting back  
17 on certain lines of business.

18 Q. So basically if it's under 200 they have to  
19 file a plan with you while explaining how they are going  
20 to get --

21 A. Or potentially 300, but yeah.

22 Q. And then under 300 is that a trend test level?

23 A. Yeah. So if they are trending down to a  
24 significant degree, then they have to do that same type of  
25 reporting to us as if they are at the 200 percent RBC.



1 Q. And then over 300 that's the no action level?

2 A. Yes. There's no action statutorily. I would  
3 say between 300 and 500 the Department informally would  
4 want to know what they are doing to get back to their  
5 range, and also I want to point out that Blue Cross Blue  
6 Shield has their own RBC targets and triggers. So at I  
7 think it's 375 percent Blue Cross Blue Shield's parent  
8 association is going to come in and require additional  
9 reporting, additional information about how they are going  
10 to get back into a more positive RBC range.

11 I'll just mention I think the real issue is  
12 coming between 400 and let's call it 200 percent because  
13 if you have to start meeting very regularly with the  
14 parent of Blue Cross Blue Shield, with myself, with our  
15 department, it distracts you from your core business  
16 organization. It takes -- it's time intensive, resource  
17 intensive. So that's not a position where any insurer  
18 wants to be in.

19 Q. Sure. MVP's RBC is substantially less than  
20 Blue Cross's, right?

21 A. So you may be familiar with this, but MVP is  
22 not a domiciled company here in Vermont. So we look at  
23 their rate, but we don't look at their solvency in the  
24 same significant degree that we do for Blue Cross.

25 Q. Sure. They are not a domicile, but if they

1 were would you have a concern about their current RBC?

2 A. Well RBC is obviously a confidential number.  
3 So I'm not sure how we would get MVP's RBC, but if any  
4 company were trending down, if any company were at the  
5 bottom of its range, certainly we would have the same  
6 concerns.

7 Q. MVP's RBC is in the answers to one of the L&E  
8 questions in this proceeding. You understand the 16  
9 million that Blue Cross will get this year under the Trump  
10 tax bill that's not included -- you understand that's not  
11 reflected in the rate filing?

12 A. Well just a couple things to point out. One,  
13 it's not this year. It's going to be earliest 2019, maybe  
14 2020, and then, secondly, the money is not guaranteed in  
15 our opinion. It is money that's scheduled to come to Blue  
16 Cross Blue Shield, but in this current administration in  
17 Washington D.C. certainly this was an unintentional  
18 windfall, if you will, to Blue Cross Blue Shield. Because  
19 of that it gives us even greater concern whether the  
20 schedule will actually be paid out as we anticipate.

21 Q. You understand though, as Member Lunge said,  
22 this is -- the windfall that will come to Blue Cross is  
23 not part of the ACA. It's not something that HHS has  
24 authority over. It's the IRS. It's a separate bill. The  
25 IRS does not have a history of not refunding money that is

1 -- that Congress has mandated that they refund?

2 A. But I think you will agree with me all of  
3 those agencies report up to the President of the United  
4 States and I think that's where all these health care  
5 policies are emanating from, and again because it was an  
6 unintentional decision I think that raises the level of  
7 concern that the schedule will be paid out as it is, and I  
8 also want to touch upon this idea it's not reflected in  
9 the rate filing because I do understand from my own review  
10 and our team's review that the contribution to reserve  
11 normally at 2 percent has come down to 1.5 percent  
12 reflective of not having to pay federal income tax into  
13 the future.

14 Secondly, and I applaud Blue Cross Blue  
15 Shield for this, they are not trying to get back at the  
16 reduction in the CSR payments in this year's rate filing,  
17 but anticipating using that ATM tax credit in the future  
18 to mitigate what would otherwise be a risk -- would  
19 otherwise be a rate increase. So that is good, and then  
20 also they have also very prominently said they are going  
21 to use all of the remaining money for risk -- for rate  
22 mitigation in the future.

23 Q. That is what they have said. So I think we  
24 understand each other. I didn't understand at the  
25 beginning of this Blue Cross's position they were dropping

1 what they call contribution to reserves, what the federal  
2 government calls profit. They are dropping that from 2  
3 percent to 1.5 percent not because they are using any of  
4 that 16 million or any of the 14 million in the next years  
5 for that purpose, but only dealing with the second part of  
6 the windfall which is they don't have to pay federal tax  
7 in the future, right?

8 A. For that one piece, yes, but of course, you  
9 know, there's six and a half million dollars they lost due  
10 to CSR defunding and that's not incorporated into the rate  
11 because they anticipate using that alternative minimum tax  
12 payment to mitigate that increase. Then also again they  
13 very publicly stated they are going to use the remainder  
14 for rate mitigation.

15 Q. They have stated that. Do you agree with Blue  
16 Cross that a point of RBC is equal to about four million  
17 dollars?

18 A. I believe that's correct for Blue Cross Blue  
19 Shield and their revenues.

20 Q. Did I get that wrong? I'm sorry. A million  
21 dollars -- a CTR -- if you reduce CTR from 2 percent to  
22 1.5 that's worth about 4 million bucks?

23 A. Yes. I think I understood what you said.

24 Q. The other way is four million dollars. If you  
25 increase it, it's four million dollars, right? So this 16

1 million that they will get back from the government that  
2 would be equal then, wouldn't it, to about 64 points of  
3 RBC?

4 A. I think Blue Cross Blue Shield's answers to  
5 one of the questions -- I don't know if it came from the  
6 Health Care Advocate or from the Board -- showed the  
7 impact on RBC for those various amounts and 16 million I  
8 think it was about 64 points.

9 Q. And then of course just carrying that out for  
10 30 million then would be 120 million -- I'm sorry. For 30  
11 million it would be 120?

12 A. I understand it to be about a hundred, yeah.

13 Q. You mean it's not linear. The more -- the  
14 greater the contribution the less a point is worth?

15 A. I think I just need to suggest that all else  
16 being equal if they get the full amount, I understand the  
17 impact to be around 100 points on the RBC.

18 Q. On page 3 of your solvency opinion you note  
19 that membership growth is a risk factor. If the company  
20 is growing, it's going to have a higher RBC. Well it also  
21 acknowledged, don't you, the opposite is also true. If  
22 the company is shrinking, then it can have a lower RBC?

23 A. That's correct. Now when we look at Blue  
24 Cross Blue Shield holistically and if you look at that  
25 premium to earn number, there's also a per member month

1 number there as well and both those numbers have gone up.  
2 So when you look at Blue Cross Blue Shield globally their  
3 covered lives has continued to increase even if those in a  
4 qualified market has decreased.

5 Q. This 500 to 700 percent RBC range is that  
6 something that the Department mandates? Sorry. Have you  
7 put out an order mandating that Blue Cross retain RBC  
8 ratio between 500 and 700?

9 A. So it's definitely a Department mandate.  
10 That's something we've worked with Blue Cross Blue Shield  
11 and set that parameter. Again we think that's a  
12 reasonable parameter given the situation in Vermont,  
13 stability of our market, and again I just referenced the  
14 fact that on average the RBC number for all other health  
15 carriers is 925. So even our range is considerably below  
16 that, but again that's a range that we worked with Blue  
17 Cross Blue Shield on with our financial team and it is  
18 something that is a mandate from us for them to work in.

19 Q. By the way are you sure that 925 is the number  
20 for all carriers and not all Blue Cross?

21 A. No. All health care. All health care.

22 Q. Don't the for profit carriers in general have  
23 much lower RBCs than the non-profits?

24 A. Some do. Some could have higher.

25 Q. You're pretty confident that 925 is country

1 wide all carriers?

2 A. That's a NAIC statistic.

3 Q. So is there an order that you or Betty Costle  
4 or some predecessor of yours put out saying Blue Cross  
5 must have 500 to 700 RBC?

6 A. We don't do it by order, but again we have had  
7 -- we have mandated that via our general regulatory  
8 oversight with Blue Cross Blue Shield.

9 Q. And the mandate is in what form? I mean is  
10 there anything in writing an outsider can see?

11 A. There's not, but again the RBC and the  
12 function of the Blue Cross is really a regulatory role so  
13 not necessarily I think required in this instance, but  
14 something that we work with Blue Cross Blue Shield to get  
15 them in between that range and also to mandate that range.

16 Q. Was the 500 to 700 percent RBC -- was that  
17 something that was initially targeted by Blue Cross or did  
18 you all say Blue Cross that's where we want it?

19 A. So Blue Cross Blue Shield it wasn't sort of a  
20 number that was picked out of the sky. It was something  
21 that was done with great thought on Blue Cross Blue Shield  
22 presenting to us a range. We looked at that and then we  
23 confirmed and included that as a mandatory range. I  
24 understand Blue Cross Blue Shield is engaging in a process  
25 of looking at whether that's the appropriate range again.

1 I guess both actuarially, financially, and other sort of  
2 analysis that go into that, but that was something that's  
3 developed by the carrier, brought to us, we review for  
4 reasonableness, and then approve and mandate.

5 Q. I don't want to spend much time at all on this  
6 because I haven't read the amendment, but are you familiar  
7 with the Blue Cross amendment on AHPs?

8 A. Yes.

9 Q. Okay, and am I correct in understanding -- I  
10 think I am based on an answer that Blue Cross gave to the  
11 Chair -- that this new AHP market Blue Cross wants to --  
12 is actively trying to participate in?

13 A. My understanding is that there are individuals  
14 in Vermont that are trying to actively participate in it  
15 and they have reached out to Blue Cross Blue Shield.

16 Q. Okay, and were you here for Blue Cross  
17 testimony where Blue Cross said in answer to a question by  
18 the Chair we hope to be selected as either the carrier on  
19 risk or the ASO prior in this market, and they also said  
20 if and when we are selected we're going to participate in  
21 this market. Were you here for that?

22 A. Yes.

23 Q. Does it trouble you at all that what Blue  
24 Cross is now trying to do is to charge the individual  
25 members, QHP purchases, for products that it's going to



1 create or help create or participate in that takes some of  
2 the good risk out of the QHP pool and so Blue Cross is  
3 charging the people in the individual market so that it  
4 can make additional money in this new AHP market and at  
5 the same time mess up the individual market. As the  
6 Insurance Commissioner does that trouble you at all?

7 A. Well what troubles me is again the federal  
8 policy that's been laid out. What would trouble me more  
9 as an out-of-state carrier coming in and taking those  
10 lives away from our exchange and not having robust  
11 regulatory requirements that our emergency rules are  
12 anticipating having. I would suspect that any carrier in  
13 Vermont would react to -- from a business perspective  
14 would react to change and regulation particularly at the  
15 federal level. So at some degree in Blue Cross not  
16 responding to this thing that none of us in the room have  
17 any control over that would somewhat trouble me, and then  
18 again it seems to -- you seem to elude to the fact that  
19 Blue Cross Blue Shield is not cross subsidizing among the  
20 various offerings, and again that's something that we look  
21 for in any rate filing is that cross-subsidization. We  
22 would not want to see that. We would want to see each  
23 risk pool standing on its own.

24 So I think Blue Cross Blue Shield is  
25 responding from a business perspective in a way that you

1 would anticipate a carrier responding to, and again if  
2 they weren't responding, if they are flat footed, that  
3 might be cause for concern.

4 Q. But they have control, don't they? They don't  
5 have a hundred percent control, but they have substantial  
6 control on how -- the extent to which this new market,  
7 which would mess up the individual market, how big a part  
8 of the entire Vermont insurance market -- how big a part  
9 that becomes of the entire Vermont insurance market, and  
10 obviously neither you nor I have any control over the  
11 federal government, but as Insurance Commissioner you do  
12 have control over your domestics, and again that they are  
13 now asking, as I understand it, to raise the rate for  
14 individuals more because they are going to go off and help  
15 create -- help facilitate this new market that's going to  
16 mess up the individual market. That's not something that  
17 caused you concern?

18 A. Well I think the characterization is somewhat  
19 unfair. Again, as I understand it, the marketplace has  
20 dictated the interest in these plans. That have gone to  
21 carriers including Blue Cross Blue Shield. Once realized  
22 it's a business opportunity. Presumably they are now  
23 interested in being selected for that business  
24 opportunity, but again it's going to be the individual  
25 businesses or providers that are driving interest in the

1 association health plans not Blue Cross Blue Shield, and  
2 if Blue Cross Blue Shield didn't do it, again, someone  
3 would do it. More likely than not someone from out of  
4 state and I would much more prefer someone in-state having  
5 that risk.

6 Q. But you agree Blue Cross could decline to do  
7 it?

8 A. They could. I might have some concern about  
9 that business decision.

10 Q. Are you saying that the Department would step  
11 in and force Blue Cross to -- what are you saying when you  
12 may have some concerns about that?

13 A. Because I think there's an opportunity there  
14 for a domestic insurer to fill a gap that's been created  
15 by the federal government. So I see no reason why they  
16 wouldn't want to pursue that opportunity.

17 Q. And the reason they would raise rates to  
18 individuals in the exchange market?

19 A. Again that brings me concern, but it is a  
20 federal issue. All rate filing -- amended rate filing  
21 does is rerate the risk pool that remains after the  
22 association health plans are in operation. We might  
23 disagree with the association health plans generally and  
24 in concept, but that's the reality. So I think that's  
25 where my concern is more directed.

1           At this point I think too the Department and  
2 the carriers in the market are responding as practically  
3 responsibly and quickly as we can.

4           Q.       Of course none of us know how substantial the  
5 AHP market is going to be?

6           A.       That's true.

7           Q.       And we don't know how long it's going to last?

8           A.       That's also true.

9                   MR. ANGOFF: No questions.

10                  MS. HENKIN: Board.

11                  MR. MULLIN: Welcome Commissioner.

12                  COMMISSIONER PIECIAK: Thank you.

13                  MR. MULLIN: What do you believe is the  
14 number of carriers that will be necessary to create a  
15 true competitive marketplace?

16                  COMMISSIONER PIECIAK: I think the  
17 Vermont marketplace now has two major carriers in the  
18 qualified health exchange and I think there is  
19 competition within that marketplace. So I think we  
20 see competition with two. I think any number greater  
21 than that would add greater competition obviously,  
22 but I think we certainly see competition with two  
23 carriers.

24                  MR. MULLIN: When you were talking about  
25 the percentage increase did the national association

1 also share a spreadsheet that showed out of pocket  
2 per member per month costs for individuals enrolled  
3 in plans by state?

4 COMMISSIONER PIECIAK: I haven't seen  
5 that information.

6 MR. MULLIN: I think it would be an  
7 interesting thing for you to look at.

8 COMMISSIONER PIECIAK: Yes.

9 MR. MULLIN: We started a lot higher  
10 because we were already at guaranteed issue with a  
11 community rating and a lot of states are catching up.

12 COMMISSIONER PIECIAK: In terms of the  
13 rate increases.

14 MR. MULLIN: In terms of the final  
15 rates. We don't have much to pat ourselves on the  
16 back about unfortunately. We wish we could. You  
17 have thrown some numbers and I got to say the court  
18 reporter inspired me because I can't even take notes  
19 fast enough to keep up, but you were talking about  
20 premium revenues versus total dollars of reserves.  
21 Those total revenues was that across Blue Cross Blue  
22 Shield's book of businesses or was that only QHP  
23 filings?

24 COMMISSIONER PIECIAK: That was anything  
25 they were bearing the risk.

1 MR. MULLIN: Okay. So you did subtract  
2 out anything they were just doing the administration  
3 only?

4 COMMISSIONER PIECIAK: Yes. Exactly  
5 right.

6 MR. MULLIN: Great. That's helpful.  
7 Vermont uses RBC. Other states are not necessarily  
8 using that same standard. I think we heard last year  
9 in MVP's testimony that New York uses a different  
10 standard.

11 COMMISSIONER PIECIAK: New York does a  
12 lot of things different.

13 MR. MULLIN: What makes RBC special?

14 COMMISSIONER PIECIAK: So I don't know  
15 there's anything particularly special about it, but  
16 what it does provide for regulators is, again, an  
17 uniform standard. Most states do use RBC and it's  
18 objective in that you know a carrier in Vermont can  
19 be viewed compared to a carrier in California by  
20 these metrics that we are all using. So I think it's  
21 that uniformity and that objective analysis that  
22 provides regulators somewhat of a comfort. It also  
23 provides regulators clear triggers. So again if they  
24 get to a 30 percent RBC, there's a clear trigger in  
25 terms of action that they have to take under our

1 statute, and again if they get to 375, for Blue Cross  
2 Blue Shield there's a clear trigger as to action they  
3 have to take. So it also provides that clarity and  
4 not that subjective analysis as to where they stand.

5 MR. MULLIN: So not saying that this is  
6 the case in this particular situation, but if a  
7 carrier failed to comply with a regulatory decision,  
8 should that be used as an excuse to ask for  
9 additional reserves?

10 COMMISSIONER PIECIAK: I'm thinking.  
11 I'm trying to understand the question.

12 MR. MULLIN: So in earlier testimony  
13 today from Blue Cross Blue Shield they testified that  
14 cuts in other rating factors, other actuarial  
15 factors, resulted in lowering their reserves, and my  
16 question to you is should a company be able to use  
17 their own inability to manage to a regulatory  
18 decision to argue for higher reserves?

19 COMMISSIONER PIECIAK: I think I  
20 understand your question now. So I mean I guess I  
21 tried to make sure that this was clear at the  
22 beginning, but you know we obviously are concerned  
23 with Blue Cross Blue Shield and their solvency, but  
24 ultimately we're concerned with consumers and the  
25 consumers being able to get their claims paid. So

1           regardless of what caused the company to get to a  
2           place where they need additional surplus, looking out  
3           for consumers I would say that they should have  
4           sufficient surplus on hand to ensure their solvency.

5                   MR. MULLIN:  So basically any carrier  
6           could ignore any reduction in the trend and come back  
7           the following year and ask for a higher reserve?

8                   COMMISSIONER PIECIAK:  If they needed a  
9           reserve increase, then again I think it's a separate  
10          conversation about not following the regulatory  
11          order, but certainly again we look at the solvency of  
12          the company and protecting the consumer.  So that's  
13          our ultimate concern.

14                   MR. MULLIN:  So what would incent a  
15          carrier to make structural changes?

16                   COMMISSIONER PIECIAK:  Well I think, you  
17          know, there have been a number of changes that have  
18          occurred from Blue Cross Blue Shield in testimony  
19          that you heard earlier when it comes to their  
20          administrative cost, when it comes to the way they  
21          are trying to provide access to care, and also  
22          increase the quality of care.  So there seems to be  
23          some progress from the carrier.  It's not a main  
24          component of what our regulatory outlook is in terms  
25          of looking at the company, but certainly I think this



1 process creates a certain degree of incentive  
2 certainly.

3 MR. MULLIN: I guess I'll just close  
4 with an analogy not a question and I will say New  
5 York Yankee's have the second best record in baseball  
6 yet they are five games behind in their division.

7 COMMISSIONER PIECIAK: And I'm happy for  
8 that.

9 MS. HENKIN: Let's move along.

10 MS. HOLMES: Two questions. So in your  
11 solvency analysis do you review the fiscal management  
12 of premium dollars and, in particular, do you review  
13 how carriers spend revenues on personnel costs, board  
14 salaries, executive compensation, investment choices,  
15 administrative overhead, and cost containment  
16 strategies?

17 COMMISSIONER PIECIAK: Yes. I would put  
18 those more into the bucket of our ongoing overview --  
19 oversight certainly on an annual basis and an exam,  
20 conversation with management happen at the annual  
21 level and also through the examination process, and  
22 so how they are using premium dollars is certainly  
23 something that we have a concern about. If  
24 administrative costs were increasing for reasons that  
25 couldn't be explained or they are increasing above

1 what was happening on the national level, that would  
2 be a concern for us.

3 MS. HOLMES: That's more in your ongoing  
4 analysis not in your specific solvency analysis?

5 COMMISSIONER PIECIAK: I think that's  
6 correct. Our solvency analysis, again, we're looking  
7 for rate adequacy. Obviously the administrative  
8 component is part of that. So we think the rate as  
9 filed would cover the administrative cost as well as  
10 the claims so that they anticipate being paid.

11 MS. HOLMES: And the second question is  
12 increasing enrollments. Obviously you testified here  
13 that requires a greater surplus to protect against  
14 solvency. So did your solvency analysis take into  
15 account the potential for decreased enrollment  
16 because of the individual mandate change, because of  
17 the migration from the AHPS, and also the potential  
18 for future losses in market share due to the  
19 differential in prices of the two carriers that are  
20 --

21 COMMISSIONER PIECIAK: Yes. So that's a  
22 question. Yes. I'll start with the AHPs. So  
23 certainly those are individuals that aren't being  
24 removed from the global marketplace. They might be  
25 moved from a certain segment and presumably some of

1 those will end up at Blue Cross Blue Shield.

2 MS. HOLMES: But not all. You don't  
3 know.

4 COMMISSIONER PIECIAK: Not all. That's  
5 true, but the ones we anticipate having interest in  
6 Vermont would be fully insured association health  
7 plans. So again not all, but some would migrate.  
8 With the individual mandate repeal those individuals  
9 would just be out of the marketplace altogether. So  
10 certainly you could see a decreased membership and  
11 corresponding increase in RBC because there would be  
12 less reserves required for that, but again we view  
13 all of those things when issuing our solvency  
14 opinion.

15 MS. HOLMES: The third one was the  
16 potential loss of market share because of the rate  
17 differential between Blue Cross Blue Shield and MVP.

18 COMMISSIONER PIECIAK: Yeah. We've seen  
19 Blue Cross's RBC in the last year go up or not  
20 decrease as much as it would otherwise because they  
21 have lost some of their membership under the  
22 qualified health market, but again looking globally  
23 their per member per month lives has continued to  
24 increase. So large group and other types of  
25 insurance have continued to grow. So they haven't

1 necessarily lost market share globally and the  
2 covered lives globally looking at the company.

3 MS. HOLMES: We have to make a decision  
4 about CTR for this filing. We have to look at what  
5 is the impact of this filing.

6 COMMISSIONER PIECIAK: I think that's  
7 exactly right, and again we look at solvency globally  
8 and I think this is looking at how this filing  
9 impacts solvency globally. So certainly the  
10 qualified health market is decreased, but again their  
11 overall risk profile is either the same or increasing  
12 from last year.

13 MS. HOLMES: Thank you.

14 MS. USIFER: Just a question on the  
15 schedule that under the capital and surplus and  
16 change from 13 to 17, are you able to talk about what  
17 the RBC was at the start of that and what it is at  
18 the end?

19 COMMISSIONER PIECIAK: So I can't speak  
20 to the exact RBC, but I can tell you during that  
21 entire period it was within the range. At the start  
22 of that it was much higher in the range. I would  
23 call it in the mid to high and now it's low toward  
24 the bottom of the range.

25 MS. USIFER: And if it goes above the

1 range, what type of actions do you take if it were  
2 800?

3 COMMISSIONER PIECIAK: That's a good  
4 question. So we would view anything over 700 as  
5 excessive and we would have an opinion that stated as  
6 much. So we anticipate and expect Blue Cross Blue  
7 Shield to try to plan to that range on the low end  
8 and also then on the high end.

9 MS. HENKIN: Robin.

10 MS. LUNGE: Hi. How are you?

11 COMMISSIONER PIECIAK: Good.

12 MS. LUNGE: Have you reviewed the  
13 Federal Department of Labor rule related to  
14 association health plans?

15 COMMISSIONER PIECIAK: I have and my  
16 team has more specifically.

17 MS. LUNGE: And are you aware of any  
18 changes to preemptive rules in that?

19 COMMISSIONER PIECIAK: So that's a good  
20 question. The way we view the federal rules in terms  
21 of preemption is -- and the Secretary of the  
22 Department of Labor had stated this prior to the  
23 rules coming out that their intent was not to preempt  
24 the states. We had heard that orally a number of  
25 times. Clearly the rules have stated that there's no

1 intended preemption, but then of course the rules  
2 have also said that there is a threat of preemption.

3 States are not enacting the association  
4 health plans in line with the spirit of the final  
5 rules and I don't think I have the language exactly  
6 correct on that, but what we take that to mean we  
7 disallow them or did something to that extent that  
8 Vermont or other states could base preemption on. So  
9 I think we're free to regulate, but I think we are  
10 handcuffed to some degree about how far we can go in  
11 that regulation.

12 MS. LUNGE: You wouldn't be surprised  
13 that I also have reviewed the rule. The comment  
14 related to preemption in my recollection, and you're  
15 welcome to submit something if I'm incorrect to that,  
16 was specific to self-insured association health  
17 plans. So if you could please let me know if I'm  
18 wrong about that in the future.

19 COMMISSIONER PIECIAK: Sure.

20 MS. LUNGE: But my understanding from my  
21 review was the preemptive comment was specific as to  
22 self insured.

23 COMMISSIONER PIECIAK: Sure. I'll ask  
24 our team to look at that.

25 MS. LUNGE: Thank you.

1                   MR. PELHAM: Just a quick question. So  
2 you talked about the 2017 surplus at 130 million  
3 dollars and I've seen that in the Blue Cross Blue  
4 Shield, and I know that's the numerator of the RBC  
5 calculation and I know that it's a confidential  
6 number, but what comprises the denominator? What are  
7 the ingredients that go into the denominator?

8                   COMMISSIONER PIECIAK: I'll just talk  
9 generally about the category. Certainly we look at  
10 what I call the asset quality, but you could also  
11 look at it as asset risk, what are the assets that  
12 the company has on its balance sheet, how open are  
13 those to risk. Certainly a life insurance company  
14 that has long term bonds or something they are  
15 anticipating a lot of interest rate, you know,  
16 income, and so a low interest environment or changing  
17 interest rate environment could be an impact for  
18 them.

19                   We also look at the underwriting risk;  
20 so what's the pool, what's the population that's  
21 being underwritten, what's the age, what's the  
22 mortality, morbidity, all of those categories, and  
23 then there's sort of other general category. To  
24 break that down a little bit more we would look at I  
25 guess I would call it enterprise risk or operational

1 risk, reputational risk, credit risk, all those sort  
2 of things that don't fall neatly into asset risk or  
3 underwriting risk.

4 MR. PELHAM: So these are -- are these  
5 kind of established parameters or steps, indicators  
6 by the National Association of Commissioners?

7 COMMISSIONER PIECIAK: Yes. That's  
8 exactly right. There's the RBC statute that was  
9 formulated through the NAIC process and then passed  
10 here in Vermont and many other states across the  
11 country.

12 MR. PELHAM: Thanks.

13 MS. HENKIN: Thank you.

14 COMMISSIONER PIECIAK: Thank you.

15 MS. HENKIN: I would like to move ahead  
16 to have David Dillon come up. We're hoping to get  
17 through this today. We may be arrested for staying  
18 in the State House too long.

19 DAVID DILLON,

20 Having been duly sworn, testified  
21 as follows:

22 DIRECT EXAMINATION

23 BY MR. ARDUENGO:

24 Q. Good afternoon. Could you tell us who you  
25 are?



1           A.       I'm Dave Dillon. I'm senior vice president  
2 and principal with Lewis & Ellis.

3           Q.       What is Lewis & Ellis?

4           A.       So Lewis & Ellis is an actuarial consulting  
5 firm. We're founded in 1968, however, we do other  
6 insurance consulting as well. I'm also involved with  
7 insurance compliance work and insurance financial  
8 solvency, financial examination work in addition to the  
9 traditional actuarial work.

10          Q.       What is your educational background?

11          A.       So I have an undergraduate degree from  
12 Oklahoma State University in mathematics, and then I have  
13 a graduate degree from the University of Iowa in  
14 statistics and actuarial science.

15          Q.       How long have you been an actuary?

16          A.       So I have been in the field for 22 years.  
17 Started about 1996. I've been a credentialed actuary for  
18 16 years. I've been at Lewis & Ellis almost 20. It will  
19 be 20 in February.

20          Q.       Do you have any professional certifications?

21          A.       So I have two primary certifications. I don't  
22 know exactly how this came about, but the actuarial world  
23 has two organizations that we're kind of beholden to. One  
24 is the Society of Actuaries and that is more education and  
25 research body, and that's kind of the passing our exams

1 and being certified to become an actuary. Once we pass  
2 our exams and become a member of the Society of Actuaries  
3 we also have a professional requirement which includes  
4 continuing education and that's through the American  
5 Academy of Actuaries which I'm also a member.

6 Q. How long have you been retained by the Board  
7 to provide actuarial services?

8 A. So we were engaged beginning in 2014.

9 Q. How many Vermont health insurance rate filings  
10 have you worked on in that time?

11 A. Including the two we're discussing this week  
12 it is 66 in that time.

13 Q. And in what market segments?

14 A. So it's primarily individual, small group, and  
15 large markets.

16 Q. Do you work on health insurance rate filings  
17 in other states?

18 A. Yes. Since 2010 and the passage of the ACA my  
19 team that this Vermont team is a subset of we have worked  
20 with 22 states regarding rate review and health care  
21 reform issues. We are currently assisting eight other  
22 states. So nine this year on record review issues with  
23 the ACA specifically.

24 Q. And in that work do you get a comparative look  
25 at the health insurance market nationwide?

1           A.           Absolutely.  So my clients -- we have a wide  
2 range of states that do have different issues.  So it's  
3 kind of good to see how some of these market impacts like  
4 have been discussed today; the mandate, non-funding of the  
5 CSR, things like that we definitely see a wide range.  I  
6 would say we have -- of the nine states my team works with  
7 we have three in the northeast; DC, Maryland, you guys.  
8 Then we also see kind of opposite of that we work with  
9 Louisiana, Arkansas, South Carolina, and we have some in  
10 the middle as well; Kentucky and Nebraska.

11           Q.           In your work how do you keep up with changing  
12 reform issues?

13           A.           I do -- I'm a very active volunteer with the  
14 Society of Actuaries.  I am the Chair of the Society of  
15 Actuaries strategic initiative called Commercial Health  
16 Care What's Next.  We started that a year ago, almost  
17 exactly a year ago, and it is a series of upheld white  
18 papers that addresses issues such as the individual  
19 mandate, association health plans, things like that.  So  
20 I'm heavily involved in that process as an editor there.

21                        I am also involved -- I'm with the Society of  
22 Actuaries.  I am the chair and lead interviewer for the  
23 health podcast series.  So I produce podcasts on behalf of  
24 the Society of Actuaries regarding all health related  
25 issues.  So that really keeps me informed of what's going

1 on, and then just corporately with Lewis & Ellis I do a  
2 few things. I issue a newsletter to send out to clients  
3 who are interested regarding what's going on. I do that  
4 quarterly, and then if anyone in this room is a friend of  
5 mine on LinkedIn, you will know that I try to disseminate  
6 as much information as possible to interested parties as  
7 it comes. I probably post three times a week, if not  
8 more, on related issues.

9 Q. And generally speaking how is the health  
10 insurance rate filing reviewed?

11 A. So I'll kind of start with the big picture.  
12 There is a company that files and as actuary that reviews  
13 it there's probably 200 pages of guidance that the actuary  
14 has to submit -- has to follow and primary things we do is  
15 we make sure that guidance is followed. There's three  
16 sources -- primarily three sources of guidance. There's  
17 the federal regulation with the ACA, there is the state  
18 based rules and statutes, and then from an actuarial  
19 standpoint we have actuarial standards of practice. So we  
20 follow -- we make sure that the company follows all of  
21 those regulations.

22 Generally speaking your state based  
23 regulations and actuarial standards of practice are more  
24 general in nature. They are a little bit maybe more about  
25 the standards of review. While a lot of the federal

1 guidance now is much more -- I don't know if you want to  
2 use the word prescriptive, but it is a little more  
3 targeted on what we have to review.

4           For a state to have an effective rate review  
5 program there are 15 categories of things that we have to  
6 review. I won't go over the whole laundry list, but it is  
7 things like the -- that have been discussed today; medical  
8 trend, changes in benefits, change in reserve needs,  
9 change in capital and surplus. So we hit all of those  
10 items in the review.

11           You know one thing I was going to say as part  
12 of doing the rate review, not just with you guys but with  
13 all of our states, I kind of view our role as kind of an  
14 actuarial translator. Right. We take all the  
15 regulations. We sanitize it. We tell you what that  
16 means. I kind of look at it as -- you know as kind of a  
17 Goldilocks analogy; is the filing too hot, too cold, or  
18 right in the middle just perfect, something in between.

19           Now I will say that one thing we are not are  
20 actuarial fortune tellers. While we can review a process  
21 a company does, we review the process, we make sure all  
22 the factors that they should consider are considered.  
23 Once we look at those factors we make sure that they have  
24 had a decent process, you know over the 200 rigorous pages  
25 of guidance, but we might say the porridge is just right,

1 but we can't -- you know we don't know if it's 150 degrees  
2 temperature or 190 degrees temperature. There could be a  
3 variance. There's different -- everyone sitting up here  
4 has a different definition of hot. So we try our best to  
5 say it's within a range, but if -- generally speaking so  
6 if something is too hot, we'll say all you guys are going  
7 to say it's too hot or if it's too cold we're going to say  
8 it's an extreme it's too cold. We try to keep it in the  
9 middle, but we're never going to be able to exactly nail  
10 what will happen two years down the road even though we  
11 will use rigorous models to develop a range.

12 Q. And what's the process for reviewing a health  
13 insurance rate filing in Vermont?

14 A. So specifically when the submission date comes  
15 around and kind of the button gets pushed, the company  
16 submits the filing, it usually takes about a day, but  
17 Green Mountain Care Board staff let us know it has been  
18 submitted, and we have access on SERFF which is the system  
19 for rates, forms, and filings. So that is the NAIC's  
20 mechanism in every state, but one uses that and so we --  
21 Blue Cross will submit all of their filing documentation,  
22 all their requirements for the federal rules, state rules  
23 all that through SERFF. So that is how we receive that  
24 information, and then over the review period we utilize  
25 that system to communicate with the company through what

1 are called objection questions in the filing, and the term  
2 objection doesn't necessarily mean they are negative.  
3 That is kind of a SERFF definition, but it's just the way  
4 we ask questions through that system.

5 Q. So would you say that when you are reviewing a  
6 filing you're performing an independent analysis and  
7 calculation?

8 A. So I would say partially. It really depends  
9 on the assumption and the materiality of that assumption.  
10 Several of the assumptions that have been discussed today;  
11 risk adjustment, utilization trend that are very material  
12 to the filing we -- a lot of times we will do an  
13 independent calculation if maybe the company doesn't use  
14 an approach that we have used in the past. So maybe we'll  
15 -- we're just more comfortable with using our approach we  
16 might do that, but if a company utilizes kind of a formula  
17 or process that's similar to what we have done we're not  
18 going to necessarily recreate the wheel. So it kind of  
19 does depend on the assumptions.

20 Q. So you mentioned earlier the process of  
21 sending out objection letters. Is that how you receive  
22 additional information of a company during your review?

23 A. That is correct.

24 Q. And in your review do you do a peer review?

25 A. Yeah. So when you kind of asked about the how

1 we do a specific review what we do is when we get it in  
2 SERFF we really are set up -- we have three people  
3 assigned to each filing. Josh Hammerquist is what I would  
4 call our lead reviewer. Okay. I am the primary peer  
5 reviewer and then Jackie Lee is a secondary peer reviewer  
6 and we kind of have different roles. Jackie and I also  
7 both -- we both are kind of assigned to the MVP filing as  
8 well.

9           So Josh when he gets the filing and submits it  
10 through SERFF I would say the first thing Josh does is a  
11 completeness -- make sure all the requirements are  
12 included, things like that, and then Josh is going to be  
13 the one that really kind of lays it out, really do the  
14 deep, deep digger in all of the little assumptions. So  
15 there's probably 30 to 40 different assumptions that are  
16 changing in each rate filing and so he reviews all of  
17 those changes submitted by Blue Cross. He kind of  
18 presents a summary to me, and then what I do when we first  
19 get the filing I kind of do a big picture look. I kind of  
20 want to know what's going on before I know what the  
21 company is telling me.

22           As to what's been discussed today is the 2019  
23 filing is primarily based on 2017 experience. It's kind  
24 of the starting point and there's some adjustments along  
25 the way. So typically what I do is I will jump in. Even



1 before I look at what the rate increase request is I ask  
2 Josh to give me just the 2017 results. Okay. I look at  
3 that and then I assess based on big picture market issues  
4 how I think that might change that experience. We talked  
5 about the non-enforcement or the non-payment. CSR's, the  
6 health insurance fee going away that's going to change the  
7 rate request, things like that. So I kind of end up doing  
8 an informal upper and lower bound on the rate increase  
9 even before I see what they say. I think that helps me  
10 get engaged once I see that number how kind of crazy it is  
11 or there's some reasonableness to it just from a starting  
12 standpoint, and for this year I came up with a ball park  
13 of 5 to 10 percent and it fell right into the middle of  
14 that. So there weren't any initial red flags that it was  
15 extremely high or extremely low. We're obviously going to  
16 beat on every assumption in there, but at least there were  
17 no significant red flags, and I will say there are a lot  
18 of times we do see significant red flags in other states  
19 in other carriers that fall outside of that range.

20 Q. So you mentioned today's filing. Are you  
21 familiar with today's filing?

22 A. Yes.

23 Q. How long did you have to review it?

24 A. We had 60 days.

25 Q. So if you turn to your report, you put into

1 your report there's a standard of review and you mentioned  
2 before the actuarial standards of practice. I was  
3 wondering if you could just tell me a little bit about  
4 that standard of review and which of the factors are  
5 relevant to you?

6 A. So as I mentioned earlier kind of big picture  
7 review. We review the filing to make sure they comply  
8 with the federal rules, state rules, and actuarial  
9 standards of practice, and then within the state rules you  
10 guys are charged with multiple factors to review, and  
11 three of those are actuarial in nature and those are  
12 defined in actuarial standards of practice and that is  
13 excessive, inadequate, and unfairly discriminatory. So  
14 when we do our review and write our report we are making a  
15 recommendation to you on those three items about the  
16 filing.

17 Excessive. We'll get into that a little bit.  
18 So excessive basically means we need to review all of the  
19 claims, the expectation of the claims the company is  
20 doing, the expectation of admin. We review those  
21 provisions to make sure they are reasonable and that the  
22 premium that is being charged is reasonable in relation to  
23 the sum of those pieces. So we look at the claims, we  
24 look at the admin, we look at the profit margin, kind of  
25 add those up and make sure the premium charge makes sense

1 to that.

2 Q. And can you define adequate as an actuarial  
3 term?

4 A. So inadequate is kind of defined as the flip  
5 side to the excessive. So it's really, again, we look at  
6 the claims, we look at admin, we look at the profit  
7 provision. We kind of sum those up and compare that to  
8 what the premiums being charged, and if we do not believe  
9 that the premium charged is enough to cover what we would  
10 expect the company's population to use in terms of  
11 benefits or anything like that, we would call that  
12 inadequate.

13 Q. And can you define unfairly discriminatory?

14 A. Sure. Unfairly discriminatory is really kind  
15 of defined as charging one person too much if they are  
16 substantially similar to somebody else, but typically in  
17 Vermont that is not typically as big a consideration  
18 because you guys are different in a lot of ways and a lot  
19 of states in terms of community rating and merged market  
20 and so that kind of almost takes a lot of those  
21 considerations out.

22 Q. So when you say in your report that a given  
23 assumption is reasonable and appropriate what does that  
24 mean?

25 A. So when we say something is reasonable and

1 appropriate that is basically -- as I was when we talk  
2 about excessive we'll talk about the claims and all that  
3 you implies, right? When we say incurred claims there's a  
4 lot of assumptions there. When we look at admin there's  
5 assumptions in that. So when we say something is  
6 reasonable and appropriate that is saying when we've  
7 looked at those components we believe those components are  
8 not excessive, they are not inadequate, they are not  
9 unfairly discriminatory, and as I alluded to earlier we're  
10 not necessarily a fortune teller. This isn't going to be  
11 the exact number that's going to be realized in years, but  
12 based on information the company has at that time we say  
13 that is a reasonable projection.

14 Q. And when you give an actuarially reasonable  
15 range in your report does that mean that all of the  
16 numbers in that range are equally likely?

17 A. No it does not. You know as an actuary it can  
18 be a little tricky to give ranges and people have a  
19 different view of ranges. Typically when we give a range,  
20 not all the time but most of the time, it is based on -- a  
21 lot of you would know -- in the normal distribution  
22 there's a bell curve. So when you give a range on that,  
23 that is typically 95 percent likely. So when you see a  
24 bell curve people give ranges that's the most common.

25 So what that means is when you have a bottom

1 of the range even with a bell curve that observation is  
2 not that likely. It could happen, but it's not super  
3 likely. So even within a range it can be a little tricky  
4 to make recommendations with ranges. We would say right  
5 around kind of best estimate. That is a lot more likely.

6 Q. And in your report did you make  
7 recommendations to modify the filing as originally  
8 submitted?

9 A. Yes. We made five recommendations.

10 Q. Let me just stop right there. Is it your  
11 understanding based on the testimony today that the  
12 company agrees with those recommendations?

13 A. Yes.

14 Q. For the sake of time we're not going to go  
15 through each of them since they are undisputed.

16 A. Okay.

17 Q. But as to your recommendations can you explain  
18 what the ultimate projected rate increase is in the  
19 individual and small group market?

20 A. Sure. So when I answer that I'm going to kind  
21 of answer it two ways. The first way is I'll say kind of  
22 strict definition. The original proposed rate increase  
23 was 7 and a half percent. Okay. So simplistically if  
24 they were charging a hundred bucks before, they are going  
25 to charge 107.50. After the four recommendations that had

1 been reduced to 7.2 percent. So it was about a four  
2 percent reduction when you kind of do it relative nature  
3 to that.

4           The second way I'm going to answer that  
5 question is I'll call kind of from the effective rate  
6 increase view. As has been mentioned several times today,  
7 but a lot of the premium that is going to be charged will  
8 be covered by the federal government and be subsidized by  
9 the federal government. So even though Blue Cross might  
10 be charging -- proposing to charge 7 and a half percent  
11 before, in reality that was 5.3 percent as an effective  
12 rate increase because so many of the people on the silver  
13 plans and some on the bronze and gold plans get subsidies  
14 from the federal government. So the actual increase to  
15 premiums like out of their wallet was about 5.3 percent  
16 proposed and based on the recommendations that is 4.6  
17 percent. So that .7 percent is about a 13, 14 percent  
18 reduction in the rate increase that was proposed by the  
19 company.

20           Q.       So I wanted to discuss some elements of your  
21 report that you didn't issue a specific recommendation on.  
22 In your report you said that the company's proposed  
23 administrative costs were reasonable and appropriate.  
24 Could you go through that assumption?

25           A.       Yeah sure. So we did a couple things with the

1 admin. Similar to the claims 2017 is kind of really the  
2 starting point and that's where we start in our analysis.  
3 With the annual statement there's a supplemental health  
4 care exhibit which provides -- which was kind of mandated  
5 through the ACA and all companies have to provide this  
6 information and so we start there. Okay. So that is kind  
7 of the first -- we find that out in March. So we know  
8 this information before the filing and so it's kind of the  
9 first piece of information on claims. We look at that and  
10 go okay how does the admin in the filing compare to what  
11 they are reporting to the state. If you do that exercise,  
12 you will see there are differences and so that begs the  
13 question what are the differences. Multiple questions  
14 were asked through the review. I think the first thing  
15 that has to be pointed out is the annual statement is  
16 based on statutory accounting principles which we have  
17 heard today in multiple cases is different than the  
18 generally accepted accounting principles or GAAP. So if  
19 you account for that, that is one big difference between  
20 the statement and the filing. So that's kind of the next  
21 kind of starting point.

22 And then there are the company proposed  
23 changes based on a lot of the membership changes with the  
24 different plans and things. We reviewed that. The  
25 company basically assumed 50 percent of their costs were

1 fixed overhead. In our experience of doing financial  
2 examinations and reviewing rate filings that is a  
3 reasonable assumption to us, and so based on that, that  
4 was kind of the next starting point kind of adjusting the  
5 '17 and then the company made some projections from -- for  
6 wages from '17 to '19 to increase the admin. What we did  
7 there is we did research in Vermont from over the last 10  
8 years with the information reported by the Department of  
9 Labor and confirmed that a three percent wage increase was  
10 reasonable across the State of Vermont over those ten  
11 years and we concluded that Blue Cross's assumption was  
12 reasonable.

13 Q. Okay. So I also want to ask you about the  
14 company's proposed utilization trend. In your report you  
15 said that that trend was reasonable and appropriate and I  
16 wanted to ask if you still agree with that opinion after  
17 it was -- after listening to Paul's testimony today?

18 A. Yes I do.

19 Q. Did you determine what would be a range of  
20 reasonable utilization trends in your report?

21 A. Yeah. So the utilization trend has been a  
22 topic of discussion in the last few filings over the  
23 years, and this one was a little bit different this year  
24 in that the company historically has done kind of two  
25 approaches to analyzing utilization trend. Last year we



1 discussed a third way, going to the independent  
2 calculation approach. We used a different approach.  
3 Probably -- I'm not going to get into their heads, but  
4 probably to cut me off at the pass a little bit the  
5 company did some of those approaches this year because  
6 they knew I was going to ask the questions utilizing that  
7 approach. So the company did utilize three. So we were  
8 able to use a lot of the information provided by the  
9 company in addition to maybe doing our own independent  
10 work.

11 So based on that information and relying on a  
12 lot of the work we do with other states and similar  
13 utilization trending we base our utilization trend range  
14 on a plus or minus 20 percent to that factor, and then  
15 again that's kind of the 95 percent. The bulk of that  
16 range would be in the middle there around 2 percent best  
17 estimate.

18 Q. So if the company had filed a 1.6 percent  
19 utilization trend, would that also have been reasonable?

20 A. So that's kind of tricky as I was alluding to.  
21 If I were doing the filing, I would not file 1.6. I do  
22 not believe it is that likely. So what I would say is  
23 with the range I would say that if it's lower than 1.6 or  
24 above 2.4, I would definitely kick it out as unreasonable  
25 right away, but if it's in the range, I would probably say

1 that, you know, the numbers closer to the middle are  
2 better reasonable numbers. So I would probably say -- I  
3 would just answer it by saying that would not be an  
4 assumption I would utilize if I filed the rates.

5 Q. Let's talk about overall medical trend. What  
6 was your range for the company's overall medical trend?

7 A. Let's see. I believe it was 3.6 to 4.6 with  
8 the best estimate of 4.1.

9 Q. How is that determined?

10 A. So basically we kind of did it from the  
11 component standpoint. We talked about the utilization  
12 trend and we also looked at the unit costs. The unit cost  
13 here in Vermont there's not as much variability as with  
14 the utilization trend. Obviously because you guys have so  
15 much control over a significant portion we don't see as  
16 much variability in Vermont on a unit cost side as we do  
17 in other states. So we use I'll say a similar approach  
18 but not an exact approach, and I think our range for the  
19 total was roughly a weighted average of plus or minus 12  
20 percent from the best estimate.

21 Q. Did you use the same approach to evaluate the  
22 company's proposed pharmacy trend?

23 A. So what we did with the pharmacy trend was --  
24 this is one I alluded to earlier. We won't necessarily do  
25 an independent calculation if a company does something

1 that is similar to what we would do, and the company in  
2 this case did do an analysis very similar. So this is one  
3 where we've relied quite a bit on their calculation. They  
4 appeared reasonable and so it was done a little bit  
5 differently.

6 Q. Okay. So one of the -- one of the other key  
7 changes in this filing is an increase in premiums  
8 resulting from the removal of the individual mandate  
9 penalty. Did you review the company's assumption in this  
10 regard?

11 A. Yes.

12 Q. And did you find it to be reasonable and  
13 appropriate?

14 A. Yes we did.

15 Q. After the filing was submitted Vermont passed  
16 a law implementing a state based individual mandate. Does  
17 that change your opinion regarding the reasonableness of  
18 the company's assumption?

19 A. No it does not. As the company alluded to,  
20 L&E was engaged by both the Board and DFR to do an  
21 analysis on the individual mandate. So we have -- through  
22 that work we have pretty intimate knowledge of a lot of  
23 the information about Vermonters and as alluded to we had  
24 a different method to calculate the impact, but as can be  
25 found about our estimate we primarily focused on the

1 financial aspects of the mandate. If any of you guys have  
2 read the Congressional Budget Office Report on the mandate  
3 non-enforcement, they talk about there's some financial  
4 and non-financial. We think it's much maybe cleaner to  
5 focus on the financial aspects; primarily the income  
6 level, the premium level, the health status of the person  
7 in question.

8           So when -- we have also -- through the reviews  
9 over the last few years we have learned that Vermonters  
10 are very savvy. They are very well informed regarding  
11 health care reform issues relative to other states. So  
12 when a mandate comes in for 2020 it is our opinion that  
13 that will not impact the 2019 rates because of the  
14 financial aspects that people will heavily weight what the  
15 non-enforcement in '19 will mean to them. So we believe  
16 that the 2 percent or the Blue Cross's estimate is still  
17 reasonable even in light of a mandate for 2020 and later.

18           Q.       Now let's turn to contribution to reserves.  
19 Do you review for solvency risk margin and CTR?

20           A.       Yes. So even though the DFR does it as part  
21 of the federal regulations regarding rate reviews, I  
22 alluded to earlier a couple of the bullet points that have  
23 to be reviewed, our change in reserve needs and change in  
24 capital and surplus.

25           Q.       Did you get a chance to look at confidential

1 information concerning the company's RBC?

2 A. So we're provided a lot of the information --  
3 a lot of information about that. So we definitely review  
4 and assess the appropriateness of the CTR assumption in  
5 light of the company's financial situation.

6 Q. And did you find the company's 1.5 percent  
7 proposed CTR to be reasonable and appropriate in this  
8 case?

9 A. Yes.

10 Q. Are you aware of what Blue Cross's target  
11 range is for RBC?

12 A. Yes. 500 to 700 percent.

13 Q. And what is your opinion as to what CTR would  
14 be needed to keep the company within the midrange of that  
15 target RBC?

16 A. So relying on the company's detailed  
17 calculations I believe it's right around one and a half  
18 percent for the long term basis to keep them in the  
19 middle.

20 Q. So if the company had submitted a 1 percent  
21 CTR, would they still be in their target range?

22 A. I do not believe so. No.

23 Q. So there was earlier testimony today about the  
24 Tax Cuts and Jobs Act and how it impacts the carrier.  
25 Could you please describe what the carrier assumed and

1 what your assessment of that assumption is?

2 A. Sure. So there's really two implications of  
3 the tax bill. One is the non-profit nature. They no  
4 longer have to pay the 20 percent tax rate. So it's --  
5 very simplistically what we did is the company's always  
6 assumed a long term 2 percent CTR as being appropriate.  
7 Call it a factor of .8. So that is a judgment of us of a  
8 reasonableness for a CTR. So if they submitted a 1.6  
9 percent CTR, that seemed reasonable. Slightly lower than  
10 that. So that's the primary -- or that's one of the main  
11 implications is that they did modify their CTR as a result  
12 of that.

13 The other thing with the tax bill was the  
14 alternative minimum tax issue, which is a little bit more  
15 of a longer term issue, and in all of the reviews we have  
16 reviewed so far this year, and we have reviewed -- since  
17 2014 we have reviewed over 900 ACA filings, we have never  
18 seen a company take a specific capital and surplus level  
19 that is not actuarial standards practice in terms of how  
20 to rate. It is typically through the CTR process. That's  
21 what the CTR provision is for is to have a provision for  
22 the solvency side. So we think it is appropriate that the  
23 company address the AMT issue through the CTR.

24 Q. Okay. Now let's turn briefly to the silver  
25 loading that was briefly testified to earlier. Did you

1 review reflective silver plans in this filing?

2 A. That was one of the big changes for this year  
3 was that the cost sharing reductions were no longer going  
4 to be funded at the federal level so there had to be a  
5 mechanism to cover that. The -- so even though they were  
6 not funded the federal law still required that the company  
7 had to pay for that portion of the benefits. So there had  
8 to be a mechanism to fund it in some other way.

9 The State of Vermont addressed that  
10 specifically and allowed off exchange plans for those that  
11 do not have -- for persons that do not qualify for  
12 subsidies. So that approach, which was a very common  
13 approach across a lot of states, not every state did it  
14 that way, but it was a very common approach, it basically  
15 put all of the cost sharing reduction that wasn't funded  
16 on the premium plans on the exchange because the federal  
17 government would be paying it through a different  
18 mechanism through the APTC or the premium subsidies. So  
19 the reflective or off exchange were created to give the  
20 people that had higher incomes, higher than the 400  
21 percent, a mechanism to have a silver plan that wasn't  
22 loaded or more expensive as a result of the federal  
23 government not funding the CSRs.

24 Q. And your testimony earlier was that a  
25 significant portion of the premium increase for that

1 reason would be borne by the federal government. Could  
2 you say what that percentage is?

3 A. Yes. So if we go to page 17 in my report or I  
4 think PDF 307, that table after the modifications really  
5 kind of describes that. You can see that there's the  
6 silver loaded bullet there that satisfies what the  
7 proposed is, and we're saying that you can see it's really  
8 not applicable for -- the Vermonters aren't feeling that  
9 because that's being paid by the federal government. If  
10 you -- if you look at the overall numbers, you can see the  
11 difference, again I alluded to earlier, that in the  
12 proposed 7.5, 5.3 was going to be effectively the  
13 effective rate increase on consumers in Vermont. So that  
14 that 2.2 or whatever would be picked up by the federal  
15 government.

16 Q. And there's just one last question I want to  
17 ask you about with regard to the filing as originally  
18 submitted. So Paul testified earlier about Blue Cross's  
19 cost containment strategy and how he disagreed with how  
20 you incorporated that into your range. Can you briefly  
21 explain how you incorporated Blue Cross's cost containment  
22 strategy into your range and whether his testimony changed  
23 your opinion in that regard?

24 A. Yeah. So what we did, as I alluded to  
25 earlier, is we based our range based on an inherent



1 volatility around best estimates for utilization trend.  
2 We believe we have a reasonable range because our best  
3 estimate we believe is consistent with their approach of  
4 including the cost containment in the trend numbers, and  
5 so we just based our inherent volatility around the best  
6 estimate consistent with what we had seen in other  
7 utilization assumptions.

8 Q. So with the recommendations that you outlined  
9 is the filing as originally submitted excessive?

10 A. After implementation of the recommendations we  
11 do not believe the filing is excessive.

12 Q. And is it adequate?

13 A. It is adequate after the modifications.

14 Q. And is it unfairly discriminatory after the  
15 modifications?

16 A. It is not unfairly discriminatory after  
17 modifications.

18 Q. So you're aware that there's been an amendment  
19 to the filing?

20 A. Yes.

21 Q. Have you had an opportunity to review that  
22 amendment?

23 A. That was -- that amendment was submitted just  
24 a few days ago. We have made an initial and cursory look,  
25 but the information provided in that amendment was not

1 enough for us to draw any conclusions at this time. So we  
2 do not have a written response at this point. We have  
3 posed additional questions to the company based on that  
4 amendment and so we have asked them for additional  
5 information for us to utilize and then to make a full  
6 assessment regarding that amendment.

7 Q. So you do not -- you do not have a full  
8 opinion for us today as to Blue Cross's amendment?

9 A. All I will say at this point, so this is still  
10 preliminary and as I said it is not written, based on the  
11 information we have reviewed the two increases as a result  
12 of the benefit increases appear reasonable, however, we  
13 have asked for additional information. Regarding the  
14 association health plan we would really like more  
15 information. That is more of a significant amendment.  
16 However, I will say based on all of the new guidance that  
17 has come out from the federal government and apparent  
18 actions by DFR since the submission of the filing we do  
19 think it's reasonable that the company has requested this,  
20 but we don't have enough information at this point to say  
21 that -- if their amended rate change is appropriate or  
22 not.

23 MR. ARDUENGO: Thank you. I have nothing  
24 further.

25 MS. HENKIN: Can we get through some

1 questions over here in the next few moments?

2 MS. HUGHES: We can and I hope --

3 MS. HENKIN: As you can tell we will  
4 probably be finishing some of this by phone and we  
5 will have to reopen due to the amendment, but let's  
6 go to the bitter end.

7 MS. HUGHES: That last colloquy  
8 eliminated all my questions on the amendment because  
9 it's not ripe yet.

10 CROSS EXAMINATION

11 BY MS. HUGHES:

12 Q. Can you turn to page 294? You have a box  
13 there that's labeled Green Mountain Care Board or GMCB  
14 hospital budget review, and does the information contained  
15 in that box reflect the recent hospital budget  
16 submissions?

17 A. I don't believe it addresses the most recent.

18 Q. So that may not be totally accurate?

19 A. Correct.

20 Q. And could you turn to page 302 and you heard  
21 the Commissioner earlier review certain categories of  
22 regulatory uncertainty. Is the box on page 302 one of the  
23 uncertainties the Commissioner described?

24 A. Yes that is.

25 Q. And can you elaborate on the risk explained in

1 this box relative to Blue Cross?

2 A. Yes. So risk adjustment -- so recently  
3 there's been several lawsuits and obviously with the risk  
4 adjustment the payments were put on hold. I guess we'll  
5 find out at some point if that's temporary or permanent.  
6 However, the risk adjustment is really kind of one piece  
7 of incurred claims and so basically what has happened with  
8 non-payment of the risk adjustment, and this goes across  
9 all carriers and all states, is the companies that are  
10 sicker than the market are going to not receive the money  
11 that they were promised to cover the sicker people, and  
12 currently the people that -- the companies that are  
13 healthier as of today will not be paying money to those  
14 sicker companies and they will get to keep as of today --  
15 keep that money rather than give it to the people that  
16 really provided the care.

17 So it is -- this is a market disrupter if it  
18 stays this way. In the Vermont market it's very common  
19 knowledge that Blue Cross is a sicker population than MVP.  
20 So Blue Cross has significant risks that if this payment  
21 is not made that basically the actuarial soundness of  
22 their rates is no longer there.

23 Q. Thank you. On page 303 you mention a  
24 comparison of Blue Cross Blue Shield Vermont to other Blue  
25 plans with respect to their administrative costs and how

1 does Blue Cross compare with those other plans?

2 A. So while I don't remember the specific like  
3 PMPMs, but as we outlined in our report it was -- Blue  
4 Cross of Vermont was in the bottom five percent. It was  
5 by far -- had by far one of the smallest amount of admin  
6 expenses.

7 Q. Thank you, and as you know Blue Cross is  
8 requesting a 1.5 percent CTR and does that favorably  
9 compare to what you're seeing elsewhere?

10 A. So I would say since 2014 in the ACA market I  
11 would say we have seen anything from 0 to 6 percent in  
12 terms of a CTR. That can vary dramatically by market.  
13 We've seen -- in Vermont we've seen a proposed zero  
14 before. A couple years ago. I would say typically, again  
15 kind of going to most likely, I would say the most common  
16 we see are between one and a half and three percent. So  
17 yes the one and a half is very common for what we see.

18 MS. HUGHES: May I have one moment?

19 Thank you.

20 MS. HENKIN: Attorney Angoff.

21 CROSS EXAMINATION

22 BY MR. ANGOFF:

23 Q. Mr. Dillon, you said you made a recommendation  
24 as to the Blue Cross rate filing meeting increased  
25 standards, correct?

1 A. Yes.

2 Q. Those standards are the proposed rates are not  
3 excessive, right? It's not inadequate?

4 A. Correct.

5 Q. And it's not unfairly discriminatory, correct?

6 A. Correct.

7 Q. Okay, and you have got a big stable of states,  
8 it's not just Vermont, that you work with, right?

9 A. Uh-huh.

10 Q. And I couldn't quite understand what you were  
11 -- there were 22 states among your -- the states you work  
12 with or then nine states. How many is it?

13 A. So currently it is nine states. We have  
14 assisted other states with reviews. Some of those have  
15 hired staff. They don't need outside staff any more,  
16 things like that, but currently for this year for the 2019  
17 rate filings Lewis & Ellis is assisting nine states.

18 Q. Okay, and do any of those states have a rating  
19 law like the rating law that Vermont has that's before us  
20 in this case?

21 A. For the states we work with I believe the  
22 answer is no.

23 Q. Sorry. Go ahead.

24 A. No.

25 Q. So you opined that the rate here is not

1 excessive, inadequate, or unfairly discriminatory, but  
2 you're not offering an opinion as to whether the rate is  
3 affordable or not?

4 A. I am not.

5 Q. You're not offering an opinion whether it  
6 promotes quality care?

7 A. I am not.

8 Q. You're not offering an opinion as to whether  
9 it promotes access to health care?

10 A. Correct.

11 Q. Nor are you offering an opinion as to whether  
12 the rate is unjust?

13 A. Correct.

14 Q. Or unfair?

15 A. Correct.

16 Q. Or inequitable?

17 A. Someone might say inequitable and unfairly  
18 discriminatory are similar.

19 Q. Fair enough.

20 A. But from a pure definitional standpoint that's  
21 defined actuarial we are not.

22 Q. So on page 2 of your opinion -- I'm sorry.  
23 Exhibit 13, page 292 of the PDF, when you are say they are  
24 under the box -- you see there's a little paragraph  
25 standard -- labeled standard of review?

1 A. Yes.

2 Q. Okay. So when you say this letter is to  
3 assist the Board in determining whether the requested rate  
4 is and it goes through all the standards in the statute?

5 A. Yes.

6 Q. You are -- really don't mean affordable and so  
7 forth. You mean your job is to assist the Board in  
8 determining whether the rate is excessive, inadequate, or  
9 unfairly discriminatory?

10 A. That is correct.

11 MR. ANGOFF: No further questions.

12 MR. MULLIN: Anything else? Board  
13 members. Maureen. Jess.

14 MS. HOLMES: I just have one question.  
15 I have great respect for actuaries, both of you  
16 tremendous respect, but I would ask you would you  
17 agree that since you start with the experience -- the  
18 plan's experience in the prior year and then you add  
19 trend to it that any inefficiencies, fraud, or waste  
20 that were exhibited in the prior years would just be  
21 baked into the future year?

22 MR. DILLON: So I think it can be, but  
23 most companies will review those issues and we  
24 believe that -- and in this specific case we believe  
25 for 2019 that adjustment that the company's included



1 for that is appropriate.

2 MS. HOLMES: Okay. When you talk about  
3 adjustment are you talking about which --

4 MR. DILLON: Like a reduction. Just any  
5 of -- like the impact of their programs. We believe  
6 that their one for 2019 is appropriate.

7 MS. HOLMES: If we use that number of 25  
8 percent of medical expenditures are potentially  
9 wasteful with no impact on the health of the patient  
10 population, that's not being adjusted for?

11 MR. DILLON: No. I would agree with  
12 that. If there is -- maybe I would classify it as  
13 excess utilization of MRIs or things like that, that  
14 a consumer might say I need an x-ray and it's issued.  
15 No that would not be necessarily in that adjustment  
16 number.

17 MS. HOLMES: Thank you.

18 MR. MULLIN: No questions.

19 MR. PELHAM: I was looking at a question  
20 I wanted to ask.

21 MR. MULLIN: We are getting --

22 MR. PELHAM: Two quick ones. In terms  
23 of small group versus individual in this merged  
24 market do you have any sense or insight into how much  
25 health employees in small group entities get paying

1 premium versus individuals who don't get any?

2 MR. DILLON: I do not have a Vermont  
3 specific answer to that. I would say generally  
4 speaking based on my experience in other states I  
5 would say relatively small portion for smaller  
6 employers. Generally speaking small employers it's a  
7 big decision to even kind of get an offer for  
8 coverage. It's not always -- so we do not see that  
9 as often.

10 MR. PELHAM: So by small range five  
11 percent? Ten percent?

12 MR. DILLON: Don't hold me to it, but  
13 okay I'll agree with it.

14 MR. PELHAM: I won't hold you to it.  
15 Second question is in terms of administrative costs  
16 what is it that you tie out to because this is my  
17 second rate hearing and so we looked at large groups  
18 and I think in that filing the administrative cost  
19 kind of totaled up to 10 million, and then I kind of  
20 looked at the National Association Annual Report 2017  
21 and there's a -- they have general administrative  
22 costs there for Blue Cross Blue Shield of 16 million  
23 and then another 8.3 million of that is earned --  
24 that is assigned to administrative costs, but it  
25 earned non-insured book of business. So I'm just

1 wondering what is it that you tie out to?

2 MR. DILLON: So typically what we tie  
3 out to is the individual and small group numbers that  
4 are included in the supplemental health care exhibit.  
5 That exhibit was designed by the NAIC to provide  
6 boards and entities like you information on the  
7 admin, and so the company has followed that. That's  
8 our starting point, and that's what I was alluding to  
9 and then some adjustments are made, appropriate  
10 adjustments to get from like a statutory basis to  
11 pricing basis, but that is the starting point.

12 MR. PELHAM: So you're comfortable that  
13 if I have all the filings before us with Blue Cross  
14 Blue Shield, that those administrative costs plus or  
15 minus would add up to the totals?

16 MR. DILLON: I would assume so, yes.

17 MR. PELHAM: That's all. Thank you.

18 MS. HUGHES: May I ask one brief  
19 clarification question?

20 MS. HENKIN: Brief.

21 BY MS. HUGHES:

22 Q. So the small group market employer support  
23 that you were referring to does that take into  
24 consideration the fact that the Vermont small group market  
25 definition is up to a hundred employees?

1           A.       No and again, as I said, I do not have Vermont  
2 specific information and my answer was directed more  
3 towards what we've seen elsewhere which is not necessarily  
4 the same definition.

5                   MS. HUGHES: Great. Thank you.

6                   MS. HENKIN: Thank you. Are there  
7 members of the public here that have signed up to  
8 speak? There had been two names on the list. I  
9 don't know if they are still here, but if so, could I  
10 please see who they are. Mark Stanislas is the one  
11 person. Is there anyone else? Mark, would you like  
12 to make your comment?

13                  MR. STANISLAS: I just had a couple  
14 questions and I will direct them to the Board and the  
15 Board --

16                  MS. HENKIN: We take public comment. We  
17 don't take questions at this.

18                  MR. STANISLAS: Okay. So under public  
19 comment there's been some comments made that new  
20 information has become available about the rate  
21 filings, okay, particularly, you know, with the  
22 hospitals and particularly with University of Vermont  
23 Medical Center. Okay. So under public comment I  
24 would just like to say, you know, it's important to  
25 put that in context of what the total net patient

1 service revenue budget is for that hospital, and if  
2 it was put into that context, the change from 2017  
3 actual to 2019 budget was only 5.1 percent. So  
4 that's two years of rate -- that's two years of  
5 utilization, two years of unit cost, and any changes  
6 in mix. So I would ask Blue Cross Blue Shield if --  
7 did they factor that 5.1 percent change from 2017 to  
8 2019 into their rate filings.

9 MS. HENKIN: Thank you. The other  
10 person Kate Cross I do not believe is here. We do  
11 have public comment open tomorrow evening also  
12 starting at 4:30 at City Hall in the Memorial Room.

13 We are going to only recess this hearing  
14 because we are going to have to take information  
15 about the amendment. We will let everyone know as to  
16 when that will be. We do have that valve at the end  
17 of about 30 days and whether or not we will need to  
18 actually have an open hearing or whether this will be  
19 done with interrogatories we will determine that and  
20 send out something on that shortly, but today we'll  
21 take a recess and I will turn it back over to the  
22 Chair for right now.

23 MR. MULLIN: Just want to let everyone  
24 know we're encouraged to exit the building as soon as  
25 possible to keep it within our time limits.

1 MS. HENKIN: So you have about four  
2 minutes to leave the building.

3 (Whereupon, the proceeding was  
4 adjourned at 4:25 p.m.)

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1  
2 C E R T I F I C A T E  
3

4 I, JoAnn Q. Carson, do hereby certify that  
5 I recorded by stenographic means the Green Mountain Care  
6 Board hearing re: 2019 Hospital Budget Hearing, at the  
7 Vermont State House, 115 State Street, Montpelier,  
8 Vermont, on July 23, 2018, beginning at 9 a.m.

9 I further certify that the foregoing  
10 testimony was taken by me stenographically and thereafter  
11 reduced to typewriting, and the foregoing 302 pages are a  
12 transcript of the stenograph notes taken by me of the  
13 evidence and the proceedings, to the best of my ability.

14 I further certify that I am not related to  
15 any of the parties thereto or their Counsel, and I am in  
16 no way interested in the outcome of said cause.

17 Dated at Burlington, Vermont, this 25nd day  
18 of July, 2018.

19  
20 \_\_\_\_\_  
21 JoAnn Q. Carson

22 Registered Merit Reporter

23 Certified Real Time Reporter  
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