STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-006-19-rr

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

July 23, 2019
8 a.m.
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115 State Street
Montpelier, Vermont

Hearing held before the Green Mountain Care Board, at the Vermont State House, Room 11, 115 State Street, Montpelier, Vermont on July 23, 2019, beginning at 8 a.m.

P R E S E N T

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EXHIBITS

Blue Cross 18 through 20 and HCA 23 admitted on Page 7.

CHAIRMAN MULLIN: So good morning, everyone. Welcome to our day two of rate review. And, at this point, I'm going to appoint Michael Barber as the hearing officer and turn everything over to him.

MR. BARBER: Thank you, Mr. Chair. Good morning, everyone. Again, my name is Michael Barber. I've been appointed by the Chair to preside over this hearing as the hearing officer. The purpose of today's hearing to is to take evidence and argument on the 2020 Vermont Health Connect rate filing submitted by Blue Cross Blue Shield of Vermont. The docket number for this case is GMCB-006-19-rr. The Green Mountain Care Board has jurisdiction over this matter pursuant to Title 18, Section 9375(B)(6) of the Vermont Statutes Annotated, as well as Title 8, Section 4062(a).

Representing Blue Cross today are Michael Donofrio and Bridget Asay of the law firm Stris & Maher, LLP. Representing the Office of the Health Care Advocate are Jay Angoff, Kaili Kuiper, and Eric Schulteis. I also want to recognize the Board's Associate General Counsel, Amerin Aborjaily who will be conducting the direct examination of the Board's actuaries, Lewis & Ellis. And, also, Gavin Boyle is here from the Department of Financial Regulation, general counsel.

We are recording today's proceedings. We also

have a court reporter here to transcribe them, and we will be providing the parties with the transcripts as soon as they're available.

If there are any members of the public in the audience today, we will be taking public comment at the close of today's proceedings. There's a sign-up sheet outside the door for public comment. There's also a sign-in sheet for a record of attendance that I'd like people to please sign.

I don't know when we will get to public comments, probably close to 4:00. If you don't want to stick around for that, it would be much more convenient, I think, to go to the public comment forum that the Board is having from 4:30 to 6:30 at the City Hall in Montpelier that is dedicated exclusively to hearing from members of the public on these filings. The Board also takes public comments in writing. You can submit public comments via the Board's website, by regular mail. You can call the Board's offices to leave a public comment if you wish, and the Board will be taking comments through July 25th.

Before we begin, I want to remind the parties and the Board that there are confidential materials in these binders, and you should exercise caution in discussing anything that has been marked confidential,

as those documents can't be discussed in this public forum.

So, at this point, I'd like to swear in the witnesses. Typically do that all at once. So I have Ruth Greene, Paul Schultz, Andrew Garland. Brian Murphy, is he testifying?

ATTORNEY DONOFRIO: No, no.

MR. BARBER: No? Okay. Mike Fisher, David Dillon. And I don't see the Commissioner here yet. If I called your name, if you could, please stand and raise your right hand.

(All present witnesses were placed under oath.)

MR. BARBER: Thank you. You may be seated. Now that we've sworn in the Witnesses, we have two binders of exhibits here that the parties have stipulated to. They're labeled Binder Number 1 and Binder Number 2. My understanding is Binder Number 1 is Blue Cross exhibits which are marked 1 through 17. Binder Number 2 contains Office of the Health Care Advocate exhibits which are marked 1 through 22. And I understand we have some additional exhibits here. Could you inform me what these are and whether the parties have stipulated to those?

ATTORNEY DONOFRIO: Yes, absolutely. You should have four new exhibits in front of you. Three

of them are Blue Cross Exhibits 18, 19, and 20 that the parties have stipulated to. The fourth is HCA Exhibit 23 that the parties have stipulated to. The Blue Cross exhibits, one exhibit reflects Blue Cross's recent analysis of the recently submitted hospital budget information and, and how that impacts the rate.

The other two are summary tables summarizing information sort of scattered around the filings that, that we'll discuss in our testimony, and the -- I'm sorry to speak for the HCA, but their exhibit is the DFR's permitted practice order from February, and the parties have stipulated to, to add those four exhibits to the record.

MR. BARBER: So the parties have stipulated to the admissibility of the additional exhibits?

ATTORNEY ANGOFF: Yes.

MR. BARBER: Okay. I'm going to admit all these exhibits into evidence, and, if folks could please add Exhibits 18 through 20 to Binder Number 1, and Exhibit 23 to Binder Number 2.

(Blue Cross Exhibits 18 through 20 and HCA Exhibit 23 were admitted into the record.)

Okay. Do we have anything to discuss before we move to opening statements? Anything? Okay. Would you like to make an opening statement?

ATTORNEY DONOFRIO: Yes, please. Thank you. Thank you, Mr. Barber, and good morning, board members and everyone in attendance. My name's Mike Donofrio. I'm with the law firm Stris & Maher. With me today is my colleague, Bridget Asay, and together we represent Blue Cross in this proceeding. And, just to give you a quick roadmap of how our part of the proceeding will unfold, I'll present the direct testimony of Paul Schultz; Ms. Asay will present Ms. Greene and Mr. Garland's testimony; and, at the end of the presentation, Ms. Asay will provide some closing remarks.

So we recognize that the Board and staff face a difficult task this year. The, the requested rate increases are substantial. At the same time, it's very clear in the record that Blue Cross's solvency is in decline and in peril. So that puts you in a, in a tough spot. And, meanwhile, health care costs continue to increase, and, as you well know, it's those underlying costs that primarily drive the cost of health insurance.

In designing the rate review process, though, the legislature contemplated that, that we would face difficult days like this on the way to a sustainable, a more sustainable health care system so it built this

process to accommodate the push and pull among these sorts of factors, and you see that right in the words of A V.S.A. 4062. I'm going to quote it:

"The Board shall determine whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of the State."

And, as you know, the Board's rate review rule and federal law incorporate the actuarial concepts of adequacy and excessiveness into this mix as well. So what you have is a statutory construct where you're required to balance a bunch of factors. These factors are interdependent, not independent, of one another So each informs the other as you think this through, and, as the board itself recognized in your most recent Blue Cross large group decision, the failure to, to strike the right balance, and then these are your words, "impairs Vermonters' access to care", and I think that that's critical to remember as you review this year's rate filing.

Against that backdrop, the, the rates currently proposed by Blue Cross hit that proper balance and must be approved. More importantly, any reduction of the rates under today's circumstances will upset that

balance, continue to jeopardize the insurer's solvency, and, with that, access to, to quality health care and ultimately affordability.

The record amply supports that conclusion, and I want to highlight three overarching considerations that really put a fine point on it. First, you're going to hear a lot of about solvency, because the circumstances this year are, are unique among those that you've faced as a board. This is evident in the rate filing and the materials in the binder. Among other things, they show that Blue Cross's reserves now sit at about $110 million, at least as of the end of 2018, and that's down about $24 million from the previous year.

Lewis & Ellis, in their actuarial analysis, confirms this. They observe that only four Blue plans in the country have lower risk-based capital percentages than Blue Cross did as of the end of 2018 and that the high end of the target range set for Blue Cross's RBC by the Department of Financial Regulation is lower than more than half of the RBC percentages of Blues plans nationwide.

And then DFR, the solvency regulator, again puts a fine point on it, highlighting in its report that Blue Cross's RBC is at its lowest point since the Board began doing this work. It's the lowest among

comparable companies around the country. It sits at about half of the average RBC for comparable companies around the country. It's the only company in its peer group whose RBC has a decline each of the last four years, and it, its RBC currently sits well below the low end of the range that DFR recently set in its February order.

So, in light of DFR's observation that it, that it consistently made over the years that solvency is the most fundamental aspect of consumer protection in health care, DFR concluded, and I'm going to quote, that "any departure from the filed rate should be made with great caution this year". So, more than ever before, your decision has to be mindful of Blue Cross's solvency.

The second overarching consideration that I want to highlight is that Blue Cross has lost significant market share in the individual and small group market over the last couple of years, down approximately 24 percent from 2016 to 2018. That, that gives Blue Cross the most powerful incentive to keep its rates as low as it possibly can without dipping into inadequacy, because continued membership losses obviously will, will be highly detrimental for the company in many ways.

Third, the third overarching concern, underfunding insurance premiums does not reduce health care costs. The premiums are based on the costs of the underlying care. Those costs have to be paid, and underfunding the premiums puts stress on the system, like what we've seen at some of our hospitals over the past, over the past year. So and it, it builds a debt for future policyholders that eventually will have to be paid and with great pain.

So we recognize that these dynamics make the Board's job difficult this year. We also recognize, because we've read the public comments, that many Vermonters struggle right now to pay for their health insurance. There, there, the words in the public comments are compelling, and what they, what they really show is that many Vermonters are struggling to afford the cost of their health care and, as a result, the cost of their health insurance, but, at the same time, Vermonters need to maintain access to care, and the Board can't jeopardize that access by underfunding the rates.

On a practical level, there are three places in the rates where you could potentially reduce them, and I want to just touch on them briefly before I conclude, and the record shows that none is available to you this

year as, as a viable option. First, administrative expenses, that pathway is unavailable because Blue Cross has continued to maintain best-in-class low administrative expenses, and Ms. Greene and, to some extent, Mr. Schultz will testify about that, and it's clear in the materials before you. And Lewis & Ellis confirms that, highlighting, for example, that Blue Cross's admin remains lower than about 80 percent of the 63 plans that the NAIC analyzed in 2018.

The second pathway, contribution to member reserves, for the reasons I've already highlighted, given Blue Cross's current solvency position, that is not a viable pathway by which to reduce the rates this year either. That would send Blue Cross further off course and further away from meeting the range that DFR has required it to meet.

And, finally, the projected costs of claims, that pathway is also unavailable this year because Blue Cross has not overestimated those costs in its rate filing, as is evident in the record and as we'll highlight through testimony. Lewis & Ellis identifies a couple of areas where it believes Blue Cross has done so, but, again, we think that's contradicted by the record, and we'll try to draw that out in our testimony today.

And, even if you were to conclude that Lewis & Ellis's recommendations sat within a reasonable range of outcomes, under the, the current circumstances as I've outlined them for you, it would, you would, you must proceed with the greatest caution if you were to make a choice between results that you view as reasonable, you know, whether you were going lean to the lower or not, under the, the circumstances as they exist today, and, again, the reason for that is there is a real risk of underfunding these rates, which leads to a real risk of continuing the decline of Blue Cross's solvency.

Now, there's a lot of information in the record. We will not attempt to cover it all today. We'll attempt to move as quickly as we possibly can and highlight the critical points. Mr. Schultz will be our first witness, Blue Cross's chief actuary. He'll describe the development of the rates and clarify some key points of disagreement between Blue Cross and Lewis & Ellis. Ruth Greene, Blue Cross's CFO, will then testify about Blue Cross's financial position, administrative costs, and contribution to reserves and current solvency position, and, finally, Andrew Garland, Blue Cross's Vice President of Client Relations and Client Affairs will testify about issues

around Blue Cross's negotiations with providers, work with the ACO, and how that impacts the rates.

So, to conclude very briefly, the system can no longer afford to borrow from future ratepayers to reduce current rates. That's, that's not sustainable. And so we're asking the Board to approve the rates as currently proposed to avoid making reductions that will undermine Blue Cross's solvency and to maintain the access to care that the folks in these plans need. Thank you.

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

ATTORNEY ANGOFF: Yes, I do. Thank you, Mr. Hearing Officer, Mr. Chairman, the Board. I'm Jay Angoff. I represent the Health Care Advocate. The theme of this rate filing, the concept underlying this rate filing is overreaching. If that sounds harsh, it's not personal. Blue Cross is well-represented. But this is a severely overreaching rate filing. I'd like to give you three illustrative examples, and then I want to talk in a little more detail about the biggest example.

You remember we spoke yesterday about the fact that MVP assumed that, because of the zero, the zero penalty for the individual mandate, the healthy people

would leave the company, and MVP thought that. MVP's actuary was wrong. L&E thought that. L&E was wrong. Blue Cross's actuary thought that, and he was wrong. What MVP did was to say, We were wrong. We thought we should raise rates because of the zero penalty, but it turns out that the zero penalty did not drive people away so we're going to reduce rates.

Blue Cross doesn't do that. Blue Cross comes up with some convoluted, forced explanation as to why, despite the fact that the zero penalty clearly did not result in healthy people leaving, they should still keep most of that in the rate.

Second, you remember we spoke yesterday about the AHP issue, about how we thought a few months ago that AHPs were going to be permitted so the companies raised their rates to take account of people, again, the healthy people, leaving to go into AHPs, but, because of the federal court decision and because of the DFR reg more recently, it was made clear that, no, AHPs are not going to be permitted in Vermont in 2020. So MVP simply backed that amount that they had proposed to raise rates out of the rate.

Blue Cross does something different, though. Blue Cross says, when they first, when they filed their rate increase, they say the continue, the continuation of

the Vermont AHP market adds 1 percent to rates. That was reasonable then, but now it's clear that it's not going to continue in Vermont. So one would expect that that 1 percent would not be in the rate, but, no, they've got another complicated explanation for why they should still be able to raise rates based on what's going on with AHPs.

The third example, you may remember yesterday that the first question I asked to the MVP representative was to explain to the Board what IBNR is, and he explained that very accurately that there's a, there's a little bit of a claims runout that the company has to account for, and so they added 2.4 percent to the pay amount. That's perfectly reasonable, but they didn't have any fudge factor. They didn't have any factor for adverse deviation.

What Blue Cross does, though, is they not only have this IBNR amount, which is legitimate, but they have a 15 percent additional fudge factor for adverse deviation. What that does is, among other things, is artificially depress their surplus level that they report. That's just one of the many things that they do is artificially suppress the surplus level.

So those are three illustrative examples, but let me get to the big one by far. Do you remember last

year we talked about the $34 million that Blue Cross gets back, is getting back because of the Trump tax bill? Under accepted statutory accounting principles, that money, certainly, a majority of that money and arguably the whole thing should go into surplus. What Blue Cross has done is to fight like crazy to go through all kinds of machinations and convolutions in order to keep, not just a little of that money, but every penny of that money out of surplus.

And so one thing what we will be doing is to be going through with Blue Cross's witnesses an explanation of what they report on their annual statement, and I believe the evidence will show that their surplus the way they report it is artificially suppressed and that it should actually be much, much higher, as a result of which the contribution to reserve factor should be much, much lower.

MR. BARBER: Thank you. Mr. Donofrio, you can call your first witness when you're ready.

ATTORNEY DONOFRIO: We call Paul Schultz.

MR. BARBER: While he's coming up, I should just say we went until 3:00 yesterday with one witness from the carrier, so I'm a little concerned about time. If we could just all monitor how we're doing on time as we proceed. Okay when you're ready.

ATTORNEY DONOFRIO: May I proceed?

MR. BARBER: Yes.

DIRECT EXAMINATION BY ATTORNEY DONOFRIO

Q. Thank you. Good morning, Mr. Schultz.

A. Good morning.

Q. What is your current position at Blue Cross?

A. I'm Chief Actuary at Blue Cross. As part of that, I direct the actuarial underwriting departments. Part of those responsibilities include preparing all rate filings for Blue Cross Blue Shield of Vermont, including the one before you today.

Q. Would you -- I should have asked you this first. Would you just state and spell your full name for the record?

A. Sure. My name is Paul Schultz. That's P-A-U-L S-C-H-U-L-T-Z.

Q. Thank you. How long have you held the position of Chief Actuary?

A. Since January of 2015.

Q. And do you hold any professional credentials?

A. Yes. I've been an associate of the American Academy of Actuaries since 2000 and a fellow of the Society of Actuaries since 2001.

Q. And is all of that reflected in your CV, which is part of Blue Cross Exhibit 12?

A. Yes, that's right.
Q. If you'd direct your attention to Exhibit Blue Cross Exhibit 1?
A. Sure.
Q. And what is that?
A. That is our rate filing as submitted in May.
Q. Are you familiar with that document?
A. Yes. It was prepared under my direction, and I certified that it meets actuarial standards of practice and is compliant with state and federal law and regulation.
Q. And you're familiar with the criteria that the Green Mountain Care Board uses to evaluate a rate filing, correct?
A. Yes, I am.
Q. I just want to talk about a couple of those before we dive into the filing itself. Could you turn to Page 19 of Exhibit 1?
A. Yes.
Q. And do you see about halfway down the page there's a Section 1.8? Could you just read the title of that section
A. "Vermont Statutory Rate Review Criteria".
Q. Okay. And do you see the statutory criteria just below that title on the page there?

A. I do.
Q. Can I just ask you read those criteria and tell me are there others in addition to those criteria that this filing has to meet?
A. Yes. So the Green Mountain Care Board must consider whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State. Additionally, the Board must consider what we've, in the past, referred to as actuarial criteria, which are that the rate is not excessive, it's not inadequate, and it's not unfairly discriminatory.
Q. What does it mean for a rate to be inadequate?
A. That's defined for us in Actuarial Standards of Practice. It's ASOP Number 8, and that defines a rate as adequate if it provides for sufficient funds to pay for claims, administrative costs, regulatory fees, taxes, and a reasonable profit or contingency margin. So a rate is inadequate if it's less than the amount required to cover those items.
Q. Are Blue Cross's proposed rates adequate?
A. They are adequate, yes.
Q. And what does it mean for a proposed rate to be excessive?

A. A rate is excessive if it provides for more than what is needed to require those items that I just mentioned.
Q. Is that also defined in the Actuarial Standards of Practice?
A. That's right. That's in ASOP Number 8 as well.
Q. Are Blue Cross's proposed rates excessive?
A. They are not excessive.
Q. Now, is it possible to know with certainty whether a proposed rate is adequate or excessive at the time it's proposed?
A. At the time it's proposed, no. All rates, by definition, are estimates. We have to wait to see what the experience actually brings to make an absolute determination of whether rates are excessive or inadequate.
Q. And so can you evaluate whether a rate was inadequate or excessive in hindsight?
A. Yes, by observing what the actual experience was compared to the rate.
Q. Did you do that for past results as part of your rate development this year?
A. We did.
Q. And what did that analysis -- first of all, is that analysis shown in the record anywhere?

A. It is in the record. It's on the previous page in, of Exhibit 1, Page 17 if you flip back under Section 1.6, "Historical Financial Results". We've also updated that for information that became available after the time of the rate filing, and that is, I believe, in Exhibit --

Q. 20?

A. -- 20.

Q. And what was updated?

A. What was updated is that the final risk adjustment receivable amount was determined for 2018, and that was higher than our original expectation by about $3 million. So the, the 2018 line has been updated in terms of the actual contribution to reserves.

Q. Based on this information, were Blue Cross's rates inadequate for any of the years reflected in Exhibit 20?

A. Yes, they were inadequate for all five years. It's clear to see the inadequacy in years 2015 through 2018 in that the actual contribution to reserve was negative. That is to say that the shortfall between premiums and those things I talked about, claims, costs, taxes, fees, etc., that shortfall had to come out of surplus or member policy boarder reserves.

In 2014, even though there was a positive return

of 1 percent, those rates also turned out to be inadequate. In 2014 Blue Cross was subject to federal income taxes of 20 percent. So a 2 percent CTR is what was needed to maintain reserves, maintain RBC at the level where it was. So, again, we had to dip into, into policyholder reserves in order to fund that shortfall to, to hit the right -- well, said differently, RBC went down so we know the rate was inadequate.

Q. Thank you. So were the, were the results of the rate review process for the years shown in Exhibit 20, did those results yield inadequate rates for those years?

A. Yes. You can see the, the comparison of the filed contribution to reserve versus the approved contribution to reserve. The average approved CTR was about 1.8 percent lower than what was filed. So what that says is that, if rates had been approved as filed, rather than a negative 1.6 percent CTR over that time period, we would have had a positive 0.2 percent. Still inadequate, but much less so.

Q. Now, I'd like to turn more generally to how you developed the proposed rates in this filing.

A. Okay.

Q. So can you, can you describe how the rate filing,

Exhibit 1, was prepared?
A. Yes. So the way to prepare really any rate filing is you're attempting to estimate what the cost of claims and the cost of insurance is going to be in some future period. For a continuing product like this one, the way we do that is to take a look at experience, and, and so in this case in 2018, and to then project that forward to 2020, and there are really two main ways where the experience in 2020 will differ from what we saw in 2018.

One is that there's going to be trend. So unit costs are going to go up through the hospital budget review process and other things like that. Utilization may also change. The number of services may change, and the mix of those services will change from 2018 to 2020. So we have to determine how to project that. The other thing that's going to be different is that we're likely to cover a different population in 2020 than the population we covered in 2018. So we need to use a set of population change adjustments in order to project that population.

So, really, the starting point and the biggest component of the rate is a generation of allowed claims cost projection. So we do that by taking, again, taking a look at 2018 experience. And allowed claim

costs, I should say, that's the total cost of care that is provided to Vermonters that are in these plans, so total compensation to providers for the care that they provide to Vermonters. We start with 2018 experience, which is over 600,000 member months. We then trend that forward to 2020. We allow for any sort of population adjustments that we need to make, and the result is a projection of allowed claims in 2020.

Once we're there, we then have to split that into two components. There's paid claims, which is the amount that's paid by Blue Cross to providers to, to pay them for the care they provide Vermonters, and the cost sharing, the member cost sharing is the other component of that. So the way that we develop that split is through a set of what's called allowable adjustments, and they include two main things. One is a paid-to-allowed ratio. We look at a standard population. So, for a standard population for a given benefit design, we are able to project with, with a very high degree of accuracy what portion of those total costs will be paid by Blue Cross and what portion will be paid by the member.

The other thing that goes into that is something called a benefit richness adjustment which is based on a set of federal factors that were developed to say

that members in richer plans tend to use more health care, use more benefits. So we apply those federal factors in determining the rates for each plan. So, once we apply those things, we get to a paid claim projection, and that is about 87 percent of the total rate of the total premium.

To that we need to add a number of things. First, we add taxes and fees. That's about 4 percent of premium this year. That includes things like the Vermont HCCA, the Green Mountain Care Board billback, the federal insurer fee or the health insurance tax. Those are one and the same, but we use different terminology for it. And that's the big difference this year. That health insurance tax is back in 2020 after a one-year hiatus in 2019. So that 4 percent is quite a bit higher than it was in 2020.

We then need to add items that I'll refer to collectively as the cost of insurance, and I'm thinking of that as administrative costs and CTR. So administrative costs, we use a similar process to what we do for claims. We take a look at 2018 experience. We then project that forward. We use 3 percent as our projection for personnel costs, zero percent for all other costs. We also, I should note, we remove any nonrecurring items from the 2018 experience before we

do that projection. So that gets us to 2020 on administrative costs, and that's about 7 percent of premium. That's a number that's very competitive both in Vermont and nationally.

Finally, CTR contribution reserve, at the direction of management, we added a 1.5 percent CTR. We also include 0.1 percent for something called the cost of bad debt, and that is some members drop their coverage during the course of the year without having fully paid their premiums, and then we're not able to collect that money from them. That's been running at very close to 0.1 percent for a number of years now so we included that .1 percent in this filing as well. So that's about 1.6 percent, and that should get you to the total.

Notably, there is nothing in here for profit. Blue Cross Blue Shield of Vermont is a local Vermont nonprofit company. So there's zero profit in here.

Q. Can you summarize Blue Cross's objectives in developing these rates?

A. Yes, I can. My goal was to develop rates that would yield a 1.5 percent CTR and to do that by using assumptions that are reasonable both individually and in the aggregate. So, to expand upon that a little bit, the, Mr. Donofrio has already spoken about a range

of possible results.

My goal was not to develop assumptions that are at the highest end of that range. My goal was not to develop assumptions that will allow us to make back the shortfall in 2018 or the expected shortfall in 2019. I was trying to use assumptions, and successfully so, I believe, to produce premiums that would yield a 1.5 percent CTR. That's the amount that's necessary to keep RBC at a constant level with respect to increasing health care costs.

Q. Can you explain how you developed your trend assumptions? You've already spoken about them a bit generally.

A. Yes. So the development, we can separate this into kind of two different components. We look at medical trend and pharmacy trend, retail pharmacy trend separately, and for both of those we look at two pieces. There's unit cost, which is quite simply increases in the amount providers are paid for a given service, and there's utilization, which sounds simple but actually has two different components. So utilization is both the number of services and also the mix of those services. Both of those things are factored into what we call utilization.

So I'll start on the medical side. For unit cost

trend, we can split that up into kind of three categories. A little bit over 50 percent, it's about 51 percent of claims are for hospitals that are under your review through the hospital budget process. So, for that 51 percent, we assume that hospitals will have the same increases in the future as were approved in the most recent round of hospital budget review.

Now, we know that's not going to be 100 percent accurate. It's, each hospital will not literally have the exact same increase. Some will go up. Some will come down. We've found over the years that that tends to be a pretty accurate assumption in the aggregate.

About 15 percent is for out-of-network providers with which Blue Cross Blue Shield of Vermont does not contract directly. So, for those unit cost trends, we base those on confidential information from the Blue Cross Blue Shield Association, and that leaves about 34 percent of claims for other providers, mostly in Vermont, but some along the Connecticut River in New Hampshire, with which Blue Cross Blue Shield of Vermont does contract directly.

For those we use a similar process to the hospital budget assumption. We assume those increases will be the same moving from year to year, but we do augment that knowledge with any, with any information we're

able to get from ongoing contract negotiations. So that's unit cost.

For utilization, we apply a number of, of statistical analyses to past experience, and we also consider what's likely to happen in the future with these services, and, in applying all those different analyses, we're attempting to project utilization trend and how that might differ from the past. So we've projected a 4.1 percent utilization trend. That consists of a number of kind of components that we look at separately, and then we look at it in the aggregate to make sure that the total makes sense once you fit the pieces together.

So, typically, we split this out into inpatient hospital, outpatient facility, professional, and other, kind of your main categories. What we've seen recently is that pharmacy claims, prescription drug claims that flow through the medical benefit have been having a very impactful, a very large impact on the trends. So we split those out this year. We took a look at those, at those drugs separately. These tend to be very high-cost medications that are dispensed in a hospital, for example, a lot of cancer medications, immunodeficiency medications, very high-cost but lifesaving drugs with a very high trend.

So for this category we wanted to look very specifically at the drivers of what we've observed as drivers of these, of this trend in the past. So, for eleven drugs which drove over half of the increase, we specifically went drug by drug with our clinical team to think about, Are these going to continue to trend at a very high amount, or will that come down?

I can give you a couple of examples. There were some drugs that were, for example, released in late 2017. So they were only available for a couple of weeks in 2017 but for the full year in 2018. So, if you just look on the surface, it looks like that trend might be 1,000 percent or something totally unreasonable like that. We've brought that down in many cases to zero. There were some exceptions. There are some drugs on that list for which new indications have become available. So they will be prescribed for additional disease states moving into 2019 and into 2020. So, for some of those drugs, we kept a very high trend, in some cases as high as 50 percent.

So we worked very closely with our clinical team in coming up with those estimates, and we've selected overall a medical pharmacy utilization trend of 15 percent. That's one component of the 4.1. It's not in addition to the 4.1. It's a piece of the 4.1. For the

other pieces we selected a zero percent inpatient hospital utilization trend, a 5 percent professional trend, and a 2.5 percent outpatient trend, and that, in itself, consists of 4 percent for outpatient surgical procedures and 2 percent for all other outpatient procedures.

So, once we've applied all of our statistical methods and we've come up with our answer, we believe the 4.1 percent is what we've converged to, and, by applying a number of different statistical analyses, if we're able to converge on a single point and the same number tends to come up over and over, we can feel pretty confident that that's a really good trend selection. So, once we have that, we don't stop there. We then review that with our clinical team to make sure we understand the underlying drivers of that trend and how that's going to continue into the future.

So, in this case by way of example, I already talked about the, the prescription drugs flowing through the medical benefit. We also have things like mental health professional claims were up about 7 percent. We saw an increase in both the percentage of the covered population who were taking advantage of their free preventive benefits and also the total number of preventive services. So both of those things

help us to realize goals of the all-payer model so they're things that we support. They're going to increase trend in the short term, but the vision of the all-payer model was that, in the long term, it's better for Vermont both from a cost and from a quality of care perspective.

Other things we saw are outpatient surgery procedures are up. We saw that diagnostic procedures were up about 13 percent from 2017 to 2018. That, we believe to have been driven by the increase in preventive visits. So we, we put all these things together, and we, we confirmed with our clinical team that we expect all of these trends to continue into the future. So we, we, again, felt comfortable with our 4.1 percent utilization trend.

Q. Did you make any subsequent adjustments to trend to reflect any Blue Cross initiatives?

A. Yes, we did. So there are a number of initiatives going on at Blue Cross to reduce trend for 2019. We are working closely with both OneCare and our other provider partners and to accomplish two goals. One is to reduce ER visits by 5 percent. The other is to reduce hospital admissions by 4 percent by reducing readmissions. So we're, we're working closely with our, with our partners to do that. Those two things

combined reduce trend in 2019 by 1.1 percent.

We're continuing to work with OneCare Vermont into 2020. We included a separate factor for that. It wasn't kind of baked into the trend, but we included an adjustment through ongoing data sharing and shared care management programs. We and OneCare expect to be able to reduce claims by 0.4 percent for the attributed lives, which has about a .2 percent impact across the entire population.

Finally, we've contracted with a lab benefit manager. So kind of most of us are familiar with a PBM, a pharmacy benefit manager. Similar concept but for labs. We've also introduced a voluntarily home infusion program, and we believe the combination of those two programs, and the lab benefit management is really the bigger by far of those two, will further reduce trend by about a half percent moving into 2020.

Q. How did you develop your population morbidity assumptions reflected in the filing?

A. Sure. So this is the other kind of major set of assumptions that I, that I referred to. We have kind of three typical or usual categories in the absence of some sort of outside legislative change. We have people who have left us since 2018, we have new members since 2018, and we have the continuing population. So

fairly straightforward.

The, the folks who left us, we can observe what their claims costs were in 2018. So we can see what the, how their departure changes the average claim cost as we move from 2018 into 2019. Those who left us were slightly healthier than the ongoing population. So their departure led a .4 percent increase in claim, in claims.

New members tend to be younger and healthier than the departing members. So we take a look at -- we assess new members on the basis of, of age curves, of demographic adjustments, pure demographic adjustments, because we don't have any claims experience for them. So we look at their age. The other thing we look at is kind of what segment of the market they came from. Are they from small group? Are they from individual, subsidized, etc? So, based on those, we were able to reduce claims by almost 2 percent for new members.

Finally, continuing members from 2018 to 2020, if you're still here, you're two years older. So, again, we use an age curve that's published by the Society of Actuaries to determine what kind of impact that's going to have, and, over the 2 years, that's a 3.5 percent impact on claims.

So, in addition to that, we have some outside

changes in legislation that impact the way we think about who's going to be covered in 2020. The first one is the Vermont Silver Solution. Because of the Silver Solution, we have to make -- that went into place in 2019. We had to make some assumptions from 2018 into the future how members are going to move from, from the silver-loaded plans to silver-reflective plans. We made such assumptions in this filing it had no impact on the overall premium rate.

Secondly, the individual mandate, as we know, the federal government removed the penalty associated with that mandate. We talked about that last year. Vermont, for its part, also enacted its own individual mandate last year with the instruction to the legislature to determine a penalty in the next legislative session. So what we observed is that -- and we attribute a lot of this to the fact that Vermont enacted that legislation -- that there, we did not see a whole lot of movement out of these plans for the, for the lack of a penalty.

In 2019 the Vermont legislature decided there would be no penalty for the Vermont mandate either. So we're kind of back to the situation we were with the federal mandate. It exists, but there's no penalty. We therefore believe that there will be a movement out

of these plans. That belief, I believe, is supported by public comments that I've read. And we don't think the impact is going to be anywhere near as great as what we, as what a study that the Green Mountain Care Board published or what we put into rates last year, but we do believe that there will be an additional half percent impact for members leaving due to the lack of a penalty.

Finally, AHPs. At the time of filing, that, AHPs were alive and well and were expected to continue into 2020. So, at the time of filing, we did believe there would be a 1 percent impact for members leaving and going to AHPs. Since the time of filing, that market will not exist. However, the combined risk pool is not the only landing place for groups that are in the AHP market. They also have an opportunity to go self-funded, and we believe that some will take advantage of that opportunity, which is why we don't think the 1 percent will come back in. We don't think all those members will return. Therefore, we can't just put the 1 percent back. We calculated that the best result would be a .87 percent assumption, so slightly down from the 1 percent.

Finally, risk adjustment is closely associated with these population changes. For risk adjustment

kind of our primary assumption is that we, the underlying kind of slope or the, the distribution of membership for each carrier would remain similar to what it is in 2018, with the exception of a few of these specific changes, the few specific ins and outs that we talked about.

Risk adjustment was put in place to kind of level the playing field between a carrier who has all the kind of less healthy people and a carrier who attracted all the healthy risk, and that's exactly what we have going on in Vermont, as can be seen from our increasing risk adjustment transfer payments from MVP. And the key with risk adjustment is that it's a comparison. The thing that drives risk adjustment is a comparison between the two carriers. It's not the absolute risk of either one; it's how those compare to each other.

So, in the absence of specific groups moving from one to the another, we believe that that comparison should stay consistent from year to year. So that's an important assumption in how we develop risk adjustment.

Q. And could you remind the Board what is the contribution to member reserves that you've requested in this filing?

A. It's 1.5 percent.

Q. And what was the average requested rate increase

in the initial filing?
A. 15.6 percent.
Q. And, finally, could you, can you detail the numerical components of the request? You've talked a lot about the trends and assumptions.
A. Sure. So I'd like to actually do this, and I'll try to do it quickly, in two different ways. One is sort of the actuarial factor-based approach, and the other one has more to do with what's kind of driving some of those numbers.

So the, quote, unquote, actuarial way, we start with what I'll call rebasing. If we were to refile 2019 rates at the time when we filed these 2020 rates, the filing, that filing would have been 4 percent higher. That consists of a few different things. If you look at specific 2018 experience, that experience, again, at the time of filing, was 2.5 percent higher than what we had anticipated in the 2019 filing. So we, that's, that's the baseline. We have to start with the correct baseline.

Additionally, we changed trend assumptions from 2018 to 2019, and that includes the 1 percent affordability adjustment that Green Mountain Care Board put in there. So, moving to trend assumptions as we now believe are the best assumptions from 2018 to 2019,

that added about another 2.2 percent to the premium. That's offset by certain things with the population adjustments. Most notably, the impact of the individual mandate was much less than we expected. So altogether we're rebasing for 4 percent.

To that we add another year of trend. We have to trend from 2019 to 2020 based on the, the trends that I discussed earlier, and that is about an 8 percent increase due to trend. To that we add a couple of factors. I talked a lot about population assumptions. When you put them all together, they almost net out. We were at an increase of about .3 percent for all these population changes from 2018 to 2020.

Another .3 percent comes from benefit changes and how that's offset by deductible and other fixed-limit leverage. So, for example, a $6,000 deductible this year is, is worth less in two years from now as health care costs continue to escalate. So that's, that drives benefit leverage. If we don't change the plan designs at all, we would expect a greater portion to be paid by the company and, therefore, floated premiums as opposed to paid through member cost sharing. So benefit changes tended to offset that but not completely. That's about a .3 increase to the premiums.

Finally, a couple of items: Administrative costs are up this year, and that drives about a 1 percent increase in premiums. We're still at 7 percent overall, which, which is a great number. And, finally, taxes and fees, I talked about there are some big increases there. That's driving about 3.2 percent of this premium increase. Again, the biggest one is the health insurance tax at the federal level coming back.

That, if you're following along and doing some really quick multiplication, you get to 18.5 percent for all of those items. So our filed increase was 15.6. It's lower than that. The reason for that are the initiatives that Blue Cross has in place to try to lower those numbers. So we continue working closely with our PBM to drive better discounts, to drive better rebates, and those things, those efforts this year were, allowed us to decrease the rate by .9 percent.

I spoke earlier about some of the programs that Blue Cross has in place with OneCare. Also, with the lab benefit manager, the voluntary home infusion program, those sorts of things, and that, as well as some system enhancements, gets us to an additional .4 because of our work with OneCare, 1.2 percent because of all these other initiatives. So, altogether, we are decreasing premiums by 2.5 percent due to the

initiatives that we have in place.

And I will, quickly, I also want to go through kind of the drivers. So, when we think about really what's driving that increase, 10.9 percent is due to increases in health care costs, and that's almost entirely driven by two things. One is specialty medications, and I'm talking about both those that were, that are, that flow through the medical benefit that I discussed earlier as well as specialty medications that are part of the retail prescription benefit.

These lifesaving drugs are extremely expensive. They make up almost all of the pipeline at big pharma, and it's extremely important that we provide access to these drugs for our members. They make enormous differences in quality of life and can cure previously incurable disease. So here's a case where affordability is sacrificed because we need to make these drugs available. We need to make sure that the access is there. Specialty drugs drive about 8 percent of the increase altogether. It's a very big number.

About 2 percent is driven by preventive services. We are very excited about that, and we want that and are making efforts to make sure that that continues. We're working closely with OneCare Vermont to make sure

that members are receiving the preventive care they need. We're also working with them to close gaps in care. These are, we see these as positives. Even though they're driving two points of the rate increase, in the very long term, this is going to improve quality. It's going to reduce cost. It's a goal that I think we all share.

Beyond that, we have some other health care costs that are almost entirely offset by the Blue Cross initiatives that I talked about, and we're really left with just the 3.2 percent for taxes and fees and the 1 percent for administrative costs going up, and that gets us back to the 15.6 again.

Q. At this point, I want to direct your attention to Exhibit 19. It's one of the new exhibits. And I'd like to suggest to everyone following along in your binders it might make your lives easier if you pull out 19 and 20 and turn to Exhibit 14, because we're going to kind of use those in conjunction. I'm sorry. You should bring 18 along as well. It will just save some flipping around later.

Mr. Schultz, have you followed my instructions?

A. To the letter, yes, sir.

Q. Thank you. Can you please describe what Exhibit 19 reflects?

A. Yes. Exhibit 19 is a summary of the recommendations in the Lewis & Ellis report and essentially a summary of whether we agree with those recommendations or if we continue to propose something different.

Q. And does it reflect additional Blue Cross proposed changes to the rate that have occurred since you filed the initial filing?

A. Yes. It also reflects certain items that arose during the questions and answers with L&E.

Q. So, making sure everyone is on the same page, could you just point to the columns in which the L&E information appears and the, and the Blue Cross proposals appear?

A. Sure. So we have, moving from left to right, we have a description of each factor. We have a column for the assumption that was originally filed. Next to that is the Lewis & Ellis recommendation. The next column to the right is the Blue Cross proposed factor, and, finally, the last two columns show an impact versus filed. We have captured the L&E recommendation in the first of those columns, and in the second we've captured the impact of the Blue Cross proposed rates.

Q. And did you prepare this document and/or oversee its preparation?

A. Yes, that's right.
Q. What is the average rate increase that would result from accepting Lewis & Ellis's recommendations as shown on Exhibit 19?
A. Lewis & Ellis recommended an 11.4 percent rate increase, plus or minus any new information that is received relative to unit costs, and by that I believe they mean the hospital budget proposals that were recently submitted.
Q. And what does this, what does Exhibit 19 show as the average rate increase if you were to adopt, if the Board were to adopt all of Blue Cross's proposed adjustments reflected here?
A. 14.3 percent to 14.5 percent.
Q. So is that the average rate increase that Blue Cross is, in fact, requesting?
A. Yes.
Q. Not the 15.6?
A. Correct. We, we do accept several of the Lewis & Ellis recommendations, and, as a result, that figure has come down to 14.3 to 14.5 percent.
Q. You anticipated my next question. Could you identify on Exhibit 19 the Lewis & Ellis recommendations that Blue Cross agrees with?
A. Yes. We've tried to color-code this. So the ones

that are in green are recommendations that we, we flat out agree with. For the AHP morbidity impact, Lewis & Ellis recommended a .3 percent decrease from filed rates, and, while we calculated something slightly higher, we agree that their recommendation is reasonable. So we agree to move to the .3 reduction from filed rates.

We agree with their recommendation on the impact of selection, which essentially just moves that factor from one place to another within the filing with no impact on the increase. We, we have no problem moving that to where they instructed us to do so. Finally, for the high-cost member program, information has come out since the time of filing that indicates that the, the chargeback for that program will be less than what we put in the filing. So we agreed to use .25 percent for the chargeback for that high-cost member program rather than the half percent that appeared in our original filing.

Finally, there is a, there's a blue line which is to consider, the second line down from the top, to consider cost trend from 2019 to 2020. We agree with Lewis & Ellis that that information should be considered, and we have calculated what the impact of, of submitted hospital budgets would be on the filed

rates.
Q. What was Lewis & Ellis's recommendation with respect to that item?
A. Their recommendation is on the bottom of Page 24 of Exhibit 14, and that is, if updated information regarding unit cost trends are known at the time of the board order, L&E recommends updating the assumed unit cost trends in the 2020 premium rate calculations.
Q. Did, did such updated information become available during this process?
A. Yes. Since the time of filing and within the last several weeks, Vermont hospitals have submitted their budget proposals to the Green Mountain Care Board.
Q. Would you please take a look at Exhibit 18 --
A. Yes.
Q. -- and explain what that shows?
A. Yes. So this is another document prepared at my direction. The top box with some of the yellow highlighting, which is just for ease of reading, summarizes the commercial rate request information that we were able to take out of the hospital budget proposals. The bottom box with the green headings is a calculation of the impact of those commercial rate proposals on rates, on both medical cost trends and on rates.

So we have a number of columns here. We have a column for as-filed, which gives you the 15.6 percent rate increase we've been talking about. Based on Lewis & Ellis's, one of their very first inquiries identified a few typographical errors in our unit cost trend spreadsheet. When we fixed those, there's a very slight adjustment upwards. So we include that as a baseline.

We then included information on Vermont hospital budgets as submitted, and there's a footnote that says we also considered any finalized New Hampshire contracts that have occurred since the time of filing. I'll note that those New Hampshire contracts were in the downward direction. So that served as a partial offset to the hospital budget proposals being higher than anticipated. So, if we were to just accept the hospital budgets as submitted, it would be a half percent increase on rates. You can see that in the right-most column of that particular chart.

Finally, we have a line that reads, "With submitted hospital budgets being reduced by .4 percent by the Green Mountain Care Board". .4 percent has been actually fairly consistently over the past few years what the Board has ordered with hospital budgets as opposed to the original submissions. So we -- you

know, the Board, in deciding this matter, I'm sure, has a strong opinion as to what your practice will be relative to hospital budgets this year. So we've supplied you with the math here, and we're confident that your order will be well-aligned with your, with your intentions as to hospital budgets. So we've expressed this as a range of .3 to .5 percent.

Q. So does that represent your, your best effort using the information available to, to take up Lewis & Ellis's recommendation to update the assumed unit cost trend in the face of new information?

A. Yes, that's correct.

Q. Okay. Back on Exhibit 19, there's an orange line called "Changes to Risk Adjustment".

A. Yes.

Q. Could you explain the information reflected in that row?

A. Yes. So Lewis & Ellis, on Page 25 of their recommendation, makes three recommendations relative to risk adjustment. We agree with all three of those recommendations, and we intend to follow those. However, there's a fourth recommendation that we feel is missing from their analysis. They asked a question -- and this appears in Exhibit 4, Pages 3 and 4, where they posed a question to us of, you know, so members in

groups that are no longer with Blue Cross, wouldn't it be reasonable to assume, since the overall group market actually increased very slightly from 2018 to 2019, wouldn't it be reasonable to then, therefore, assume that these groups moved to MVP so, therefore, there would be a risk adjustment impact for that membership movement?

In this response we, we agree with their assertion. That makes sense to us. The resulting, the result of that is that these groups are actually slightly less healthy than the typical MVP member. So, therefore, the risk adjustment transfer, again, it's the relationship between the two carriers. So, if MVP gets very slightly less healthy, that relationship comes a little bit closer together, and the risk adjustment impact is a plus .2 percent. So we believe that, based on that Q-and-A, we, we agree with the L&E analysis, and we expected that .2 percent to be part of their recommendation as well.

So that's reflected in the impact versus filed. L&E suggested 1.4 for the three things they recommend that we agree with relative to risk adjustment. We've done that calculation, and we actually get minus 1.5, but then we have this plus 2 for the recommendation that, that didn't make its way into their opinion,

which moves us from minus 1.4 to minus 1.3.
Q. I'd like to turn now to medical utilization trend, the top line on Exhibit 19.
A. Yes.
Q. Can you explain what's reflected in that row in Exhibit 19?
A. Yes. So our originally filed medical utilization trend, as I testified, was 4.1 percent. L&E recommends a move to 2.5 percent after cost containment initiatives, which I believe is analogous to a 3.4 percent trend before cost containment initiatives.
Q. So does the 4.1 percent Blue Cross proposed trend, is that, that's before cost containment initiatives?
A. That's before cost containment initiatives. After, it's 3.2 percent.
Q. Okay. And you, Blue Cross, disagrees with this particular recommendation, right?
A. That's right.
Q. Can you explain why?
A. Yes. So the, the bulk of L&E's argument has to do with a concept called durational antiselection, and L&E is arguing that we failed to adequately adjust for durational antiselection. I disagree with that. We adjusted in a couple ways. One is any groups that left us, we removed from our trend analysis. We also made

aging and benefit richness adjustments in our trend analysis to normalize over the full time period so that we don't kind of pollute our trend analysis with this impact.

What durational antiselection is is essentially that a, you know, a group of people choose -- I'll just use Blue Cross -- at the beginning of a series of years. Those people, over time, may develop medical conditions while they're with Blue Cross, and, in the event that they do so, they're much less likely than other people to switch carriers, to move to MVP to be specific. So we agree that that's a factor that must be normalized for. We believe we've done so appropriately.

As part of the Q-and-A, L&E asked some questions about risks, risk adjustment. Is another way to adjust for this different from what we did is to adjust based on risk scores? So we did that work. It appears in the L&E opinion on Page 9. And we're left with trends, utilization trends that are negative. Now, that contradicts everything we're seeing on a year-to-year basis. That conclusion didn't make sense to us, and, in fact, L&E agrees that part of the reason we're seeing this is due to coding efforts.

So we furthermore performed an analysis to show

what we believe the coding growth is in Vermont. L&E disagreed with that and said, You really need to look harder to see what is the right balance between what portion of the risk score increase is due to coding growth and what portion is due to people actually getting less healthy.

Again, that's way back in Section 4 of the binder. So on, in Section 4 -- so Exhibit 4, I should say, Page 3, there's a chart at the top of that box that I'd like to discuss. We viewed coding growth as being perhaps as high as 7 seven percent in Vermont. If that's the case, we end up -- so that 7.3 percent, that's in the box at the top right-most column, next-to-the-last row, 7.3 percent. If we believe that that is 7 percent coding growth, if we think that's true, we yield utilization trends of 9.3 percent, which is just as unbelievable, if you will, as the negative trends that we saw when we assumed no coding growth whatsoever.

L&E suggests we need to strike a balance between the two. So we did some further work to do just that. There's a report that's been published by Milliman, which is a very well-respected actuarial consulting firm, that suggests that, even in the absence of specific efforts to improve coding -- and those specific efforts might be things that take place within

an ACO, for example -- as providers start to get paid on the basis of how they're performing relative to expectation, risk adjustment becomes a very important thing.

So, if we're trying to compare Provider A to Provider B, we need to take a look at, Does Provider A just have a sicker panel than Provider B? If so, it wouldn't be fair to judge them on the same number. You need to risk adjust. So, as providers start to get judged based upon their performance and risk adjustment is part of that, coding tends to get better. We've seen that in Medicare Advantage across the country, and that's something that's true of any sort of payment reform initiative.

But let's set that aside, and let's look at what a typical coding growth is even in the absence of those kinds of efforts. Because of things like new EMRs, a carryover effect from, for example, Medicare Advantage penetration is on the rise in Vermont, and we expect that to have some carryover elsewhere within Vermont.

Milliman suggests that 1 to 3 percent is a typical coding growth number. So let's take 2 percent. It's the middle of that. And I'll ask you -- I apologize for asking you to follow along a little math early in the morning, but, if we take 2 percent and plug it into

this chart for coding growth instead of the 7.3, that's a difference of 5.3 percent. The bottom number, the trend -- and I'm looking at the closed cohort column, by the way.

The reason I'm doing that is because a closed cohort kind of takes all the ins and outs out of it. So we're looking at just this closed cohort. Obviously, it's aging. So we adjust for that. We normalize for all the things I talked about. If we change coding growth to 2 percent, the bottom number also comes down by 5.3 and yields 4 percent. 4 percent is extremely close to the 4.1 percent that we've proposed. So we're using an entirely different methodology, and it's resulting in an extremely similar utilization trend.

Beyond that, flipping back to the Lewis & Ellis opinion, Lewis & Ellis did us the service of performing a methodology that we would be unable to perform ourselves. They looked at the overall market trend by combining our data with MVP's, and what they concluded on the top of Page 10 is that the 24-month marketwide estimate of 4.2 percent is substantially similar to the previously stated Blue Cross-only estimate of 4.1 percent. That estimate is found a few pages earlier on Page 6. That's the Blue Cross 2-year average, 4.1

percent, which is the average, the average trend from 2016 to 2018. So we have yet a third methodology completely different from the other two methodologies yielding 4.2 percent based on the Lewis & Ellis calculations.

Now, they go on to say that the 36-month estimate is materially lower than Blue Cross's observation of 3.1. So, again, on Page 6 we can find the 3.1. It's in the bottom of the chart on Page 6. It's the 3-year average. The difference between the 2-year average and the 3-year average is the inclusion of the year 2015 to 2016.

So L&E is using this to say, Okay, these long-term trends are much different. So, therefore, there's durational antiselection that's polluting it. However, they only become different when we start to include a year 2015 to 2016 in which Blue Cross experienced very -- in fact, I think it, membership went very slightly up, and risk adjustment, which is L&E's indication that we're getting less healthy, our risk adjustment transfer went down from 2015 to 2016. So, in other words, there was no movement of members away from Blue Cross from '15 to '16. There could not have been durational antiselection from 2015 to 2016.

I therefore disagree with the L&E conclusion that

this is indicative that we, indicative of us not adjusting properly for durational antiselection, again, because, when they look at the period where members were leaving Blue Cross from 2016 to 2018, L&E themselves conclude that their marketwide estimate of 4.2 percent is substantially similar to ours of 4.1 percent. So now we have three different techniques that arrive within .1 of each other, centering on 4.1 percent.

So we, we believe that L&E's concern about durational antiselection is correct, but we believe that we adjusted properly for that effect and that our answer is the better answer.

Q. Mr. Schultz, could you briefly describe what durational antiselection is?

A. Yes. So I think I hit that a little bit earlier. So that's, if you have a population, as that population develops medical conditions over time, they're less likely to leave a certain carrier than a healthy member might be.

Q. Thank you. Take a look back at Exhibit 19.

A. Yes.

Q. The fifth row is labeled "Individual Mandate Morbidity Impact".

A. Correct.

Q. And that's another area where you disagreed with Lewis & Ellis, right?
A. That's right.
Q. Could you explain what's reflected in this row here and the reasons for your disagreement?
A. Yes. I'm just looking for -- okay. So L&E described their rationale on Page 16 of their opinion, and there's a couple pieces in here with which I disagree. The very last sentence of the bullet on individual mandates about halfway down the page notes that L&E's expectation is that most members would leave, most members who would leave the market due to the repeal of the individual mandate penalty will have already done so in 2019.

First of all, I disagree with that expectation for the reason that Vermont law changed. In 2018 when we were looking at this last year, the legislature had, had passed a law enacting a Vermont individual mandate with a penalty to be determined. In 2019 that penalty has been determined to be zero. So I believe that membership will continue to leave in 2020 due to the lack of a penalty, and that belief is, is augmented by some of the comments that I read on this rate filing indicating that some healthy members would be doing just that.

So, beyond that, let's, let's just say that L&E's right; nobody's going to leave in 2020. What then can we conclude? The bulk of L&E's argument on Page 16 has to do with what happens to members who have left Blue Cross or will continue to leave Blue Cross. I want to note, just to clarify the record on one thing, that the first sentence of the third paragraph on this bullet reads that, "It is the company's position that, whether these members left for MVP or left the market entirely is irrelevant to the rate setting for Blue Cross".

That is not an accurate depiction of our position. Our position is that, if these members are going to leave in 2020, then it is not relevant whether they went to Blue Cross or MVP in 2019. What is relevant is that we expect them to leave the market in 2020. We completely agree that, if members move from Blue Cross to MVP, there will be a risk adjustment impact. So I don't want to leave the impression that we don't agree with that. We certainly do.

L&E goes on to argue that, for members in 2019 who were observed to leave Blue Cross -- because, again, the overall market went up. The individual market increased from '18 to '19 -- therefore, these members must have gone from Blue Cross to MVP. If we assume that's correct, we also have to assume that's correct

of all other individual members, not just this small cohort of very healthy members.

So, if we accept L&E's argument that these members moved from Blue Cross to MVP and there is therefore a risk adjustment impact, we can calculate what that impact is. We know what these members' risk scores are, because they were all with us in 2018. In doing that math, we calculate that the risk adjustment transfer would decrease because the, the individual members, not just the healthy ones, but all of them, moving to MVP are less healthy than their current population. Risk adjustment goes down. Premiums on our side have to go up. That would have a plus 1 percent impact on premiums.

So, if we take L&E's arguments at face value, the plus .5 percent that we have here should be a plus 1 percent. We're not suggesting that that's necessary. We believe that the half percent will be sufficient. But I think it's important to understand the, the mathematical conclusions of L&E's argument as you consider this item.

Q. Finally, Mr. Schultz, could you look at the last row in the, the main box on Exhibit 19 that's labeled "Newborn Morbidity Adjustment"?

A. Yes.

Q. Can you, first of all, what does that term mean?
A. So that has to do with the fact that the, that babies will continue to be born in Vermont in 2020 and we have to account for that in the rates.
Q. And can you explain what's reflected in that row there and the reasons for your disagreement with L&E on this point?
A. Yes. So this is addressed on Page 17, third paragraph of L&E's opinion, and, and I think it's very well-summarized. They note that, in the course of L&E's review, it was discovered that the calculation -- and this has to do with demographic shifts -- does not reflect the impact of newborns born during the middle of a plan year. So we do expect continued births in 2020. They note that we estimated that, if we change our methodology to reflect the newborns, claims go up by .6 percent.

However, they also note that there would be an offsetting impact due to additional premiums that we would collect and changes in risk adjustment. I agree with them on that, but they did not calculate the value of those offsets in their opinion; neither did they ask Blue Cross about the calculation of the value of those offsets.

Since the time of the, that the L&E opinion was

issued, we have performed those calculations. What we found is that the premium offset would be 0.2 percent. It's not surprising that that's a small number. Recall that we're on a family tiering structuring in Vermont. So, really, it's only the first child who's going to generate additional premium. We also don't charge additional premium for newborns for the first two months of their life. So, if a newborn is born during the year, the premium offset is not going to fully offset the claims impact.

Finally, for risk adjustment, and consider, again, risk adjustment is a comparison of the two carriers. So, as long as there is no change in the relative birth rate between Blue Cross and MVP as we move forward, there will be no change in risk adjustment transfer. It's a comparison of the two. So, as long as those relative birth rates are the same, the population curve is going to remain the same, the transfer amount is going to remain the same.

So our calculation of the offset is .2 rather than the .6 that L&E implies without actually doing the calculation. We, therefore, are proposing to include a .4 percent impact for newborns, which is different from the L&E proposal of zero.

Q. And, Mr. Schultz, that's also different from what

Blue Cross had originally proposed with respect to this factor; is that correct?
A. It is. As L&E noted, we had not, we had erroneously not included that in the original filing, and that was discovered during the course of the Q-and-A back-and-forth.
Q. Thank you. Would you please turn back to Exhibit 1, Page 9, Section 1.8, which is the section of the actuarial memorandum regarding statutory criteria?
A. That, I think, is Page 19 of the exhibit.
Q. Yes, thank you. So, to summarize, in your professional opinion, are the proposed rates inadequate?
A. No, they are not.
Q. Are they excessive?
A. No, they are not.
Q. Are they unfairly discriminatory?
A. No.
Q. Are they reasonable in relation to the benefits provided?
A. Yes, they are.
Q. Are they unjust, unfair, inequitable, misleading, or contrary to law?
A. No, they are not.
Q. Are they affordable while promoting quality care

and promoting access to care?
A. Yes, they are. They strike the best balance among all of those factors.
Q. And do they protect solvency?
A. They do.
Q. Now, to, to wrap up, how do you understand the relationship among those, that last group of criteria? And by that I mean whether the rates are affordable, whether they promote access to care, whether they promote quality care, and whether they protect solvency?
A. Solvency is really the framework upon which those other three criteria can be built. The reason I say that is that, in the absence of solvency, in insolvency, we cannot have affordability, we can't have access to care, and we can't have quality care. The reason for that is that, if you're in a state of insolvency, providers are no longer receiving the payments from the insurance company that they were promised. So, to keep their doors open, they're going to have to make some very tough choices about to whom they provide care and what care they provide. Those are going to have detrimental impacts on access to care and on quality care.
Affordability is also impacted, because many

providers will turn to the policyholders to pay for these services that they need and are being provided. So that would be far less affordable than the insurance that they're purchasing through Blue Cross. Solvency is, therefore, really the underpinning of these other factors.

Q. Mr. Schultz --

A. Yes.

Q. -- you mentioned earlier in your testimony that you read the public comments that the Board has received during this proceeding, right?

A. That's right.

Q. And, as those public comments reflect, many, many Vermonters struggle to pay for their health insurance, right?

A. Yes.

Q. In that context, how are you able to conclude that these rates strike that appropriate balance among affordability, access, and quality?

A. So I, I conclude that because we have to assess those things on the basis of the community. We can't do it on the basis of one individual, because I can't provide a rate for one individual. Based on the structure that we're provided here in Vermont law, I can't provide an affordable rate for the healthy

30-year-old couple who's not going to use a lot of services that's different from a rate for an unhealthy 60-year-old who might have several high-cost medical conditions. I'm not allowed to rate those things separately. We've had a very longstanding ideal of community rating in Vermont for many decades. So the rating must be done at the community basis.

When I, when I think about that, we have to consider, Does this reflect quality care, does it reflect access to care, and does it reflect affordability? And these rates strike the best balance available among the three for many reasons that you can find in the record. Most importantly is, again, this idea of the community. It's a community rate.

We have kind of three pieces to the rates here: One, our taxes and fees. These are things that are outside of our control. They have to be included in the rates. We don't really have any choice over those things. Second, we have what I called earlier the cost of insurance, and how can we think about the affordability of the cost of insurance? Well, we know, based on federal MLR, medical loss ratio, guidelines that the cost of insurance is considered to be unaffordable if the MLR falls below 80 percent, in other words, if you're spending more than 20 percent on

the cost of insurance, insurers are required to submit refund checks to members, because that is not an affordable amount.

Blue Cross has done a calculation that is included in this filing. It's on Page 98 of Exhibit 1, and it shows the federal MLR calculation that's projected for this filing. It's 91.2 percent. In other words, Blue Cross's cost of insurance is 8.8 percent. That's less than half of what the federal government and what Vermont, in adopting those federal standards, has defined as an unaffordable cost of insurance. So we're very proud of that number.

That leaves us with kind of the bulk of it, which is the claims, and, again, we need to think about the community. For every nine Vermonters for whom they're not really using a lot of care and they don't get the benefit, they don't get the return on these premiums that they're paying in, there's their neighbor, the one Vermonter who has a high-cost medical condition, and it takes the premiums from all ten of those Vermonters to cover what can be very, very high costs of care for the one sick person.

So, on the community basis, we need to look at these, and we believe that they strike the best available balance between these factors that are in

tension between access to care and affordability.

ATTORNEY DONOFRIO: Thank you, Mr. Schultz. This concludes Mr. Schultz's direct examination. I'm going to reserve the right to call him in rebuttal, time permitting. Thank you.

MR. BARBER: Thank you. Mr. Angoff, do you have questions for Mr. Schultz?

ATTORNEY ANGOFF: Just a few.

CROSS-EXAMINATION BY ATTORNEY ANGOFF

Q. Good morning, Mr. Schultz.

A. Good morning, Mr. Angoff.

Q. Mr. Schultz, I'd like to start off by thanking you, and what I'd like to thank you for is talking loud. It makes a huge difference. For the first time, you're my favorite witness.

A. You're quite welcome.

Q. For the first time, I could understand every word. Just a couple of questions. Do you all agree with L&E's risk adjustment methodology?

A. Yes.

Q. And what is the difference between the risk adjustment methodology you all used and the risk adjustment methodology they're using?

A. So two, two things. One is, after the time of filing, we learned what the final 2018 risk adjustment

amount would be. So L&E recommended that we consider that in building our projection for 2020. That was worth about $3 million of -- it's a difference of $3 million.

The second thing that L&E did, which we also support, is that they were able to gather data from both carriers. So this type of analysis is not available to me, as I don't have access to MVP's information. L&E does have access to that, and they were able to assess how the model changes, the risk adjustment model changes from 2018 to 2020, would impact the risk adjustment. That added about another $3 million to the transfer we expect to receive.

Q. So, so the L&E risk adjustment methodology would reduce your rate slightly?

A. That's correct.

Q. And, conversely, raise MVP's rate, because it's a zero-sum system.

A. Well, I don't know what MVP filed. So I can't really answer that question. But, yes, it is a zero-sum system.

Q. You said something about a factor that you originally had which was .5 which you reduced to .25, and I forget exactly what that concerned. Can you, do you remember?

A. Sure. Yes, I do. So that's the, that's the charge for the high-cost risk pool. So this is a national program that CMS put in place, because there are a certain very, very few claimants who can have claims of upward of $20 million. So, to really be able to spread that across something that makes sense, you can't even do it on a state level; you have to do it nationally.

So this program includes a chargeback to all carriers who participate in the ACA. CMS had put in their publication they do not expect that chargeback to exceed a half percent of premium. So that's what we put in our filing. Since the time of filing, again, the new information came out to say what that chargeback was in 2018. L&E took that into account, projected it to 2020. We agreed that we, we can and should use that new information, and we agree with their recommendation.

Q. And so is that the -- does this .25 factor, is that to pay for claims above a million dollars?

A. Yes, on a national, a portion of claims above a million dollars, yes.

Q. So, if you had a, if Blue Cross had a claim that's above a million dollars, you would get some of that back, right?

A. That's right.
Q. And so the net would be a little less than .25?
A. Correct.
Q. Okay. But you don't anticipate a claim over a million dollars in 2020?
A. No.
Q. Have you had claims over a million dollars since 2014?
A. No.
Q. You also said something to the effect that there's a certain methodology which you thought didn't make sense to apply but that, under that methodology, a type of trend was negative. Could you explain what trend that was and what methodology produced that negative trend?
A. I believe you're talking about, if you adjust all claims experience, if you normalize it for changes in risk score without assuming any coding growth at all, you end up with an assessment that trend is negative.
Q. Okay. And you think that's unrealistic?
A. That's right.
Q. Okay. And why is that?
A. That's because it's unrealistic to believe that there is no coding growth at all.
Q. And why, why is it unrealistic to believe that

there's no coding growth?
A. Coding growth has been observed kind of nationally. I cited a Milliman study that suggests that a 1 to 3 percent is a typical amount of coding growth in the complete absence of any initiatives for risk coding specifically. So, based on that national study, zero is not within their range of reasonable results.
Q. Could you explain what you did last year, what you assumed last year as to what the effect of having no penalty for the individual mandate would be?
A. Yes. We, last year, we observed a study that was published by the Green Mountain Care Board that suggested that there would be a 1.6 to 2.4 percent impact. We did some analysis that, admittedly, we didn't have all the same data that L&E did when they did that analysis. So our analysis was necessarily simplified, and we agreed with that range.
Q. Okay. And so you assumed that what would happen? And, yeah, you assumed that what would happen to your members as a result of the zero penalty for the individual mandate?
A. We assumed that some members would leave and the result would be an impact of about 2 percent on claims.
Q. Okay. And you assumed that all the healthy

members, right, all the people that did not use their insurance who were unsubsidized would leave; is that right?
A. Yes.
Q. Okay. And, in fairness, L&E assumed essentially the same thing, right?
A. They, their methodology was very different, but they arrived at a similar result, yes.
Q. So you both assumed that the rate should go up about 2 percent?
A. Yes, that's right.
Q. Okay. And, in fact, that's, in fact, what actually happened last year?
A. We observed that not a lot of these members left us. It looks like about .3 percent was the impact rather than 2 percent.
Q. Okay. So are you reducing, then, the rate this year by the difference between 2 and .3, that is, 1.7?
A. No. We're reducing it by, we're reducing the file rate by 1.2. I speak that way because the Green Mountain Care Board ordered a reduction from our file rate last year for that assumption. We're reducing the file rate by 1.2 rather than 1.7, as we believe that some members will leave in 2020, especially in light of Vermont passing a zero-dollar penalty.

Q. Did you consider the possibility that you might be wrong, that people just are not that impacted by the elimination of the zero, by the elimination of the penalty?
A. Yes, I was, I was influenced by the results to lower an expectation to something much less than 2 percent.
Q. I mean, the penalty wasn't very big to begin with, was it?
A. I wouldn't say that.
Q. You haven't -- you, have you ever read any commentary by the industry or by actuaries to the effect that the individual mandate penalty just does not have the, cannot reasonably be expected to have a meaningful effect?
A. No, just the opposite. I've read commentary that it is expected to have a very meaningful effect.
Q. Do you remember what the original individual mandate penalty was?
A. I don't.
Q. Okay. Would it surprise you to know that it was $95?
A. That's right, and I believe that, that it sounds like the right answer. However, it increased significantly after that on a year-to-year basis, and

it was much higher than that in 2018.
Q. But you will concede that not everyone is necessarily influenced by the elimination of the penalty?
A. Absolutely.
Q. Could you explain to the Board what you originally assumed would happen because, to your members, because of the continuation of the AHP market in Vermont in 2020?
A. For this filing, we originally assumed there would be a 1 percent upward impact.
Q. Okay. You originally assumed that there, because of the continuation of the Vermont AHP market, 1 percent would be added to rates, correct?
A. Yes.
Q. Okay. And now we know that the AHP market is not going to continue in Vermont, right?
A. Yes.
Q. Okay. Then isn't it reasonable to expect that, if you say that the continuation of the Vermont AHP market adds 1 percent to rates, that, if the market's not going to continue, you take that, you back out that 1 percent?
A. No, that's actually not reasonable.
Q. Okay. Can you explain that?

A. Yes, I can. To do that, I am probably going to have to touch on confidential information.

MR. BARBER: Okay. Which document are we talking about?

THE WITNESS: It will take me a minute to find it. There was a Q-and-A with L&E about this particular item.

MR. BARBER: Yeah.

ATTORNEY DONOFRIO: Exhibit 8.

THE WITNESS: Thank you.

ATTORNEY ANGOFF: Mr. Hearing Officer, in the interest of time, I'd like to withdraw that question.

MR. BARBER: Okay. So your question is withdrawn.

BY ATTORNEY ANGOFF:

Q. You've testified that the rates as proposed by Blue Cross are not excessive, inadequate, or unfairly discriminatory, correct?

A. Yes.

Q. Okay. And, when you determine whether a rate is excessive, inadequate, or unfairly discriminatory, you don't look at whether or not people can afford those rates, correct?

A. That's true.

Q. Okay. So you're not testifying that this, that

the proposed rate that is, that, in your view, is excessive, not excessive, inadequate, or unfairly discriminatory, you're not testifying that that rate is affordable?

A. I am testifying that it is affordable and that it strikes the best balance between affordability and the other factors.

Q. Okay. Well, the Board will determine what strikes the best balance, but you're not testifying, are you, that the rates which you are testifying are not excessive, inadequate, or unfairly discriminatory are affordable?

A. I did testify to that, yes.

Q. What, what is the basis for it? What research did you do to determine that individuals could afford this rate?

A. So it goes back to the question that, I think the final question that I answered in my direct testimony, which is the rate consists of three parts, taxes and fees that are things that are outside of our control but we must include in the rates; the cost of insurance, which the federal government has defined as unaffordable if it's greater than 20 percent. Our cost of insurance is 8.8 percent. That's a big difference from 20 to 8.8.

And, finally, affordability needs to be considered on a community basis, and, as such, I'm required to develop rates the way that I do on a community basis.

Q. On the -- you're, as an actuary, you look at the ASOP standards, right?

A. Yes.

Q. And do any of those standards refer to affordability at all?

A. No.

Q. Okay. And you're not testifying, are you, that the MLR rule defines affordability in any way?

A. I, I think it does define affordability for the cost of insurance. That's different from the full premium rate. But I do think it does define it for the cost of insurance.

Q. You believe that the MLR rule uses the term "affordability" and defines that?

A. No, it doesn't.

Q. Okay. It doesn't do that, does it?

A. It does not.

ATTORNEY ANGOFF: I think that's all the questions I have.

THE WITNESS: Thank you.

MR. BARBER: Okay. I think, at this point before we get to Board questions, we should take a

quick ten-minute break. I got scolded for not taking breaks yesterday. Be back here at five until.

(A recess was taken from 9:45 a.m. to 9:58 a.m.)

MR. BARBER: Okay. So we are back on record in the case of Blue Cross Blue Shield of Vermont's 2020 Vermont Health Connect rate filing. We left off just before we got to Board questions. So we will just go down the row, starting with Member Lunge. Do you have questions for Mr. Schultz?

MS. LUNGE: Yes, thank you. Do I need the mic, or can everybody hear me? You guys can hear me okay? All right. I can project pretty well. Thank you for coming this morning.

THE WITNESS: Of course.

MS. LUNGE: I wanted to start with some questions around a trend that you mentioned in which was the 7, about 7 percent increase in mental health visits. Could you talk to us a little bit about that trend and what you think is driving it?

THE WITNESS: So we think that's a movement of care to more appropriate clinical settings. So, actually, driving less inpatient care that's, that's been moved more to the professional setting. So we see a pretty big increase there. As I testified, we have a zero percent inpatient trend, which is great. So we

have seen evidence of that move to a more appropriate setting.

MS. LUNGE: So, so that decrease then in inpatient is reflected in the zero percent trend?

THE WITNESS: That's right.

MS. LUNGE: Okay, thank you. I also wanted to talk a little bit about your cost-containment efforts this year. I was quite excited to hear about some of your new initiatives --

THE WITNESS: Oh, good.

MS. LUNGE: -- around cost-containment, and to see that you had indicated an offset in your trend related to those. Could you talk -- and, if this is more appropriate to one of the other witnesses, please just let me know, but could you speak a little bit more in depth to the shared savings arrangement with the lab benefit manager in terms of what the shared savings arrangement actually is?

THE WITNESS: Yeah. I'm hoping Andrew might have some of those details, and, if not, we'll follow up with you.

MS. LUNGE: Okay, great. I will direct that question to him.

THE WITNESS: Yeah. Sorry.

MS. LUNGE: No, no, that's okay. You also

talked about a convenient care program, and, again, this may be more Andrew's line of questions.

THE WITNESS: That one I can hit at a high level. So that's the home infusion that I discussed, and so it was completely voluntary, and, rather than going into the facility for infusion, members can have that service performed at their own home. That has a really significant cost savings on a per member basis of about $50,000. So it can be impactful. But we're doing it on a voluntary basis, and we just, we haven't seen much uptake of folks taking advantage of doing that in their home. We will continue to look at that program, and that's something we'd like to think about, how we can expand that in the future.

MS. LUNGE: And so that would moving from the outpatient hospital setting to --

THE WITNESS: Yes.

MS. LUNGE: -- home?

THE WITNESS: Correct.

MS. LUNGE: Great. And I'll direct ACO-related questions to Andrew as well.

THE WITNESS: Naturally.

MS. LUNGE: All right. I did notice in your filing that there was no assumptions related to the ambulatory surgical center. Is that something that you

can speak to?

THE WITNESS: Yes, I can. So that, at the, at the time of filing, I don't believe the, the new center was even approved.

MS. LUNGE: They were approved but not yet open.

THE WITNESS: Ah, okay, thank you. So, as of now, my understanding is that we have completed contracting for one particular type of service. Obviously, we, we have no means of really estimating utilization, and, while we believe, while there will be savings for members choosing that site for their care, it's really not likely to be material to this rate filing for 2020.

MS. LUNGE: And could you explain that? Like, why is that? Why wouldn't it be material?

THE WITNESS: So we believe the number of services is going to be fairly limited when you compare it to the, like, the entirety of the claims volume. So, even if you're talking about a decent number of savings of, you know, several hundred thousand dollars, that's still really not going to move the needle when you're looking at $330 million of total spend.

MS. LUNGE: Thank you. You testified earlier that there was an increase in the individual market

from 2018 to 2019 overall; is that correct?

THE WITNESS: That's my understanding, yes.

MS. LUNGE: And you also testified that there was a .3 percent decrease related to the individual mandate in your book of business. Is that, do I have that correct?

THE WITNESS: Yes. That's on the basis of the modeling that we performed. So we were looking at kind of modeling what the size of the impact might be by looking very specifically at particularly healthy families, particularly healthy subscribers. So, of those individuals we identified, which came to a grand total of .8 percent claims impact, a portion related to .3 percent claims impact have already left as of 2019.

MS. LUNGE: According to your modeling?

THE WITNESS: No. We can actually observe those members did leave. So whether they left because of the individual mandate or for some other reason is something of an open question, but yeah.

MS. LUNGE: Okay. So you don't survey the members that leave to find out where they went, necessarily?

THE WITNESS: Correct, correct. We know a few things such as if a member passes away.

MS. LUNGE: Sure.

THE WITNESS: We assume that, if they're 65, they've retired. So there's some limited knowledge, but we don't survey to see exactly where they landed.

MS. LUNGE: That makes sense. So they could, for example, have lost income and joined Medicaid?

THE WITNESS: Yes.

MS. LUNGE: Thanks. In 2019 did your company offer association health plans?

THE WITNESS: Yes.

MS. LUNGE: And do you know approximately what the membership in those plans was?

THE WITNESS: I believe it's close to 6,000.

MS. LUNGE: And do you have any idea where those members who are currently in 2019 in those plans moved from?

THE WITNESS: Yes, we do.

MS. LUNGE: And could you explain a little bit about where they moved from?

THE WITNESS: Yes. So a bulk of them came from Blue Cross small group plans in 2018. There were an -- I don't have the splits at top of mind, but there were some members who joined from MVP as well. We also have a limited number of small groups who previously had not offered insurance to their employees at all, and then we had a small but, I believe, meaningful

chunk of membership that came from Cigna-level funded products and other self-funded opportunities that are available to small groups.

MS. LUNGE: Thank you. And so those members will continue to be your clients until the end of this year?

THE WITNESS: That's right.

MS. LUNGE: So you testified earlier that you know that your rates in, the prior rates were inadequate because the RBC levels went down; is that right?

THE WITNESS: Yes.

MS. LUNGE: And RBC levels are a range, within a range approved by the Department of Financial Regulation; is that correct?

THE WITNESS: They're targeted for that, yes.

MS. LUNGE: But, within that range, your company would target a specific level that meets your comfort level; do I have that right?

THE WITNESS: Sort of. I mean, so within, within the new range that's been ordered by DFR, the consultant who prepared that identified 690 percent as the kind of optimal level within that range, in other words, the level where we're least likely to fall outside the range within the next year.

MS. LUNGE: But in the previous range --
THE WITNESS: Yes.
MS. LUNGE: -- which we don't have to speak to, because some of that -- we don't have to use that number, but, in the previous range, did your company have a targeted level that you wanted to be making?
THE WITNESS: No.
MS. LUNGE: So you also testified earlier that you included the 1 percent affordability reduction into your 2019 trend; is that right?
THE WITNESS: So what, what I mean by that is that, when I'm, when I'm setting rates from an actuarial perspective, I need to come up with what I think the cost is going to be. So that 1 percent affordability reduction kind of never really appears in my work. So what I meant by that was is we looked for the, to the trend from 2018 to 2019. The 2019 premiums themselves include that 1 percent affordability reduction, but I'm not, I don't include that in the work that I do. So that's a difference and causes an additional increase from one year to the next.
MS. LUNGE: Are you familiar with any changes that your company made in 2019 to its business model to achieve that 1 percent affordability target?
THE WITNESS: So I believe these are the

things that we, we listed in here as we're continuing to work on. So it's our ongoing collaboration with OneCare Vermont. From the time of the order to actual 2019, that's, you know, that gives us about four months to identify and try to implement something that's going to be impactful. So that's, that's really not a timeframe where we can accomplish something like that.

So my answer is that we've continued the work that we already had in place, and we continue to look for opportunities really, frankly, both in 2019 and 2020, any quick wins we might have in 2019 as they relate to cost-containment, and then things like the lab benefit manager is an opportunity that we identified. Now, that's a good example of one that we've tried to work as quickly as we can to get that up and running. Couldn't do it by January 1 of 2019, but that will absolutely have an impact on 2020 rates, and we included that here.

MS. LUNGE: Does your company do outreach to current clients?

THE WITNESS: Yes.

MS. LUNGE: And do you, does your company work with current clients to choose what product they would enroll in in the following year?

THE WITNESS: Yes, I believe we do.

MS. LUNGE: Thank you. No further questions.
THE WITNESS: Sure.
MR. BARBER: Okay. Member Pelham?
MR. PELHAM: So welcome.
THE WITNESS: Thank you.
MR. PELHAM: My first question has to do with the actuarial memorandum on having to do with your administrative expenses.
THE WITNESS: Okay.
MR. PELHAM: And I think it's on Page 52 of the filing.
THE WITNESS: I'm ready.
MR. PELHAM: So, rough numbers here, I think that you said that the administrative expenses were about 7 percent of premium.
THE WITNESS: Yes.
MR. PELHAM: And so, if you do the simple math here and you, you take the total administrative expenses at $79 million and divide that by 7 percent, you come up with over a billion dollars in premium which I don't think is, is what we're looking at. So my guess is that this, and this is a guess, or my question is, Is this an estimate of administrative expenses enterprise-wide?
THE WITNESS: It's a very good guess. It's

correct.

MR. PELHAM: Okay. So, so, following that bouncing ball, I'd like to go to Exhibit 21, Page 21.

MR. BARBER: Are you referring to the HCA exhibit?

MR. PELHAM: Pardon me?

MS. USIFER: You're talking Book 2?

MR. BARBER: I think we're all in Binder 2.

MR. PELHAM: I am in Book 2.

CHAIRMAN MULLIN: What page?

MR. PELHAM: 21.

MS. USIFER: Page what?

MR. PELHAM: Page 21 of Exhibit 21. So my question there is, this is a profile of administrative expenses, and I see that there is a net there which is the premium received from your uninsured population of $33.4 million, and I, I think that the -- I'm guessing that the way that that's been done is to kind of take the uninsured, separate the uninsured population and, and assign them those revenues to their administrative expenses in order to get a net number here for the insured population, and that is the 32,087,000 which you carry on this, this part of your annual statement, as well as going -- you have it later on. You don't need to turn there, but it's also the exact same number

that's carried in your five-year trends for 2018.

So my question is, Do you actuarially separate the cost per member per month or cost per covered life of administration for your insured population from that of your uninsured population because they are significantly different?

THE WITNESS: Yes. So we -- and I think Ms. Greene will be able to speak to this in a lot more detail than I can, but it's an accounting exercise rather than an actuarial exercise.

MR. PELHAM: Right.

THE WITNESS: So we use the results of that accounting exercise that you described and Ms. Greene can speak to as input into our actuarial exercise.

MR. PELHAM: Okay. So how, how do you then actuarially get to the $79.7 million?

THE WITNESS: So that figure is, that's the total enterprise-wide administrative expenses. In terms of why those numbers differ from what's in these exhibits, that's a great question for Ms. Greene.

MR. PELHAM: Okay.

THE WITNESS: Sorry.

MR. PELHAM: That's okay. I just, I can't find the $79 million anywhere in the, in the annual statements, and there are different categories. I

mean, and using the exact same phraseology, total administrative expenses, you find different numbers for the same year.

So, speaking to the actuarial number, last year in your filing, that number was $75,000,634. $75,634,934, and this year it is, as you can see the 79 million 71. That's a 5.4 percent increase over the prior year. Can you explain that increase?

THE WITNESS: Again, I think Ruth will have more detail for you. I can tell you that there were certain nonrecurring expenses related to an operating platform transformation that would have been included in that number, and, as I testified, we did remove certain nonrecurring items.

MR. PELHAM: In the prior year number or the current year number, the 2020 number?

THE WITNESS: In the 2018 number.

MR. PELHAM: Okay. So the transition from 2018 to 2019 was a 2 percent increase, which seems consistent with your methodology, and but it does jump to a 5.4 percent increase in 2020, which is, is what it is. But, you know, I was -- so the, my other question is, In your responses to the nonactuarial questions, it was stated that the 2018 MLR would be filed with CMS on July 31st --

THE WITNESS: Right.
MR. PELHAM: -- which we're close to.
THE WITNESS: We are.
MR. PELHAM: Any indication as to whether you're hitting your target for 2018 or you hit your target for 2018, which was 92.5?
THE WITNESS: I, I don't know what that calculation is going to yield. I do know that we lost money in 2018. So I suspect that the MLR will turn out to be higher than target.
MR. PELHAM: Thank you.
THE WITNESS: I do want to -- so the 5 percent I think you're looking at on Page 52, also, that's a two-year trend projection. So I just want to point you to the exclusion of nonrecurring expenses. That's, that I discussed. That's a dollar six reduction --
MR. PELHAM: Okay. So --
THE WITNESS: -- and then that 5 percent trend is a --
MR. PELHAM: So, as I look at the year-over-year increase from 2018 to 2017 at 1 percent, that's a one-year?
THE WITNESS: That's a one-year.
MR. PELHAM: And the 2019 over 2018 is a

one-year, which is a 2 percent number?

THE WITNESS: Yeah. Yes.

MR. PELHAM: And 2020 over 2019 is a two-year number?

THE WITNESS: 2020 over 2018 is a two-year number.

MR. PELHAM: Okay.

THE WITNESS: So, in other words, the trend projection we have on this page of just over 5 percent, that's two years worth of trend.

MR. BARBER: Member Holmes?

MS. HOLMES: I up next? How are you?

THE WITNESS: Oh, getting there. How are you?

MS. HOLMES: This is your favorite day, right, of the year?

THE WITNESS: Oh, yes.

MS. HOLMES: So I have a couple questions for you. So first is, as we've been hearing about yesterday and today, is about market share and, you know, how that's changed over time, and so, as you testified, you know, Blue Cross Blue Shield's market share has shrunk markedly over the past three years, and, in one of the documents in your filing, it's referred to a pricing advantage of the competitor. I'm

wondering if you can speak from an actuarial perspective what do you think is driving that price advantage?

THE WITNESS: Oh, that's a great question. So I, I think that the bulk of it, and maybe even the entirety of it, is that the risk adjustment program in Vermont is not a one-to-one on claims. I've seen national numbers from actuaries who have looked at this who believe that it's 70 cents on the dollar.

Another thing I can tell you is that the model is based on national data. So it's, it's going to kind of work on average. If you have an environment where providers are very, very good at capturing diagnosis information both in their charts and then on the claims themselves, then that risk adjustment number is probably going to more than compensate for the claims impact.

If, on the other hand, you're in a provider environment where the opposite is true, where they're not very good relative to average of capturing those diagnoses, risk adjustment is going to be even worse than average across the country for that particular market.

In Vermont we know we have very low Medicare Advantage penetration. Medicare Advantage risk

adjustment is a really big deal in Medicare Advantage. So carriers who are involved in that product spend a lot of time and money on provider education trying to get those, those risk scores to where they should be to accurately reflect the health of the population, and they do that because the revenue they get from the federal government is based directly on those risk scores. So they have to pay a lot of attention to it.

Vermont has the third lowest Medicare Advantage penetration in the country, and, if you compare, for instance, risk scores in Vermont to risk scores of neighboring states, if you're looking at New Hampshire, for example, we're about 10 to 12 points behind them on the, on the Medicare population. So, you know, this filing isn't for the Medicare population, but, for me, that's strongly indicative, along with the very low Medicare Advantage population, it's strongly indicative that in Vermont providers just haven't been, they haven't had the need to code to the full extent as they may have had in other states.

So, if you have a risk adjustment program that's supposed to work on a, that works to balance on a national level, even though some actuaries don't believe it even does that, when you come to a state like Vermont with a different set of coding patterns,

the risk adjustment numbers just aren't going to be high enough.

Based on some analysis I've done for internal work to think about, you know, What can we do about this? Are there opportunities here? I believe that, if we were able to get risk adjustment to kind of where it ought to be or where it was envisioned to be when the ACA was passed, then it would eliminate most or all of the rate difference between us and MVP.

MS. HOLMES: Well, that's actually interesting, and it leads to my second question. So, as you're losing market share and, if that trend continues, two questions: One, if you're losing market share, how does that impact your ability to cover your fixed costs, your administrative costs largely, and is a deviation in the administrative costs between you and your competitor going to grow, and what can we expect in the future?

And, second of all, if you, if Blue Cross Blue Shield continues to lose low-risk, healthier people and the risk adjustment doesn't fully one-to-one match that increased risk, what is the impact on solvency, and what has been the impact in the three years on your growing administrative costs and your declining solvency because of the loss of market share?

THE WITNESS: Yeah, you've put your finger on a key issue. I mean, I can't, I can't speak to what MVP is going to do in the future so I don't know how the relativity might change. But, yes, if we continue to lose membership, there will be upward pressure on our administrative costs. We do look at membership from an enterprise-wide basis when we make those adjustments in the filing. We don't look at it specific to QHP. So but, if the enterprise-wide membership goes down, then, yes, there's, there would be an impact, an upward impact, on administrative costs, on fixed costs.

And the, the second part of your question is, is also right on the money. So as, if we lose healthier members and risk adjustment doesn't make up for it, then, yes, there's a, there is an impact on our financial results, and, ultimately, an impact on our solvency for that.

MS. HOLMES: So, to some degree, the solvency issues that have been raised are, to some degree, a component or a result of lost market share?

THE WITNESS: To some degree, yes.

MS. HOLMES: Okay. Then I guess then, on that note, I'll have some other questions for Ruth related to that as a vision for your future, but I

won't ask you to do that.

THE WITNESS: Okay.

MS. HOLMES: But you brought up coding growth, and I'm wondering. I mean, coding growth has come up in multiple contexts now in this hearing, and I'm thinking ahead about, as we move from fee-for-service to capitation as we're all hoping to do in this all-payer model, what happens to providers' incentives to code accurately? And my sense would be that, actually, we'd see coding shrinkage, because, if you're getting paid a capitated amount, there's less incentive to code for every single item that you may get paid fee-for-service for. How does that -- is my assumption there correct? Incorrect? What should I be thinking about there?

THE WITNESS: Interesting question. I see it as the opposite. So, when you're in one of these payment reform type models and for particularly an ACO, the ACO is going to do a lot of work to kind of compare providers, right? Their contract with us is such that, if there's shared savings, they get a check. They need to figure out what to do with, like, which providers are responsible for generating those savings or the opposite, if they fail to meet the targets, which providers were really driving that result?

So in typical models such as that, you will see the ACO itself will do a lot of comparison of different service areas or different provider groups, and risk adjustment is a key component of those comparisons. When you start to get to, like, really small populations, it's, it's very important to be able to, to assess a -- you know, you have two different providers. Their panel might look the same, but one might have a much sicker population or a much more -- you know, even if they both have the same number of diabetics, the severity of one provider's diabetics might be much different.

So my understanding nationally -- I can't speak specifically to what OneCare is doing, but nationally what is typically done is there is a risk adjustment component to that kind of outflow of, How do we take that overall result and then send it out to specific providers? So, because of that, providers are judged based in part on accurate coding, right? Because, if you have, if you have a population that's less healthy, be just don't reflect that in the coding that you're doing, you don't get credit for it in that financial arrangement. Whereas, if you capture everything appropriately, then you know you're getting full credit for it, and you can feel that you're getting the right

kind of share of that savings or risk.

MS. HOLMES: Yeah. Okay. Well, that will be interesting, because, anecdotally, I'm hearing from providers less incentive to code extensively.

THE WITNESS: Well, I hope not.

MS. HOLMES: But I hear what you're saying, and it makes sense, and I think it's a fair question, and we'll see as we move that way. And this is actually related to Robin's question. Last year's we've talked about and you've referred to the Board cut the rate request by 1 percent for affordability, and it looks like, from what you described and what I gleaned from the filing, that, effectively, you are baking in that 1 percent reduction into the rebase for 2019, '20 trend. So it's as if there was no reduction, there were not cost-shaving measures done by Blue Cross Blue Shield in '19 to '20.

But then it looks like from '19, '20 to, '19 to '20, rather, sorry, '20 to '21 your prediction is that you're going to have 2.5 percent cost-reduction savings. So, in fact, I mean, the Board wasn't too far off in an estimate of what the potential cost savings could be generated by initiatives taken by Blue Cross Blue Shield. In fact, we were off by a little bit, because you got 2.5 percent, and you only asked for 1.

Would that be right? Just asking.

THE WITNESS: I agree with all your facts. But so I just want to make it clear that, when I'm preparing these rates, I do so on the basis of programs that are in place, okay? So, as it relates to whether that 1 percent is in or out, I, when I'm coming up with 2020 premium rates and my team's helping me with that, that's on a stand-alone basis. All of this rate increase stuff that we do is kind of after the fact, right? Because we're comparing what were the 2019 rates compared to the 2020 rates.

First, I come up with 2020 rates based on programs that are actually going to be in place by 2020 and all the assumptions that we talked about. Step two is compare that to what happened in '19 and calculate this percent change. So that's kind of a construct. What I'm really trying to do is what's happening in 2020.

So, when the Board, the Board's 1 percent for affordability was an additional 1 percent into the 2018 to 2019, right? So, when I prepared the 2019 rates last year, that already had a number of cost-savings measures as well, and I don't remember the number. I think it was actually bigger than 2.5. And all those programs that were going to be in place by 2019 were already baked into rates.

So, when the Board said find another 1 percent, you didn't say find another 1 percent for 2020. You said find it in 2019 for a program that doesn't already exist. That, that's really hard to do, right? Because we're, you know, we are in a competitive position. As you noted, MVP's rates are lower than ours. We're already doing and trying to implement everything we reasonably can that does not unduly reduce access to care and will result in lower premiums.

So, if you had said find another 1 percent by 2020 last year, we would say, Yes, we will gladly do that, and, matter of fact, we have found 2.5 percent additional for 2020. So --

MS. HOLMES: Got it. And my last question to you has to do with the unit costs of your utilization assumptions that you're making. So you described today -- in part, this relates to Green Mountain Care Board regulated versus non-Green Mountain Care Board regulated providers. So what I heard today, which I don't think I saw in the filings which was interesting to me, was the 51 percent was the Green Mountain Care Board, but then you broke out the non-Green Mountain Care Board, 34 percent being providers that you contract with but are outside of the Green Mountain Care Board regulatory process and then 15 percent

sounds like it was out of network, don't contract with directly.

So I'm wondering if you might be able to -- and, if you don't have it right now in front of you, that's fine, but maybe you could follow up with a breakdown of the unit costs and assumptions for those three categories and the utilization assumptions for those three categories, and, in particular, I'm really interested in -- my understanding is that there has been a growth in expenditures outside of the Green Mountain Care Board purview, and, also, if you happen to know about that, I'd love to hear about why you think that's happening and what's driving that and what is the cost structure outside of the Green Mountain Care Board?

THE WITNESS: Yeah, another very interesting question. So, so, first, the 15 percent, I just want to clarify a term. You mentioned that was out-of-network. That's not -- so it's still within our network. Those providers are within our network, but we don't contract with them directly. Members are able to access those providers through BlueCard, which is an arrangement with all the other Blue plans in the country. We're able to sort of piggyback off of the contracting efforts that they do in their own states.

MS. HOLMES: This is like I'm on vacation in Florida and I break my leg. I go to a Blue Cross Blue Shield networked provider?

THE WITNESS: Yes.

MS. HOLMES: Okay, got it.

THE WITNESS: But not a Blue Cross Blue Shield of Vermont network provider.

MS. HOLMES: Vermont? Great, okay, yeah.

THE WITNESS: Right, yeah. And what we've -- we have absolutely seen -- I don't have a specific breakout for you on the utilization, but we are definitely seeing increased utilization of out-of-state providers. We actually saw a lot of care go to Massachusetts within the last year.

MS. HOLMES: Yeah?

THE WITNESS: Much of that looks like it's appropriate. We have some, some cancer cases that are really better treated at some of the big facilities in Boston than they can be here, and so you have some very high-cost patients kind of moving down to Massachusetts. That's, that looked like the bigger driver when we dove into it, because that is something that we noticed in preparing this year's filing. We wanted to really dig in and understand if that was, you know, what's going on there? Is that appropriate? Is

it not? Is it going to continue to be a driver?

You'll note I did not list that as an ongoing driver of trend. So we're not assuming there's going to be some sort of continued increase because of that. But we've, we've certainly seen an increase in care taking place outside of Vermont for this population.

MS. HOLMES: So do you think you'll be able to follow up with those breakdowns -- is that a possibility -- of unit costs?

THE WITNESS: Unit costs, absolutely. Utilization is a little bit harder, just because it's -- you know, so the, the way we looked at that out-of-network care is it's kind of embedded in all the other factors. We didn't necessarily break that out and say, Oh, well, that went up by 40 percent, and we think that's going -- so, essentially, our utilization assumption is that everything both in Vermont and outside will be going up at similar amounts. So I can't really give you a specific utilization number, but I could definitely get you the unit cost assumptions.

MS. HOLMES: Okay. That's fantastic, and that's it. Thank you.

THE WITNESS: You're welcome.

MS. USIFER: Okay. Good morning.

THE WITNESS: Good morning.

MS. USIFER: Just looking at your information here on Page 19 of Exhibit 1, going to have some questions on the exhibit. When you looked at the impact of changes in benefits and you looked at, you removed claims above $500,000, what about using a different threshold? If you had used $100,000 or $250,000, I mean, how would that impact? And I guess why $500,000? That seems to be pretty high, and do you have many claims over $500,000?

THE WITNESS: We do have claims over $500,000. The reason we chose that is we looked at the distribution of claims kind of on a year-over-year-over-year basis, and claims under $500,000 tend to be distributed pretty similarly from year over year, but then, when you get to the $500,000 and above mark, you start to get these sort of bizarre lumps and outliers, and one year we might have a whole handful of claims between 500 and $600,000. The next year we don't have any, but we have a number of claims at 750. So the progression is smooth up to $500,000, and then it gets lumpy afterwards.

MS. USIFER: It seems like 250 would be like a high number to get claims, 250.

THE WITNESS: Well, it could be. I mean, so

one thing to keep in mind is for our reinsurance, our corporate reinsurance, we set that at $800,000. So that, that's an even higher number where we get the reinsurance.

MS. USIFER: Okay.

THE WITNESS: And it should, to answer your other question, I'm sorry, it was, if we change that from 500 to 400 to 300, it's not going to be extremely impactful on the actuarial value. There will be some subtle differences, but it wouldn't be hugely impactful.

MS. USIFER: Okay. Next, looking at Page 32, I was really interested in this impact of the enforcement of the Medicare B, and, you know, it looks like in the prior periods, and I don't know how far back this goes, you've been absorbing costs that really should have been occurring, you know, been going through Medicare B, and it was, like, $2.5 million, and your systems are now able to pick this up, and I guess a couple questions would be, Are there anything else out there like this that we can expect in the future? You know, why didn't we know about this in the past?

And, you know, it's something that the shareholders or the policyholders have borne, and $2.5 million is pretty significant on $300 million in, you

know, claims, and, just, can you talk a little bit more to it and what happened and --

THE WITNESS: Sure. It's about a .7. My understanding of how this came to light is that we had a member who went to the other carrier and then quickly came back, because the other carrier administered it differently than we did. So that's what shed the light on it, and it's also something -- you know, we, I've talked about the operating platform transition to the new platform. So it's something we were also able to see as part of that transition. But this is something that the old platform kind of fell short on. So I agree. It's $2.5 million, about .7 of rates, and we wish we could have seen it sooner.

MS. USIFER: And has that happened year over year? So it's been --

THE WITNESS: Yeah.

MS. USIFER: -- something that's been ongoing and just never picked up?

THE WITNESS: Yes.

MS. USIFER: So I guess I would just question, make sure we look for anything like that in the future, because that was obviously something that was impacting, you know, your numbers. And how did that then reflect in the new rates? So you have a .7

percent reduction.

THE WITNESS: Correct.

MS. USIFER: Because this was based in your --

THE WITNESS: Correct. So that $2.5 million was in the experience period. So, when we project out to 2020, we wanted to remove that, because it won't take place in the projection period, and I agree with you. We want to make sure nothing else like that exists.

MS. USIFER: Right.

THE WITNESS: And we, you know, we did go through this OPT process that really went through absolutely everything in terms of how we administer claims. So we, we don't believe there's anything out like this outstanding, but, of course, we will continue to do hard work to make sure that we're paying accurately and appropriately.

MS. USIFER: Okay. It just seems like, when you're in a network of Blues, too, that one of the Blues would say, Hey, make sure you're looking for this, or, hopefully, you guys told everybody else make sure, you know, you're looking for these things so that people capture them.

Okay. On Page 37 when you talk about the fraud

and waste, you know, what other, I guess, if you had to make an estimate, how much fraud and waste do you think is out there? I mean, obviously, you're getting back about a percent, but, you know, what's out there? How do we get more of it? You know, because we know it exists.

THE WITNESS: I know those efforts are underway. We've recently contracted with a, with a national firm to take a look specifically at our fraud, waste, and abuse efforts to see if we could get more out of this program. I'd like to think, and I think providers would say the same thing, that we hope there's not a whole lot more of this out there, but there probably is some small opportunity, and we will continue to, to work with, with outside consultants to make sure that we're maximizing our efforts here.

MS. USIFER: Okay. And then on the next page, Page 28, when you look at the utilization trends and inpatient at zero percent and the past three years it was 1.5 percent .1, and minus 1.3, which I applaud. Those are a lot of efforts to get people out of the inpatient, and so we're seeing the professional go up to the 5 percent. You know, why wouldn't we assume that trend will continue to go down and rather than average it at zero when, for the past three years, it's

progressively gone down, and that's the intent of a lot of work that's being done is that that would be lower, and you haven't picked up the flipside, which is professional going up? You know, question --

THE WITNESS: Yeah, it's a good observation. We applied a whole bunch of statistical methods to this, and we found some produced a positive trend and some produced a very slightly negative trend. Some of the numbers were larger. Really, if you take a look at an average of all the ways we looked at it, it really oscillates very closely around zero. So we think zero is a good answer, and L&E, in part of their opinion, agreed that zero was a good answer for inpatient trend.

MS. USIFER: Do you have an early read on 2019, what's going on?

THE WITNESS: I'm afraid I don't. Sorry.

MS. USIFER: Okay. And then in Exhibit 10, Page 2, you haven't really talked about the AMT credits, and, you know, we did bring that up, obviously, last year in discussions of the 2019, assuming you would be most likely getting $17.9 million. What's the confidence level now that you will get that, and, you know, how does that reflect in your CTR and passing that through? So, I guess, you know, how do we look at this $35 million? And before there

was some uncertainty that it would be received, but now we're getting close to --

THE WITNESS: We're getting close. It's not yet a done deal, but we will be filing, I think, shortly in an effort to receive these funds. In terms of how it's considered, that is on the record, and I think Ruth will be testifying to this directly and can probably expand upon my answer to your question. But I'm looking at Page 128 of our original filing.

So it's Exhibit 1, Page 128, and it's part of the chart kind of in the middle of the page. You can see that we are including the $17.9 million in 2019, the $8.7 million expected to be received during 2020 as part of our movement to get into the range that's been ordered by DFR. So we, you know, looking at that, kind of the upshot of this is that, by using those AMT credits and putting them into surplus, we don't have a need to increase CTR to try to get into surplus. If we were trying to get to the same position by using CTR, we would have had to file a CTR of 7 percent.

MS. USIFER: Okay.

THE WITNESS: It's kind of a scary number. But, because of the AMT credits, they're able to be included in our plan to get into the RBC range that's been ordered.

MS. USIFER: Okay. And, because you brought us to this page, this may be something more for Ruth, but can you -- the RBC position as of December 31st was 495.

THE WITNESS: Yes.

MS. USIFER: And what was your target range at that time, December 18th?

THE WITNESS: At that time, it was 500 to 700.

MS. USIFER: Okay. Just because there's been a lot, you know, presentation before of how in the past four years you've missed CTR extensively and all the impact that would have. Yet, with all that, you know, we still -- I would look at that as a pretty good on the very, very low end, just slightly below but at 495 and, at the time, you know, knowing there may be quite a bit coming in with these reserves for the AMT. So --

THE WITNESS: Yeah.

MS. USIFER: I just want to point out, because there's been a lot of discussion about how the rates that we've done over, you know, the past four years and the changes in CTR have made such a significant impact, but, you know, I look at that you ended up on the low end with lots of pluses and minuses.

THE WITNESS: Well, true, and, in isolation, you know, for the reasons you indicate, maybe 495 doesn't look so bad, but, when you consider we started at 660 about three years ago, that, that tendency, which is probably something you hear from DFR, is pretty scary.

MS. USIFER: Sure. And the 660 was paid through by policyholders at some point to get up to 660?

THE WITNESS: That's right.

MS. USIFER: Yeah.

THE WITNESS: Yeah. Which is still, was within our range at the time and will still be within range, yeah.

MS. USIFER: Right, okay. And then, on Exhibit 14, Page 2, and this really goes to, you know, how you guys can remain competitive. I mean, you're our Vermont provider, you know, here in Vermont, and, when we look at, you know, obviously, these are not rates that have been approved right now, but the MVP rates in 2020 were 12.6 percent below on average. So they were 509 versus 573, and for 2020 the gap is now 18.9 going 556 to 662.

That's going to change with risk adjustments and things like that, but it just continues to go in the

wrong direction, and I heard what you said about the risk, you know, adjustment, because it seems like, in theory, that should be making it closer so that it can be more competitive, and so it, you know, just, it's such a challenge to continue with that, you know, process, and, and, you know, how do you look at that?

THE WITNESS: It absolutely is. I think it's worth noting that, even though our membership has been going down, we still have almost two-thirds of the market despite that 12.6 percent disadvantage, and I, I attribute that to, if you're going to use the health care system, you want to be with Blue Cross to help you, to help to guide you through that system. We have world-class customer service that we're very proud of, and I think members appreciate that, and that's why they continue to buy our products, among other reasons, of course.

I, I completely agree that the, you know, this continuing to move in the wrong direction is not tenable. I noted that there was a recommendation that MVP increase their rate and increase their utilization trend from zero to one. I don't want to comment too much on MVP's rate. I'm certainly not an expert in it.

MS. USIFER: Yeah, no.

THE WITNESS: But it's disturbing to me that

there's such a wide disconnect between what we think underlying utilization trend is, because utilization trend, even for us as well, we've normalized for all population changes. So we see that as the true underlying utilization trend in Vermont, and we have an awful lot of data to back that up.

So it is a little distressing to me that we have another carrier coming in with such a low number that, frankly, for me actuarially, for our population 1 percent would absolutely not be a reasonable utilization trend. I don't know whether it is for theirs. L&E, I'm sure, had a more expert opinion on that than I could possibly offer.

So, yes, we are disturbed by this, and we're alarmed by it. We don't want to see membership continue to move to MVP, which is why we have a lot of initiatives in place to try to increase affordability, and, quite frankly, we have initiatives in place to try to do something about risk adjustment as well, because we, we see that there's a lot of opportunity there to balance the playing field, and we really need to dive in and start working closely with providers in order to be able to do that.

MS. USIFER: And, just last question on admin costs and your increases, I mean, what opportunities

are there to cost save in the admin costs? And, you know, if your numbers continue to go down, you know, how do you then cut some of the fixed costs or look at that or, you know, get the membership up elsewhere? Because it's, that continues to be going up significantly year over year.

THE WITNESS: Yeah. It's a very good question. If you don't mind, I'll defer that to our CFO.

MS. USIFER: Okay, all right. I'm all set. Thanks.

THE WITNESS: Sure.

CHAIRMAN MULLIN: So, Mr. Schultz, do you think that being a Blue gives you a competitive advantage or disadvantage as far as the rates that are being paid when someone is, is utilizing services that are outside of those contracts that you negotiate?

THE WITNESS: I believe it's a competitive advantage.

CHAIRMAN MULLIN: Is there any industry analysis that would compare, for example, Blues versus Cigna versus others that would have a national network that would show that to be the case?

THE WITNESS: There may be, but I'm not aware of where I could point you to for that information.

It's, most of that is highly proprietary. So it's not really likely to be found in the public domain.

CHAIRMAN MULLIN: Which is why I'm trying to get my hands on it.

THE WITNESS: But, yeah, I'm sure a study could be commissioned and probably has, but I don't know that it's publicly available.

CHAIRMAN MULLIN: Okay. What, what are you doing to try to make sure that those contracts that you negotiate that are outside of the, the boundaries of the State of Vermont are kept within meaningful growth?

THE WITNESS: I think Mr. Garland will be in a better position to answer that question. I don't do the negotiation.

CHAIRMAN MULLIN: Okay. That's fair enough. Would you agree that the $17.9 million was a nonadmitted asset at the time of your filing?

THE WITNESS: Yes.

CHAIRMAN MULLIN: Okay. And, had that been an admitted asset, it would have created a 573 RBC?

THE WITNESS: That sounds about right. I would want to refer back to Page 128. Yes, 573 looks like the right number.

CHAIRMAN MULLIN: Thank you. That's the only questions I had.

THE WITNESS: Very good.

MR. BARBER: Were there any other questions from the Board?

MS. LUNGE: I have one follow-up. Mr. Schultz, you just testified that you're working on initiatives to balance out the risk adjustment. Could you explain what those are?

THE WITNESS: Yeah, so we worked in the past year with an actuarial consulting firm to have them come in and assess what we're doing from a coding perspective, what we're seeing. So let me back up a second, I guess. So, as part of the ACA, there is an opportunity to kind of go back in after the end of the plan year and look at provider charts to make sure that everything in the chart has been captured in the claim. So we've been working with an outside firm to kind of gather that chart information and do those assessments, and we've been doing that for a while.

That's certainly not unusual. Most carriers will do that. We've found that that hasn't been as impactful as we would have liked. In other words, we still believe that there's a lot of risk adjustment out there that we could work towards. So we did work with a consulting firm to try to better understand what those opportunities are.

So there are some efforts we're going to do internally and outward-facing. The biggest one is we need to find a way to really do effective provider education. It seems pretty clear that we have the, the much less healthy and far older, frankly, population than our competitor. So, if, you know, if we're able to make coding better for everybody, even if that also impacts the competitor, that's going to reflect itself in a much larger risk adjustment number.

So we're still kind of working through a lot of details of our plan of attack, but one of the main components has to be, and will be, provider education and outreach to try to make sure that all that, all the appropriate information is captured. These efforts aren't, they're not, they're not maximization efforts. It's really optimization. We want to make sure all the right conditions are captured and none of the wrong ones are captured. So it does go both ways, but we think, looking at the data, that these efforts could be very impactful.

Now, naturally, it's going to take a little while to kind of change the way that providers are tracking information in the state. So we don't think there's -- you know, it's going to take years to kind of get to where we need to be, and we'll try to accelerate that

as best we can, but that's kind of the nut we're trying to crack.

MS. LUNGE: Thanks.

MR. PELHAM: One follow-up. I appreciate on your chart -- it's in Exhibit 18 -- where you're looking at the proposed hospital budgets and then kind of give an indication of what, if those were accepted as real, it would be half a point --

THE WITNESS: Right.

MR. PELHAM: -- and then trying to factor that back a little bit to kind of actuarially value our input, and it comes down to a rough .3, but I'm still worried about looking at things in the future when most of your presentation is about things in the past and nailing those down as solidly as you can and then projecting them forward.

For example, in the hospital budgets, about 35 percent now of the revenue in the hospitals comes from Medicare. The QHP population has no Medicare people engaged in it, has no Medicaid people engaged in it, and the, the share of Medicare has been growing as a percentage of the total almost by a percent a year. So it just seems to me that it's, it's a stretch to kind of reach forward into the future that doesn't exist yet with hospital budgets that are much different than the

QHP population, and I'm just wondering, How deep has your dive been into those hospital budgets?

THE WITNESS: So the, the hospital budgets do all include a commercial rate increase. So I'm less worried about what their total revenue target is as I am those commercial rate increases, and, when those are approved, we find that hospitals are not willing to move off of that. So that's been a really good indication over the last several years of what the unit cost increases will be at those facilities.

So we, I mean, I'll, I want to be clear. We didn't do a lot of -- we don't do any analysis about what's the growing or shrinking percentage of the government programs or the cost shift and things like that, but we would anticipate that the hospitals will have done that analysis in coming up with their commercial rate ask and that the Board will do a similar analysis in deciding whether or not to approve those commercial rate asks.

So the, the difference the .4 factor that we've observed in the past, again, that's a factor on the commercial rate. It's not necessarily the factor on the revenue target, because, to your point, that may not affect us, but the commercial rate absolutely does. So that, that's what we're worried about on this

exhibit, and past experience has shown that we've, you know, this is a very good indication of what the final answer is going to be.

Now, the you, as the Board, may decide you're going to be even more aggressive in cutting hospital budgets or less aggressive than you have been in the past, and I, again, I'm confident that you'll be able to express that or to use that information in what you order us in terms of unit cost increases.

MR. PELHAM: Thank you.

MR. BARBER: Okay. Any redirect, Mr. Donofrio?

ATTORNEY DONOFRIO: Not at this time, thank you.

MR. BARBER: You're excused. Thank you.

THE WITNESS: Thank you.

MR. BARBER: You can call your next witness.

ATTORNEY ASAY: Blue Cross calls Ruth Greene.

DIRECT EXAMINATION BY ATTORNEY ASAY

Q. Ms. Greene, would you please start by stating and spelling your name for the record?

A. My name's Ruth Greene, R-U-T-H G-R-E-E-N-E.

Q. What is your position at Blue Cross?

A. I'm the Treasurer and CFO at Blue Cross Blue Shield of Vermont, and I've, I've been in that position

for about 6.5 years.
Q. What are your responsibilities in that position?
A. I'm responsible for overseeing all the financial management functions of the company, including the treasury, financial reporting and controls, actuarial analysis, as well as the premium pricing.
Q. Is your CV attached to Exhibit 13 in Binder 1?
A. Yes, it is.
Q. We'll skip over your background information. Ms. Greene, what is Blue Cross Blue Shield of Vermont's mission and vision?
A. Blue Cross, at Blue Cross Blue Shield of Vermont, we are committed to the health of Vermonters, outstanding member experiences, and responsible cost management for all the people whose lives we touch. Our vision is very much for a transformed health care system in which every Vermonter has health care coverage and receives timely, effective, and affordable care.
Q. In your view and based on your experience, is Blue Cross Blue Shield of Vermont's business guided by its mission and vision?
A. It is, very much so.
Q. Is it a for-profit company?
A. No, it is not.

Q. When Blue Cross Blue Shield of Vermont submits a filed rate for approval, does that rate include any profit?
A. It does not include any profit.
Q. In your role as Treasurer and CFO, are you familiar with Blue Cross Blue Shield of Vermont's overall financial health?
A. I am familiar with Blue Cross's overall financial health.
Q. Would you please describe that for the Board?
A. I would like to do that, and I can refer to the Exhibit 21 in Binder 2, which is the five-year history.
Q. So that's on Page 68 of Binder 2, Exhibit 21?
A. Yes, it is. It's the five-year historical data as submitted by, annually as part of the statutory filing. I'd like to just make a few observations about the financial health of the company. Start with Line 9, which shows the net underwriting gain where three out of the last five years we've had underwriting losses, which, as Paul Schultz testified earlier, when we price and set premiums for the products that we offer, we target a contribution to reserves of 1.5 percent, and you can see that, in the actual results over the last five years, we've had two years of positive results and three years of negative results, and the negative

results have been minus 3 percent of premium. So, instead of having a 1.5 percent contribution to reserves, in both 2016 and 2018 we've actually depleted reserves by 3 percent.

A couple of other observations I'd share is our total adjusted capital on Line 14. This is the statutory label for what we refer to as member reserves or, in some of the reports included in the record, it's referred to as surplus. That surplus has gone down 20 percent from $138 million down to $110 million at the end of 2018, and we've also seen a slight reduction in member months, which is shown on Line 17, and the comments earlier about declining market share, especially in the QHP market, is the driver of that.

And then, finally, I'll just point out that, despite the reduction in members, we still have had an increase in the total revenues on Line 5, which is a function of the increasing premiums, and that is the reflection of the premiums that we insure for the market. So, overall, the financial position of Blue Cross Blue Shield of Vermont in the grand scheme of things in terms of solvency has reduced over the last five years.

Q. Based on Blue Cross Blue Shield of Vermont's historical experience, would you say that the losses

experienced in the past five years are significant?
A. I would say that they are significant. It's not unusual in health insurance to have some years where you're higher or lower than your assumed prices and premiums in the market, but to have two years in the last three that were exceeding $10 million, it is unusual.

I will note that in the 2018 column the $15,000,492, if we were to reflect the 2018 final risk adjustment number that Paul mentioned and testified to, that loss is reduced to $7 million, but still it's significant to have three years with, with that level of loss and depletion of reserves.

Q. So you referred to the depletion of member reserves. Could you please describe briefly for us what member reserves are?
A. Blue Cross Blue Shield of Vermont is required to pay claims no matter what. So, when we sell a policy to our qualified health plan members or an individual small group, we promise to pay claims no matter what. So member reserves or, as in this exhibit labeled "Total Adjusted Capital", those member reserves are funds held to make sure that we can do that.
Q. When Blue Cross suffers a loss such as the underwriting losses that you've just described, where

does that money come from?
A. It comes out of member reserves.
Q. What's the importance for an insurance company like Blue Cross of having reserves?
A. Reserves, member reserves are a very important element of being sure that we can pay those claims no matter what. There will be situations where our estimates of the claims cost in a rate filing turn out to be different than we projected. If there's a increase in utilization that's unexpected, that would need to be funded by reserves. If we have an unexpected change in federal fund flows which we've experienced in the past, those reserves would also provide that insulation, if you will, to the financial solvency of the company. We also have to make sure that if there are any other unexpected events such as flu pandemics or other types of costs to be incurred as we pay our members' health care claims.
Q. Could you please briefly explain the term risk-based capital and its connection to member reserves?
A. Risk-based capital is a measure. It compares the total reserves that a company has to what's required. So it's a measure as to whether or not an insurance company has enough reserves.

Q. And is that figure based on methodology from the NAIC?
A. Yes, it is. It's a, National Association of Insurance Commissioners sets out for all insurance companies, medical insurance companies, what they're required to hold for a minimum level of reserves, and the risk-based capital ratio compares your actual reserves to that level, and the various stakeholders in our financial strength, whether it's the Blue Cross Association or the Department of Financial Regulation, that ratio is, is something that can be used to determine whether or not a company has enough reserves.
Q. And are you familiar with what the current risk-insured figure is for Blue Cross?
A. Yes. In fact, that, that minimum number is also included on Page 68 of the exhibit. It's Line 15. It's called authorized control level risk-based capital, but that $22 million is the calculation that's dictated by the National Association of Insurance Commissioners.
Q. And does Blue Cross have to meet regulatory requirements with respect to the overall risk-based capital measure?
A. Yes, we do. In February of this year, the Department of Financial Regulation issued an order and,

that our risk-based capital ratio should be managed to a range of 590 percent to 745 percent, and, to the extent that we do not fall in that range, we're required to submit a plan to the Department to outline how we will get back within the range and within a reasonable timeframe.

Q. As of the end of 2018, what is Blue Cross Blue Shield of Vermont's risk-based capital measure?

A. It's 495 percent.

Q. Is that within the required range?

A. No, it's below the range.

Q. What was the dollar amount of Blue Cross Blue Shield of Vermont's reserves as of the end of 2018?

A. $110 million.

Q. If you could put that figure into some context, how long could Blue Cross pay claims out of those reserves?

A. Blue Cross, with that $110 million, Blue Cross could pay claims for a little less than three months.

Q. Can you put that number in context of your reserves per member?

A. Yes. Another way to look at that would be, for every member, we have about $550 of reserves at the end of 2018.

Q. Could you please explain why Blue Cross's reserves

have dropped to this point, to the measure of 495?
A. Blue Cross Blue Shield of Vermont's reserves have dropped over recent periods mainly due to the underwriting losses. We had, as I mentioned earlier, three out of the last five years with underwriting losses, and the, the reserve, that comes straight out of reserves, and so that will reduce the member reserves as used in the RBC calculation. We've also been unable to have fully funded rates over the last several years, and that combined with an environment of increasing utilization trend has really depleted the reserves.
Q. Do you have a figure for the, for the loss in the individual and small group markets since 2014?
A. Yes. I, the, the information included on Page 68 in the five-year historical data is for the entire company. In the Exhibit 1, sorry, Exhibit 1 of the other binder with the actuarial reserves on Page 17, this was the exhibit that Paul provided an update, but, before the final 2018 risk adjustment calculation was included, since inception, it says here on Page 17, the individual and small group segment lost over $30 million. If we were to take the $8 million that Paul mentioned earlier, it's still an accumulated loss of over $20 million, $22 million.

Q. And has that had an impact on Blue Cross's member reserves?
A. Yes, it has. That -- excuse me. The $30 million loss has depleted the reserves. That's where it comes from when the loss occurs.
Q. Ms. Greene, in your role as treasurer, did you direct Mr. Schultz to include a contribution to reserves of 1.5 percent in the filed rate this year?
A. Yes, I did.
Q. Is the basis for that decision discussed in Binder 1, Tab 1, Binder 1, Exhibit 1, at Page 126 to 129 and also in your expert report which is at Exhibit 13?
A. Yes, that's correct.
Q. In your view, is a 1.5 percent contribution to reserves adequate and not excessive?
A. Yes. Outlined in the, the memo to Paul on Pages 126 to 129, we outlined our rationale for directing Paul to use a 1.5 percent CTR. The CTR of 1.5 percent is adequate and not excessive. It's an amount that just is intended to maintain reserves in a normal period of growth and cost trend. We, from a financial perspective, Blue Cross Blue Shield of Vermont believes that, if we maintain a consistent, a modest and consistent CTR, contribution to reserve, over time and not sort of increase it or decrease it based on the

previous year's results, that we would avoid adding further rate fluctuations.

So we use a 1.5 percent contribution to reserve across all of our lines of business. Some companies might add a higher CTR to their qualified health plan or exchange business because of a perceived higher risk, but we choose not to do that. We use the 1.5 percent CTR across all our lines of business. Finally, that is the CTR, or contribution to reserve, level that we included in the plan to move our RBC into the range required by the Department of Financial Regulation.

Q. So, looking at Exhibit 1 in Binder 1 on Page 128, does that page set forth Blue Cross's plan to move within the target RBC range?

A. Yes, that's the plan on Page 128, yes.

Q. Are there any updates to this plan that are based on information that was received after the filing?

A. Yes. Consistent with Paul's testimony earlier where he updated the 2018 individual and small group results for the final 2018 risk adjustment payment, the exhibit on Page 128, if we were to include that new information, it would add about 36 percentage points to the RBC, and so the position at the end of 12/31, or December 31, 2019, instead of being 579, it would be 615 percent, and then, likewise, if you flow that

through to the projection for the expected RBC position as of December 31st 2020, that 620 percent would be 656.

It's notable that, in the footnote to this plan, Footnote 2, that the consultant who did the RBC study did indicate that the point in the target range, the new target range, where we'd be least likely to fall outside of that range in a one-year period is 690 percent. So that 656 at the, expected at the end of 2020 is still below that level.

Q. Does the plan, Blue Cross's plan that's, that you've been describing for coming back within the RBC range account for expected federal tax refunds that have been discussed today?

A. Yes, it does, as outlined on Page 128. The 2019 AMT refund of 17.9 is expected to add 78 percentage points as the Q-and-A earlier noted, and in 2020 we expect to receive another $8.7 million in AMT credit refund for, to add 36 percent to RBC, and it's fortunate that our members have the benefit of these AMT credits such that we're able to move towards the ordered range without adding CTR, higher CTR to the premiums.

As Paul testified earlier, our, that is included at the top of Page 129 that, in the absence of those

credits, our CTR would have had to have been as high as 7 percent.

Q. I think Mr. Schultz alluded to this earlier, but, just to be clear, has Blue Cross received even a dollar of these AMT refunds yet?

A. We have not. We target to file our tax return by the end of this month, and then the IRS will forward us the actual AMT refund that's evident in that tax return.

Q. By adding the AMT refunds to reserves, does that protect against future rate increases?

A. Yes, it does. If we were not able to have the AMT credit refunds move us towards the new range, the premium rates would have to go up in order to achieve the new RBC range.

Q. Ms. Greene, could I ask you to take a look at Exhibit 23 from Binder 2, an exhibit that's been added today?

A. Sure. Yeah, I have that.

Q. Are you familiar with that document?

A. I am familiar with this document.

Q. Can you describe that for the Board, please?

A. This is an order from the Department of Financial Regulation that was received on February 15th 2018 regarding our request to grant permitted practice

relating to the deferred tax asset resulting from the elimination of the AMT.

Q. And can you describe, can you describe for the Board why this order was issued by DFR?

A. The order was issue by DFR as it says in the document, but I'll draw attention to a couple of key points. One is, when the tax jobs, Tax Cut and Jobs Act was passed at the end of 2017, it took the unprecedented action of eliminating the AMT, and it put in place a, a program, if you will, to refund the AMT credits to businesses over five years.

Statutory accounting principles, specifically SSAP Number 4, requires that we record only assets that are available for paying claims in our annual statements at the end of the year. So on Paragraph 6 you can see it summarizes pretty clearly that we are required -- the ability to meet policyholder obligations is predicated on the existence of readily marketable assets available for both current and future obligations, and it goes on to say that any assets that are not, cannot be used to fulfill policyholder obligations can't be recognized in balance sheet.

So it was deemed that the alternative minimum tax refund credits were over five years, and the permitted practice adjusts the annual statement requirement such

that those credits will be recognized when they're received.

Q. Thank you. Ms. Greene, are you familiar with the DFR opinion on solvency which is in Binder 1, Exhibit 15?

A. I am.

Q. And I know the Commissioner will speak to that and cover that in more detail, but, just briefly, do you agree with the urgency conveyed by DFR regarding the impact of nonactuarially justified downward adjustments to Blue Cross's rates?

A. I do.

Q. And do you agree with the conclusion of that report that, given the level of Blue Cross's reserves and current circumstances, a downward departure from the filed rate should be made with great caution?

A. Yes, I agree with that.

Q. Are you familiar with the factors that the Board is required to consider in reviewing Blue Cross's rates?

A. I am familiar with the factors.

Q. In addition, and, again, Mr. Schultz testified to this earlier just briefly, that, in addition to adequacy and solvency, the Board considers whether rates promote access to care, access to quality care

and are affordable?
A. Yes, the, the rates as filed satisfy and strike an appropriate balance with all of those factors, and, as mentioned earlier, those, those factors cannot be taken in isolation. They are interdependent and have to be taken together.
Q. In your view, if a rate is not adequate, how does that affect insurer solvency?
A. In, a rate that's not adequate means that the cost of care and the cost to administer that care exceeds the amount of premiums that are being collected to fund that care, and so an inadequate premium rate means that the contribution to reserve will be not met or, in some cases, will be negative, and it will deplete reserves. So the, the, an underfunded premium rate, by definition, will, that threatens an insurers's solvency will, by definition, not support affordable care and quality of care and access to care, because the, the ability for that insurer to provide access to care is undermined and is eroded over time.
Q. Are you able to address briefly for the Board steps that Blue Cross Blue Shield of Vermont takes to promote access to quality care for its members?
A. Yeah. Blue Cross Blue Shield of Vermont, Paul already went through many really good examples of that,

but we take numerous steps beyond the items already mentioned. We have a quality improvement program which, in part, focuses on member safety. We also have high-quality care management programs. We also work very hard to maintain a cost-efficient organization. Our administrative costs are very low by industry standard, and we believe that that also contributes to providing access to care and quality care.

Q. Mr. Schultz also testified earlier about affordability and a standard for affordability and the balance between affordability and the other standards that the Board considers. Could you provide your view on the relationship between affordability and access to care and quality care?

A. So there's an inherent tension between affordability of care and access to care. The Vermont policy has very high standards when it comes to access and quality of care, and so, to the extent that affordability and access very much there's a inherent tension in those two criteria, and so any rate reduction that's not actuarially sound or justified in the name of making things more affordable actually does nothing to reduce the cost of care. So the access and the affordability really play together.

Q. In your view, do the proposed rates meet the

criteria that the Board must consider in reviewing rates including that specifically the, the factors of solvency, access to care, quality care, and affordability?

A. Yes, they do.

Q. During Mr. Schultz's testimony, some questions about administrative costs were deferred for you. So I'd like to turn to that topic.

A. Sure.

Q. What percentage of the filed premium reflects administrative costs?

A. 7 percent of premium is administrative costs.

Q. How does that compare with other insurers?

A. When we do benchmarking of our enterprise costs with other insurers, the 2018 benchmark indicated that there was, on average, about 10 to 11 percent of premium in administrative costs. So our 7 percent compares very favorably. The L&E memo that is in Exhibit 14, they outlined some work, analysis that they performed. It's outlined at the top of Page 22 of Exhibit 14. They compared our administrative costs on a percentage of premium basis with 63 other plans. Based on that comparison, we ranked 50th out of 63, which meant that we had lower expenses than approximately 80 percent of those plans analyzed.

So we, we work very hard to maintain competitive administrative costs, and these, we have a number of programs internally. We have a, we call it a grassroots program called Blue Ideas where all employees can make suggestions for how to save money. We've had hard dollar savings of $4.7 million over the last four years from that program. We also are very focused on maintaining or retaining and training our staff so they can perform their roles as efficiently as possible.

Q. Recognizing that Blue Cross's administrative expenses are low, does, however, do you want to speak to the needs that Blue Cross does have for administrative resources and staff?

A. Yes, I would like to do that. The administrative costs are the resources and technology that is required to achieve many of the results that were discussed in Paul's testimony. So, to the extent that we have to find new lab benefit program management programs or work with the pharmacy benefit manager to improve rebates or find better ways to address the mental health services of our members by getting them access to the right care, all of those activities require expert staff and qualified staff, well-trained staff and technology. Even the risk adjustment and risk

coding work that we talk, that Paul talked about earlier does require that we spend time and money on achieving those results.

Q. Does the figure for administrative costs in the proposed rate assume a 3 percent cost-of-living increase for Blue Cross employees?

A. Yes, it does.

Q. Why is that increase justified?

A. The cost-of-living increase for staff is an important tool for Blue Cross Blue Shield of Vermont to retain qualified staff. We find that, if we were to have a higher turnover rate, it becomes very costly to retrain people and build that expertise over time. The cost-of-living increase is very much something that is dictated in large part by the competitive labor market and the need to attract talent to central Vermont to do our important work.

We had a look at the impact that, if we were to reduce the 3 percent merit increase or cost-of-living increase to 2 percent, it would have a very small impact on rates. In fact, it would have a .036 percent impact on rates, which is less than one half of one-tenth of a percent. So, if we eliminated the merit increase altogether and just had zero, it would have a .1 percent impact on the rate.

Q. You mentioned that the, the employment market is competitive. Do you have any examples of situations where Blue Cross has had difficulty filling a position?
A. We, we do have, as a matter of fact, in Paul's area we've been recruiting for a lettered actuary for over six months now, and we are finding it very difficult to find resources or candidates to consider. We also have, recently, we're, we had, in the last couple of years, been managing our total workforce to the level of about 440 staff members in total, most of whom which work in Berlin up the hill here, and, recently, we're down to about 415 staff members, and we have a number of vacancies that we're recruiting for.

We also, as an illustration of how important it is for us to retain staff, the, even the customer service representatives that are world-class and do a great job, they require a minimum of eight weeks of training before they're even able to take calls.

Q. You also mentioned retention as being important to Blue Cross's mission. Do you know what, how Blue Cross Blue Shield of Vermont's retention rate compares to other Blues?
A. Yes. Our, our turnover rate, I guess, is what we use internally is about 8 percent. So that would be a retention rate of 92 percent. That compares a little

bit more favorably than some of our other national Blue plans, which report in a survey that their turnover rate is about 10 percent or retention rate would be 90 percent.

Q. Staying on this topic of administrative costs, Board Member Pelham, I think, raised a question with Mr. Schultz regarding comparing the figure in Binder 2, Exhibit 21 on Page 21 with the figure in the filing for administrative costs. Is that something that you could address?

A. Sure, I can take that now, and then, if there's further questions, certainly able to respond. So this is Exhibit 21 in Binder 2, and I think the question was comparing the expenses that are on that exhibit to the actuarial memorandum that is in Tab 1 of the other binder on Page 52, my notes.

Q. Yes, that's correct.

A. All right. So the, as Paul testified, when we do the rate filings, we look at our total enterprise costs and how that's allocated to each of the segments, and the $79 million on Page 52 near the top of the page is the total costs that we would recognize as 2018 enterprise costs. The costs that are reflected on Page 21 of Exhibit 21 in the other binder is the statutory basis costs, and I think Tom mentioned that the

reimbursements by uninsured plans is a piece of that so you add that back in.

But there's also a few other differences between the exhibit on Page 21, and it also includes the federal insurer fee. It also includes broker commissions and a few other differences. So, if, and I'm happy to sort of follow up with an exhibit after the fact if it would be helpful, but I can cross-reference the -- I think it's $57 million of expenses on that exhibit -- back to the enterprise exhibit.

The enterprise costs would also include the costs for all of our entities, not just Blue Cross Blue Shield of Vermont, and the exhibit on Page 21 is just Blue Cross Blue Shield of Vermont. So it, the two numbers are aligned. It's just, from a statutory perspective, there's things that are added in. For example, they add in rent, but we don't pay rent, but the statutory accounting rules require us to impute rent as if we were renting the home office. So that would be an example of something that is a reconciling item between the two. So we can certainly provide a bridge for that right after the, the session.

Q. All right. Ms. Greene, are you familiar with AM Best?

A. I am familiar with AM Best.
Q. What is AM Best's connection with Blue Cross Blue Shield of Vermont?
A. AM Best is a rating company. They produce financial strength ratings. So, if you, people might be more familiar with Standard & Poor or Moody's as a financial strength rating company, company that will look at the financial performance of a particular company and give it a rating that's recognized in the marketplace in terms of how financially strong a particular company is.
Q. Is Blue Cross Blue Shield of Vermont required to have a rating of this kind?
A. We are required to have a rating. One of the Blue Cross Blue Shield Association requirements for us to license the brand is to have a financial strength rating.
Q. Why the does the association require these independent assessments?
A. The association, as in their role where they're ensuring that all of the Blue plans nationwide are strong enough to pay claims, this is a requirement to ensure that, even if a Vermonter was in North Dakota and used their Blue Card in North Dakota, they know that the North Dakota Blue plan is strong enough to

meet the, the claims payments for those services provided. So the, that's one of the mechanisms that the association has in place to make sure that the, the Blue provider network or the Blue Card network is robust and has strong financial underpinnings.

Q. What kind of investigation does AM Best do to support its rating and outlook for Blue Cross Blue Shield?

A. AM Best performs a thorough review of our financials. They send to us each year a long list of everything they'd like to hear about, both in terms of our financial plans, our financial results, our corporate reinsurance. They like to look at our product development and our future business strategies, and they, we provide that information to them, and, annually, they spend the better part of a whole day walking through all of that with us, usually in November or December each year, and then in, they look at the end-of-year results, and then in the late winter or early spring, they will issue their updated financial strength rating.

Q. Is that rating an independent review?

A. Yes, it is.

Q. Based on your experience in this field, is AM Best generally recognized as having expertise in this field?

A. Yes, AM Best is generally recognized. They tend to specialize in insurance company financial ratings.
Q. Do financial services entities like banks and lenders rely on their opinions?
A. Yes, they do.
Q. If I could refer you to Exhibit 16 in Binder 1, is that AM Best's announcement of its rating and outlook for Blue Cross for 2019?
A. Yes, Exhibit 16 is their announcement. AM Best, any time they make a change to a rating, they're required to issue a press release.
Q. Was there a change this year in AM Best's valuation of Blue Cross Blue Shield of Vermont?
A. Yes, there was a change. As noted in this press release, they changed our long-term insurer credit rating to, the outlook they changed from stable to negative or to negative from stable.
Q. To your knowledge, has this happened before?
A. We've had this financial strength rating process in place since 2003, and this is the first time that there's been a change.
Q. Did AM Best explain the basis for its decision?
A. It did, and, as outlined in the note, it was mainly, sort of partway down, third paragraph, it talks about reflects AM Best's expectation that our

risk-adjusted capital, which, again, I mentioned earlier as the member reserves, will remain under pressure in the medium to long term, and our capitalization has deteriorated.

They go on to talk about the fluctuation in underwriting losses, referring to them as sharp losses in underwriting results, and at the top of the second page, they specifically say the unfavorable underwriting results over the past four years have been caused primarily by Blue Cross Blue Shield of Vermont being unable to receive adequate rate increases approved through the State's rate review process.

Q. In other words, premiums have been too low?

A. Correct.

Q. Was that a conclusion that AM Best reached independently of Blue Cross?

A. Yes.

Q. So, just to wrap up, I want to just go back to, close where we started. The filed rate this year assumes a 1.5 percent CTR, right?

A. Yes, it does.

Q. In your opinion, if the Board makes downward adjustments to the filed rate that are not actuarially justified, what will happen to the CTR?

A. When the actuarial results are known, the CTR will

be below the target level, and it may well deplete reserves if the results are significantly higher than that.

Q. So, for example, if the Board approved a rate that, on its face, assumed a 1.5 percent CTR but reduces other assumptions in a way that turns out not to match experience, will Blue Cross be able to make the contribution to reserves?

A. It will not have a contribution to reserve, because, after paying for the health care services of the members and the cost to administer the plans, there won't be any money left to contribute to reserves. So it will, in fact, be a lower or negative, possibly negative CTR.

Q. And, to put some specific numbers on that, what would be the result of a 1 percent underfunding of the premium?

A. A 1 percent underfunding of premium translates to about a 3 percent depletion of reserves, and the reason that is such a stark comparison is that the individual and small group business is a significant portion of our book of insured business, and so, with 300-plus million of premium, if we were to reduce that by 1 percent, it's a much larger number relative to the $110 million of surplus or member reserves that is on hand

at the end of the year.

ATTORNEY ASAY: That concludes Ms. Greene's direct testimony. Blue Cross will reserve the right to call her in rebuttal if time permits.

MR. BARBER: Cross?

ATTORNEY ANGOFF: I would like to question Ms. Greene about Exhibit 10, which is labeled as a response dated June 14th 2019. In fact, it's, the date is June 28th 2019, And, also, although it's not marked confidential, I've heard some discussion to the effect that Blue Cross would like it being confidential. I'm happy to do it either way.

MR. BARBER: Are you talking about Exhibit 10 of Binder 1?

ATTORNEY ANGOFF: Binder 1, the June 28th 2019 letter from Stris & Maher to Amerin Aborjaily.

THE WITNESS: This one is not marked confidential. So I think --

MR. BARBER: Is there any contention that this is confidential?

ATTORNEY DONOFRIO: Can we just have one minute? To our knowledge, Exhibit 10 was submitted as a public document. No part of it was identified as confidential. So I don't see any issue in questioning Ms. Greene about Exhibit 10 in open session.

ATTORNEY ANGOFF: Very good. Thanks very much.

CROSS-EXAMINATION BY ATTORNEY ANGOFF

Q. Ms. Greene, would you please turn to Exhibit 10?
A. Yes.
Q. And would you please turn to Page 5 of Exhibit 10?
A. I'm there.
Q. And would you please start reading on the last paragraph before the bullet on Page 5 beginning with the "Tax Cuts and Jobs Act"?
A. Sure. "The 'Tax Cuts and Jobs Act' had two specific impacts on Blue Cross Blue Shield of Vermont's 2017 reserves that resulted in a net reduction in reserves of $4.1 million and a corresponding decline in RBC."
Q. And read the next sentence, please.
A. Yeah. "First, the tax law repealed the corporate AMT and made it, and made accumulated AMT credits refundable and therefore reportable as a deferred tax asset."
Q. And one more sentence, please.
A. "The AMT credits were previously assumed to have no economic value, so this initially added $33.2 million to reserves."
Q. Okay. Could you please explain what a deferred

tax asset is?
A. A deferred tax asset is a reflection of the tax law that says that there may be some future tax benefit but it's not recognizable in the current year's results.
Q. Well, under standard statutory accounting principles, a deferred tax asset is recognized on the balance sheet, correct?
A. It's on the balance sheet, but it's not in the operating results.
Q. Okay. And then you say in the next bullet that there's NAIC -- out of this $33.2 million in refundable tax credits, under NAIC guidance, Blue Cross was required to nonadmit $13.3 million. Do you see that?
A. I'm not seeing that. Is that on Page 6?
Q. On the bottom of Page 5 and the top of Page 6.
A. Okay. Yes, under the, "Under this formula, Blue Cross Blue Shield of Vermont was required to nonadmit, or remove from reserves, $13.3 million of the deferred tax asset attributable to AMT credits".
Q. So I would like to ask you. Could you cite for the Board what that NAIC guidance is?
A. It's the statutory accounting principles that have special rules around how to value deferred tax assets in the NAIC blanks, and that formula dictates how much

value you can recognize in the statements.
Q. Okay. Could you tell the Board where to find that guidance?
A. It's in the statutory accounting practices book. I don't have that here with me.
Q. And have you, have you provided it?
A. I have not.
Q. Could you?
A. I could.
Q. Will you?
A. I can. I will, yes.
Q. Okay, thank you. And can you explain then the formula pursuant to which this $13.3 million of the deferred tax asset balance is required to be nonadmitted? Can you explain how that's calculated?
A. The calculation looks at the nature of the deferred tax asset and calculates the amount that's allowed, and that determines the asset that's booked, and then, separately, the statutory principles require that a portion of that be nonadmitted, because it's not available to pay for claims to policyholders.
Q. And, when you talk about the nature of the tax asset, what do you mean?
A. The, the, what gives rise to the tax benefit that will come to you in the future. So some tax codes, and

I'm not -- we have tax experts that we use to calculate this specifically, but each of the codes in the tax code will attribute either a liability or an asset to a certain taxable piece of our business, and that's all accumulated into the net deferred tax asset at the end of any given year

Q. Is there anyplace in your testimony or attached to your testimony or in any document provided by Blue Cross that explains how this $13.3 million is calculated?

A. Um, there's a number of footnotes in the annual statement that show the various deferred tax asset calculations. I would have to refresh my memory of the details of what's in there to see if the formula itself is shown in that footnote.

Q. Okay. I don't want to delay things, and I don't want to put you on the spot. Is it unfair for me to ask you to do that now so that we can all understand how that $13.3 million is calculated?

A. So the 13, I, I don't know the relevancy of the 13.3. When the Tax Cuts and Jobs Act was implemented, it required us to both address the existing deferred tax assets, and that's what this relates to, as well as it created new deferred tax assets in the form of these AMT credit refunds. So there, the 13.3 is, is not the

same item as the AMT credit refunds. So I don't know if that helps clarify.
Q. So that $13.3 million that is nonadmitted you say is not all AMT credit money; it's AMT credit money plus something else?
A. So, under the statutory reporting rules, there's deferred tax assets before the, before the tax law change occurred, and so the 13.3 relates to those deferred tax assets outside of an AMT credit refund.
Q. And I hate to ask you this, but can you try to be a little bit more like Mr. Schultz and talk a little louder?
A. Sure.
Q. Thank you very much. Are you sure that the guidance requires the nonadmission of this $13.3 million rather than provide discretion for its nonadmission?
A. No. It requires it. It's a formula.
Q. You're sure about that?
A. Yes.
Q. Okay. Now, what about the other, the other -- now you see the first bullet on the top of Page 6?
A. Yes.
Q. Okay. And that's, that has to do with the $19.9 million of AMT credits, right?

A. Right, the balance.
Q. And that's not required to be nonadmitted, is it?
A. Right, because the formula requires a certain amount to be nonadmitted, and then the remaining is an asset.
Q. That's right. And so but that remaining $19.9 million you didn't reflect on your annual statement, right?
A. Correct.
Q. I'm sorry. Let me rephrase that. You did not include that $19.9 million in your surplus for year end 2018, correct?
A. That is correct, as noted in that bullet.
Q. Okay. And why is that?
A. It's because the, we requested a permitted practice from the Department of Financial Regulation, the one that we mentioned earlier, and the, the request was to nonadmit the balance of the AMT credits, because they were not, they're not assets available for the use in paying claims until we receive the tax refunds.
Q. Okay. Is it fair to say, if there's some question about the ultimate receipt of the tax benefit, that it shouldn't be admitted? Let me rephrase that.
A. The statutory --
Q. Under statutory accounting principles, is it fair

to say that, if there is a reasonable question about the ultimate receipt of the asset, that the Commissioner has discretion to establish a permitted practice allowing for the nonadmission of that asset?
A. It's less to do with the probability of it being received and more about, Is it an asset that's available to be used to pay claims? And, since it's not cash in our drawer, yeah, the permitted practice allows us to nonadmit that asset.
Q. But, under statutory accounting principles, without the permitted practice allowed, you would reflect this on your -- you would reflect that $19.9 million on your balance sheet as part of surplus, correct?
A. Without the, without the permitted practice, yes.
Q. Okay. And, and, by the way, just so there's no confusion about the, the language, what you all refer to, what you all refer to as reserves is what the NAIC, in its annual statement blank and, to my knowledge, most insurance departments refer to as surplus, right?
A. Insurance departments refer to it as surplus. The NAIC blank calls it total adjusted capital, to be clear.
Q. Capital surplus?
A. Capital. On Line, Exhibit 21 on the five-year

history, it's called total adjusted capital.
Q. Okay. And would you agree with me that, on Page 5 of the annual statement, Page 6 of the exhibit, it's called capital and surplus?
A. Sure, yes.
Q. Okay. Why did Blue Cross ask for a permitted practice to nonadmit the $19.9 million in AMT credits?
A. The, as I testified earlier, the elimination of the AMT was unprecedented, and it had a five-year time horizon attached to it, and the statutory accounting principles require us to only reflect assets in the annual statement if they are available to pay policyholder claims and funds, and so, since the AMT credit refund is not an asset until we receive it, we requested the permitted practice to remove that from the surplus.
Q. Well, it's pretty clear, isn't it, that Blue Cross is going to get the $17.9 million in October 2019? That's what you say in your --
A. I expect that.
Q. -- your papers, correct?
A. Yeah.
Q. And then, also, it's pretty clear, isn't it, that Blue Cross is going to receive the additional $8.7 million in October of '20, correct?

A. That's our expectation.
Q. Okay. And I suppose there's, and there's not going to be an election until after October of 2020, correct?
A. A national --
Q. Yes.
A. -- presidential election?
Q. Yes.
A. True, yes.
Q. Nor a congressional or a senatorial election. So it's reasonable to conclude, isn't it, that those two years are pretty certain, that is, that the amounts that you're going to receive in those two years is pretty certain?
A. That's true. That's why we've included it in our RBC plan that we --
Q. Right. But, under statutory accounting principles, without the permitted practice, you would have to include that on your balance sheet today as part of surplus, wouldn't you?
A. $19.9 million would.
Q. Okay. And I, and you wouldn't agree that you would have to include the 2020 amount?
A. The formula allows only a portion to be admitted, and so, without the permitted practice, it's the

balance. Whether that relates to 2020, 2021 or '22, the formula doesn't necessarily break cleanly with the year, the yearly split, but, in a sense, it's the same concept. The 19.9 would be on the balance sheet without permitted practice.

Q. So we agree about the 19.9; we can argue about the remainder, correct? That is, we agree that the, but for the permitted practice, the $19.9 million would be admitted and would be reflected on the balance sheet and included in surplus?

A. Yes.

Q. Okay. And the other part, the remainder, you're unsure about?

A. The 19.9, between the 13.3 and the 19.9, it is the total.

Q. Say that again.

A. So we're sure that, according to the rules, the whole $34 million is going to come to us. It's a question of when and when will it become available to use to pay claims.

Q. Could you turn, please, to Page 2 in Exhibit 10? And you see there the, the chart at the bottom? It's not a chart, just a list of the, the amounts and the years of the AMT refunds.

A. Yes.

Q. Okay. And then could you read the sentence right after that?
A. It says, "These figures assume that Blue Cross Blue Shield of Vermont will utilize a portion of its AMT credit balance to offset subsidiary income tax liabilities each year".
Q. Okay. So could you explain to the Board what you plan on doing then -- strike that.
Is it fair to say that then, even when you do receive these AMT credit refunds, you don't plan on putting them in surplus; rather, you plan on using them to offset subsidiary liability, tax liabilities?
A. It says that in the, in the figures above we've made estimates. Our tax position is, by definition, a consolidated enterprise tax liability. So, when we calculate how much of the AMT credit refund is coming our way from the IRS, it necessarily takes into account all of our taxable entities in our tax return, and that's what that's referring to.
Q. So the Blue Cross, the parent, is not a taxable entity, right?
A. We have a, we have paid taxes, because we have a special Section 833 of the tax code that speaks specifically to Blue plans, and it's through that tax, tax regulation that the AMT credits came to be in the

first place.
Q. That's right. But, under the Trump tax bill, isn't, going forward, isn't Blue Cross --
A. Going forward, we --
Q. Going forward -- I'm sorry. I didn't meant to interrupt you. Go ahead.
A. Going forward, Blue Cross Blue Shield of Vermont has a zero federal income tax rate.
Q. Say it again, please.
A. Going forward, Blue Cross Blue Shield of Vermont has a zero percent federal income tax rate.
Q. Okay. That was my understanding. Then what are the subsidiaries of Blue Cross that are taxable?
A. We have the Vermont Health Plan. We have Vermont Collaborative Care. We have CBA Blue. These are all subsidiaries. We have Catamount insurance services. These are all companies that make up the entire operating entities of the consolidated Blue Cross Blue Shield of Vermont tax return.
Q. Okay. And that, is it fair to say then that your intent is to use at least some of the AMT credit refunds to offset the tax liabilities of Blue Cross's for-profit subsidiaries?
A. The nature of our tax return is such that any tax liabilities that arise out of the related entities will

be first, the AMT credit refund will be first used to cover those liabilities, and then it's the balance that comes to us from the IRS.

Q. I think that was a "yes".

A. Yes.

Q. Could you explain to me the difference -- it's a relatively moderate difference -- but why there's a difference between the $34 million in AMT credit refunds that you use in Question 2, in your answer to Question 2, and the $33.2 million number that you use in your answer to Question 6?

A. In the same exhibit?

Q. And then, so let me amend that question so we can maybe resolve it all at one time. And then, in your answer to the last question, Question 8, you use a $35.8 million number. These are not huge differences, but could you explain why the differences?

A. So, depending on how the question was asked, we answered in the context of the exhibits that were being asked about. So, depending on which exhibit in the statutory statement we were looking at, one of the, the 34 is a going-forward view. The 33.2 is how it was recorded at the end of the year.

Q. Could you please turn to Exhibit 21, Blue Cross's annual statement for 2018?

A. I'm there.
Q. Okay. And I think I heard you say when you were being questioned by counsel that the drop in your surplus is mainly due to underwriting losses; is that correct?
A. Yes.
Q. Okay. Could you go through with us on Page 5 of the annual statement, Page 6 of Exhibit 6, the, the various entries there which explain how surplus went from $134 million in, $135 million in the prior year to $110 million there down on Line 49?
A. So, just so I'm clear, you're on Exhibit 21, Page 6 of the exhibit?
Q. Exhibit 21, yeah, Page 6 of the exhibit, Page 5 of the annual statement. So you start there, you see, on top with $134 million, right --
A. Yeah, sure.
Q. -- for the current year? Okay. And then there's a, there's a net income, in this case, a net loss of $6.7 million, right?
A. Right.
Q. Okay. Then down on Line 36 there's a change in net unrealized capital less capital gains tax of $4.6 million. Could you explain what that is?
A. Sure. The net unrealized capital gains is related

to the asset portfolio that we have that backs the member reserves of surplus, and, to the extent that the capital gain position in the market goes up or down in any given year, that will serve to increase or decrease surplus.

Q. Okay. So that, does that mean then that you lost $4.6 million? Let me rephrase that. You haven't, you haven't realized these gains or losses, right?

A. Correct.

Q. That means that the value of your portfolio went down by $4.6 million?

A. Correct.

Q. Okay. There are, aren't there, statutory or regulatory requirements that require Blue Cross to hold no more than a certain type of asset, correct?

A. Correct.

Q. Okay. And what is, what is the requirement with respect to equity holdings?

A. Off the top of my head, the, the state regulations, excuse me, the state regulations have a guardrail for the amount that can be invested in equity which is very small. Some of the bonds will also fluctuate in terms of unrealized gains and losses as well.

Q. It's fair to say, though, isn't it, that insurance

companies are required to hold, to hold pretty safe securities holdings?
A. That's true. And, when we benchmark against peer companies and look at our -- we review our asset portfolio every year with our board, and we have a relatively conservative asset position, and we have somewhere between 15 and 20 percent of the consolidated entity in equity position, and the rest would be in high-quality, fixed-income bonds.
Q. Do you know whether that 15 to 20 percent is relatively high for an insurance company?
A. It's, it's not very high in, in industry terms.
Q. What about for a nonprofit Blue Cross company; do you know whether it's relatively high for a nonprofit Blue Cross company?
A. If the, many insurance companies use equity securities to back their surplus, because it's a long-term growth, and you'll get a longer term accrete of growth to surplus out of equity securities than you will out of other types of securities.
Q. On Line 38 it says, "Change in net deferred income tax". What does that mean?
A. So that's a change in the, all of the deferred tax assets that we were just referring to.
Q. So that means that you, that you have --

A. So the assets increased in between the end of 2017 and the end of 2018. The net deferred tax income, net deferred income tax asset increased between the end of '17 to the end of '18.

Q. Okay. And change in nonadmitted assets on Line 39, what is that?

A. Those are the assets we were just referring to earlier that, to the extent that the statutory accounting rules require us to remove assets from the balance sheet that are not immediately available for paying claims, those are required to be taken out of our balance sheet.

Q. Okay. And so does that include some of the AMT credit refund money?

A. It does, and you can see in the prior year that it, the major driver of the $46 million was the removal of the nonadmitted AMT deferred tax.

Q. I'm sorry. I'm having trouble hearing you. The major -- can you say it again, the major driver?

A. So I'm saying, yes, the alternative minimum tax credit refund that creates the deferred tax asset was removed through this change in nonadmitted assets from reserves.

Q. And then, finally, down on Line 47 when it says "Aggregate write-ins or gains or losses in surplus",

could you explain what that is?
A. Yes. It's usually, in our case, it's the change in our pension valuation. So, at the end of each year, the pension plan is valued, both the liabilities and the assets, and, to the extent that the assets are lower than the liabilities, it would create a reduction in member reserves as outlined in 2018 and the current year on this exhibit of $5 million.
Q. Okay. So your pension plan assets declined in value, correct?
A. At the end of 2018, they did.
Q. Right. And that's in addition to the decline in value that we talked about up here on Line, Line 36, right?
A. Correct.
Q. Okay. So that's about a, just about a almost $10 million decline in value of your portfolio?
A. Correct.
Q. Would you agree with me, Ms. Greene, that there are other practices Blue Cross engages in that make its surplus appear to be lower than it really is?
A. No.
Q. Okay. Would you turn, please, to page, to Exhibit 17?
A. Is that in the first binder or the second?

Q. First binder.
A. Okay.
Q. Okay. And would you -- well, let's say, first, turn to, to Page 37 of the exhibit, Page 13 of the Axene Health Partners report, and the Axene Health Partners report, this is a report that you all commissioned, correct?
A. Yes.
Q. And do you see the heading a little below the middle of the page "Reserving Process and Accuracy"?
A. Yes, I see that.
Q. Could you please read that paragraph?
A. "AHP discussed Blue Cross Blue Shield of Vermont's reserving process with its certifying actuary Paul Schultz. It was confirmed that reserve estimates are calculated with the benefit of one month of paid runout and that an explicit provision for adverse deviation of the percent is usually held in the year-end reserve estimate."
Q. Okay. And then could you go to Page 14 and just read the last line of the top paragraph, the incomplete paragraph there?
A. Read which part of it?
Q. I'm sorry.
A. Read which part of it?

Q. The last sentence of the first paragraph which is incomplete, starting with "AHP consultants".
A. Okay. "AHP consultants believe that Blue Cross Blue Shield of Vermont could potentially lower its explicit level of provisions for adverse deviations, which would result in both higher surplus level and higher RBC ratio."
Q. Do you agree with that statement by the consultant that you commissioned?
A. I do agree with that, and I would go on to say that the decision was made at the end of 2018 to change the approach that we'd been taking for that provision for adverse deviation such that it's applied to just the incurred, but not reported, portion, not the, to reflect the fact that we have a one month's claims runout. We are required to have a provision for adverse deviation, again, as required by the accounting principles.
Q. Could you turn now to Page 15 of this same exhibit --
A. Yeah.
Q. -- which is Page 10 of the Oliver Wyman report?
A. I'm sorry. Could you repeat that?
Q. Yes. In this same Exhibit 17, could you turn to Page 10 of the exhibit, I'm sorry, Page 15 of the

exhibit, which is Page 10 of the Oliver Wyman report, which you're familiar with, correct?
A. Yes, I'm there. Thank you.
Q. Okay. And could you read the last two sentences of the paragraph beginning with the third bullet "Reserving Process", the two sentences beginning with "Blue Cross Blue Shield of Vermont"?
A. "Blue Cross Blue Shield of Vermont holds an explicit margin of 15 percent on top of their best estimate, which is conservative. As a result, from 2007 to 2016, Blue Cross Blue Shield of Vermont's reserve with margin has never been deficient, with the lowest reserve sufficiency being 13.6 and the highest being 24.9 percent. AHP did not include an additional charge for reserving process risk."
Q. And you agree with me, don't you, that, if that reserve redundancy or, as it's referred to here, sufficiency were included in surplus, Blue Cross's surplus would be higher?
A. If we eliminated, if we eliminated the explicit margin, reserves would, policyholder reserves would be lower, and surplus would be higher, yes.
Q. Okay. And, similarly, your RBC ratio would be higher, correct?
A. Yes.

Q. Okay. Could you go down on this same page, Page 10 of the Oliver Wyman report, Page 15 of the exhibit, to the third bullet from the bottom? You see under "Provider Reimbursement"? You see that?
A. Yeah, I do.
Q. Okay. And do you see at the end of that bullet that Oliver Wyman notes that Blue Cross's reimbursement levels are on par with its competitors and better than some markets; do you see that?
A. I do.
Q. Okay. And by better they mean higher, don't they? They, they certainly don't mean lower, do they?
A. No, I think they mean lower.
Q. You mean --
A. This is what, out of the provider reimbursement, is the amounts that we pay providers.
Q. Right. And you're saying that you believe that what they mean there is Blue Cross, that, when they, when Oliver Wyman says Blue Cross's reimbursement levels are on par with its competitors and better in some markets, what it's really saying is Blue Cross's reimbursement levels are lower in some markets?
A. Lower, lower reimbursements, yes.
Q. Well, that, does that make sense, though, given the first sentence in this paragraph?

A. The first sentence being, "Provider reimbursement risk" --
Q. Yes.
A. -- "by, considers the potential that Blue Cross Blue Shield of Vermont will need to increase provider reimbursement to maintain provider relations"; is that the sentence?
Q. Yeah. I mean, isn't it fair to say that Blue Cross doesn't have additional provider reimbursement risk because they're already paying providers enough? And isn't that what -- and I know you're not Oliver Wyman. Maybe it would be better if I asked them, but isn't it pretty clear that what they're saying is Blue Cross, because it pays providers so well, meaning so highly, they don't have any risk about providers going elsewhere?
A. This is, I think this is speaking to, as the Axene report spoke to as well, that, if, if we were providing, if we were paying providers more than what other payers were, were paying, our rates would be less competitive. So that they're saying that we don't, that there was, they did not include an additional charge, meaning an additional risk, to reflect that, because we reimburse on par with competitors and better, i.e. lower in some markets.

Q. All right. Let's move on. Are you familiar with Blue Cross's statutory obligation to ensure that subscriber benefits are provided at minimum cost under efficient and economical management?
A. I am familiar with that.
ATTORNEY ANGOFF: I believe that's all I have. Thank you, Ms. Greene.
THE WITNESS: Thank you.
MR. BARBER: Questions from the Board starting with Member Lunge.
MS. LUNGE: Okay. Good afternoon.
THE WITNESS: Good afternoon.
MS. LUNGE: So I asked Mr. Schultz earlier if your company had a preference for where you would be in your RBC range, and he indicated that the company did not. Do you agree with that?
THE WITNESS: I do agree with that. I'd like to add, however, that the utility of having an RBC range is such that results will go up and down over time, and you would find the Blue Cross Blue Shield of Vermont RBC at different places within that range. So it would be, as in the subsequent study from Axene, they, we identified our risk tolerances, and one of the risk tolerances that we have is that, in any given year, we'd like to not fall outside of the range.

So that risk tolerance implies that we'd want to be higher in the range than necessarily bumping along the bottom of any given range, because, if you're bumping along the bottom in any given year, you have a much higher chance of falling outside of the range.

MS. LUNGE: Okay. So you actually would prefer to be higher in the range than lower in the range given your risk tolerance?

THE WITNESS: On average.

MS. LUNGE: Thank you. Speaking of your consultants and the range, could you turn to Exhibit 17, please?

THE WITNESS: Yes.

MS. LUNGE: And, as you noted, the, the consultant had targeted a particular level --

THE WITNESS: Yes.

MS. LUNGE: -- and that's 690; is that correct?

THE WITNESS: The 690 is the place within the desired range of 590 to 745 that is the least likely to fall -- if we were at 690, we would be least likely to fall outside of that range in any given year.

MS. LUNGE: And that recommendation was based on Axene's understanding of your company's risk tolerance, among other factors?

THE WITNESS: It has less to do with the risk tolerance and more to do with the analysis they did on our insured business and the volatility of the results in our business and our ability to respond with rate changes in the case of volatile results. So their statistical analysis resulted in a range of 590 to 745, and it did incorporate our risk tolerances, yes.

MS. LUNGE: Okay. But you would agree with me that, on Page 40 of that exhibit under "Risk Appetite", that the consultant indicated the selection of the surplus range is ultimately a management decision?

THE WITNESS: Yes.

MS. LUNGE: And that their recommendation is based on an understanding of your tolerance of risk, uncertainty in its business environment, etc.?

THE WITNESS: Yes.

MS. LUNGE: Thank you. Could we turn to Exhibit 16 now, please? This is the AM Best press release.

THE WITNESS: Okay.

MS. LUNGE: And I believe that you were asked by your counsel if this was AM Best's independent conclusions contained in this release.

THE WITNESS: Yes.

MS. LUNGE: And you indicated it was --
THE WITNESS: Yes.
MS. LUNGE: -- is that right?
THE WITNESS: Yes.
MS. LUNGE: And do you know the basis for their independent conclusions?
THE WITNESS: They, through their analysis and looking at the CTR and the underwriting results and the performance of each of the lines of business, that's how they come to their conclusions.
MS. LUNGE: Okay. But it indicates, on Page 2, it talks about that Blue Cross being unable to receive adequate rate increases approved through the State's rate review process. How would they have formed that opinion?
THE WITNESS: They look at the rate filings and the decisions and, like anyone else, we would also look at the underwriting results. So they're looking at, in fact, the rates have been inadequate in the recent history, and then, through our rate review discussion when they come to meet with us, it is something that we talk through with them about the results of the decision orders.
MS. LUNGE: So you've met with them to speak about the process?

THE WITNESS: Yeah. They come and spend the better part of a day and go through, and they request a variety of information, and we provide that to them.

MS. LUNGE: Great. Thank you. I have no other questions.

MR. PELHAM: So I'm going to try to keep this simple. There's a lot of, like, different definitions of administrative costs through all of this from actuarial to two or three variations of it in the National Association of Insurance Commission documents.

THE WITNESS: Um-hum.

MR. PELHAM: But let's just start and hopefully finish on Exhibit 21, Page 21, which we've been there before. And I appreciate your comment. I'm asking this question not to get a certainly explicitly clearer answers today, but I appreciate your comment earlier that you would take a look at this so that you could respond to it appropriately.

THE WITNESS: Um-hum.

MR. PELHAM: So my basic question is, again, looking at this page, which covers cost containment expenses, other claim adjustment expenses, and general administrative expenses, it comes to a total of $57 million as you noted earlier.

THE WITNESS: Yeah.

MR. PELHAM: And it, but it includes a credit of $33,439,917 that comes from your uninsured book of business. So the combined amount there is almost $91 million in total. What I'm interested in, also in the annual supplement, is an allocation year by year of the, kind of the covered lives by book of business, and, you know, if we -- I'll take a quick look here.

If we go to, again, the, the five-year summary -- you don't have to go there. I can just read these numbers -- that the entire book of business enrollment, Exhibit 1, total members at end of period, 198,448, and that is, you'll find elsewhere in the supplements, the split is 111,404 covered lives for the uninsured book of business and 87,041 for the insured book of business. And, just because I've had a couple conversations, people get confused by this. Your uninsured are where you basically have the administrative functions for those policies, but you're not at risk for the claims?

THE WITNESS: Correct.

MR. PELHAM: Just as a simple kind of understanding. So that's what uninsured and insured --

THE WITNESS: Right.

MR. PELHAM: -- mean? So if, if I do the simple math here, and this is my question, if I do the

simple math and take the 33,439,000 for these three categories of expenses and divide that by the covered lives, it comes to $300.16 for the uninsured, and, if then I take the insured amount, the remainder of that, at $57 million, $57.5 million and divide that by the insured population covered lives, which is 87,041, I get $661 per covered life, and so my basic question is, Can you explain that difference --

THE WITNESS: Sure.

MR. PELHAM: -- as to why, why the kind of per-covered-life amount for insured folks is much richer, almost by twice, than the uninsured?

THE WITNESS: Sure. One of the things that I can provide to you as a follow-up as well is -- and, when we talk about different definitions of administrative costs, one way to simplify it would be that we have the same total of administrative costs, but many of the exhibits sort of pull segments of that into different subtotals. So, so there's not, it's not like we categorize something as administrative costs sometimes and not others. It's always categorized that way, but it's reported differently often.

MR. PELHAM: Well, what I liked about this is that it's very, you know, explicit. It's cost-containment expenses, other claim adjustment

expenses, and general administrative expenses.

THE WITNESS: Right.

MR. PELHAM: And you can go back into the NAIC documents and see that by the individual plans, by the small group --

THE WITNESS: Right.

MR. PELHAM: -- by your Medicare folks.

THE WITNESS: Right.

MR. PELHAM: So it allows you to go into the weeds a little bit, but I still can't find an answer yet that says why one group should be almost twice as costly on a per-covered-life basis.

THE WITNESS: The main driver for why -- you know, each of our lines of business requires different types of services to be offered and sustained, and one of the large differences between the individual and small group book and the uninsured book is that the uninsured book, or we call it self-funded, those clients tend to be much larger clients. So there's one group that has many, many members within that group, and that becomes very much more efficient for us to administer, because, when we are administering individual by individual or each small group, we have to set up different benefits, etc., for each of, and process invoices multiple times on smaller groups, and

then the larger groups we only have to do one, for example. So, so the major driver between the cost on an uninsured book of business versus an insured book of business will have to do with the size of the clients that are in that book.

We do have, you know, Medicare supplemental business has a much different cost profile, because the premium that we're collecting from Medicare supplemental is a much smaller premium, but the administrative cost is very similar to another type of policy. So the percent of premium for Med Supp. will be much higher than it will be for other segments of our business.

So, when we look at benchmarking, we'll actually look at the benchmarks by line of business and make sure that the line of business costs are in line with the competitive environment.

MR. PELHAM: But, as much as you can show us, I'd appreciate it. I just know that the population we're concerned about here is at the high end of that range, and so I think exploring that more would be helpful.

THE WITNESS: Okay. Thank you.

MR. PELHAM: The next question or area of questions, let's go again to the five-year historical

summary, which is on Page 68. And so I noticed, if you go to Line 12, "Net Income or Loss", that is, it's been a little bumpy road over the last five years in that, as noted earlier, it's a $6.67 million loss in 2018, a $7.58 million gain in 2017, working backwards here now, a 9.7 loss in 2016, a $12 million, plus, million dollar gain in 2015, and a $9.8 million gain. Over that five-year period, that is a net gain of $13.289 million, and so I, I'm struck a bit by that number and scale of hospital operating margins, and I, this is a document that we put out every year --

(Indicating.)

It has a five-year summary of it. It's a 2018 Vermont hospital budgets actual, and it has a five-year profile in it by hospital. And so, if you look at those same five years, the total, well, the total UVM Medical Center operating margin is $316 million, $316,101,684, and I, I'm just struck by that, because I know that, I, I know that we can't get into your relationships with customers and providers in any detail, and that's not my intent here. I want to stay at a very high level. That, I assume -- you don't have to confirm this.

I assume that UVM is one of your biggest providers and that, over the same five-year period, they have

operating margins in over $300 million, and you're down in the $13 million range, and so, in your letter to us which is Exhibit 11, you have the comment that -- I'll quote here.

MS. LUNGE: What page, Tom?

MR. PELHAM: It's Exhibit 11, Page 3, okay? You had the comment, "Additionally, as the Green Mountain Care Board has become more aggressive in the hospital budget review process, Vermont hospitals have consistently indicated that they are unwilling to remain in Blue Cross Blue Shield of Vermont's network unless Blue Cross Blue Shield of Vermont fully funds Green Mountain Care Board approved increases to commercial rates".

And so, I guess, my -- I'm just struck by the, the scale of, of these numbers. You're the largest insurer in Vermont, they're probably the largest provider in Vermont, but it seems like you're living in two different worlds in terms of premiums going to that provider and then a lot of that falling to their operating margin. And, in addition to total margin, I'm just looking at operating margin. So I wonder if you have any thoughts about that.

THE WITNESS: Well, I would like to also invoke the deferral to Andrew on negotiations, but the

response in Section 11 was just acknowledging that, in a lot of our provider discussions about reimbursement rates, once the Green Mountain Care Board has approved a commercial rate increase, it's very difficult for us to convince them to go lower than that. And we've provided that feedback to the Board multiple times, and that continues to be our belief.

MR. PELHAM: Thank you for that comment. I think it's helpful. Finally, the last question I have is that we asked you about the cost shift in that same exhibit, and you did provide a profile of the impact of the cost shift on your rates, both in terms of just if it was mitigated relative to hospitals and mitigated relative to your entire provider network, and I'm just wondering if you could give us a summary of, of that component of that exhibit.

THE WITNESS: So you're speaking to the response that starts on the bottom of Page 4 and continues on to Page 5 of Exhibit 11?

MR. PELHAM: Yes. It starts with, "The cost shift during the 2019 QHP hearing".

THE WITNESS: So, in response to the question about what impact has the cost shift had on premiums, we did pull the reports published by the Board that calculates the Medicare and Medicaid reimbursements and

quantifies the amount of cost shift, and so, at the top of Page 5, we compared the total revenue for all Vermont hospitals, what percentage of that revenue is commercial, and then did some calculations to allocate a percentage of the commercial spend that's attributable to the cost shift, which we estimate to be just under 35 percent.

And then Paul's team pulled together the response in this paragraph that just used that estimate to speak to, maybe the middle of that following paragraph, that said, you know, as the resulting calculation leads to a rate decrease of 16.8 percent from filed rates, if this cost shift at Vermont hospitals were to be completely eliminated by 2020. So it's just quantifying the fact that the cost shift is embedded in that commercial rate.

MR. PELHAM: So, so the cost shift is clearly a pressure on premiums, and I would then think indirectly a pressure on your RBC, risk-based capital, ability to earn a surplus. If you're having to deal with year and year a rising tide of cost shift from Medicaid or Medicare, then that reduces your flexibility to respond to some of the surplus issues that you're trying to address?

THE WITNESS: Well, the change in the cost

shift over year to year will be reflected in the trend analysis that the actuarial team puts together. So, to the extent that that shifts higher or lower in the form of unit costs or utilization, that will get captured into the, the trend calculation. So it's embedded in the results to date.

MR. PELHAM: And it's a big number?

THE WITNESS: It's accumulated to be a big number.

MR. PELHAM: Right, right. Thank you.

MS. HOLMES: I guess I'm up. I'm sure you're getting hungry. I'm sure everybody's getting hungry and tired, so I will do my best to be concise.

MR. PELHAM: It's not just hunger, Jess.

MS. HOLMES: Okay. Well, I don't need to hear any more. So, as the CFO, is it safe to assume that you're involved in strategy decisions for the company?

THE WITNESS: Yes.

MS. HOLMES: Okay. So then I'm hoping you can help me understand the long-run strategy here. In Exhibit 1 on Page 129, you, in your memo, referenced the pricing advantage for the competitor in this particular market.

THE WITNESS: Um-hum.

MS. HOLMES: We asked Mr. Schultz about that, and, as I suspected and Mr. Schultz confirmed, the competitor's pricing advantage has led to a declining market share for Blue Cross Blue Shield, has led to declining enrollments for Blue Cross Blue Shield, has led to increased risk for Blue Cross Blue Shield that's not been mitigated by the risk transfer amount.

So that, in turn, has led to higher administrative costs per member per month and potentially higher claims costs that, again, are not mitigated by the risk transfer agreement, which, in turn, has led to declining, you know, solvency and the need for higher and higher premiums.

So what I think I'm describing is somewhat of a death spiral, right? I mean, you're sort of getting into a model where the, the competitor's pricing advantage leads to these other consequences that leads to a need for higher and higher premium growth to cover the higher administrative costs per member per month, and then the claims costs that are not being covered by the risk adjustment leads to higher deviations, leads to higher premiums, leads to greater competitive advantage.

Where does this end? What can we expect going forward in terms of administrative costs going toward

the CTR for solvency to cover these higher claims costs? I'm just -- can you help me understand where this goes?

THE WITNESS: Well, I can tell you it's a challenge. The market share shift in a normal health insurance market, what will happen is, if the rates go up and up, the, the members will go elsewhere, and then, in an ideal world, the risk adjustment would level that out. So, as Paul indicated in his testimony, we are doubling our efforts, tripling our efforts on making sure that the risk coding results are as optimal as possible. The Vermont market is a little bit unique, so we have some special challenges there.

We also bank on just the continued good service and providing the, the services to the customers that we have on the books. We, the market share has declined a lot. It started out at 90 percent. I think many of us were thinking that there would be no world in the long term where we'd continue to maintain 90 percent, but a market share of 60 percent or two-thirds, as I think Paul testified earlier, is not a bad market share.

So I think it's important for Blue Cross Blue Shield of Vermont to do what we're doing to make sure that we are looking at the specialty drug opportunities

and lab benefit manager that Paul mentioned, look at ways that we can certainly impact the cost of care for our members, but still get them access to the care that they need.

In the meantime, we also need to make sure that we're, we're being responsive to other markets and other Vermonters. You know, the senior market and the self-funded market is a place that we'll need to continue to make sure is firing on all cylinders as we work out the issues that we have on the individual and small group market.

You know, the spiral is, if it's, if it's mostly due to the inefficiency of the risk adjustment function, I'm optimistic that we'll figure that out sooner or later. Paul mentioned that some of the provider contracting and partnering with the ACO will actually help in that regard, because those programs will require value for good coding, and so that will help achieve an equilibrium.

The other thing is we know that, and it was evident in the L&E opinions this year, is that Blue Cross Blue Shield of Vermont is kind of a platinumy type group of members, and the MVP segment is more of a bronzy type group of members. So that, in and of itself, tells us that we need to make sure that all of

the products offered in the market are, are, especially the standard plans, are priced equitably to make sure that the customers are making good, able to make good choices between the carriers.

But, beyond those technical issues, it's really back to the risk adjustment, and we, we do expect -- this year we had such a significant increase in the specialty drug and the medical, the pharmacy at the site of medical care that, you know, that's something that we'll be working on as well in terms of anything that we can do to help support pricing controls or whatever around that, because that, that is a source of this large rate increase, irrespective of the risk coding issue.

MS. HOLMES: And then my second question relates to, I mean, as you think about it, if we can figure out a way to reduce waste from the system, eliminate waste from the system, we can reduce premium costs, which will increase access and affordability for consumers. It will improve solvency to the extent that there's less waste, less claims costs, and at no expense to quality, right, of providers, I mean, of patients, effectively, if it was wasteful, nonhealth-gaining services, right?

Last year Dr. Plavin, I believe, testified that

there was significant waste in the system just in general, not in, unique to Blue Cross Blue Shield, but across the country in terms of health care wasteful expenditures. You know, we've seen various numbers in the double digits of percentages of medical expenditures.

And I'm wondering, with that in mind, you know, can you talk to me a little bit about strategically what Blue Cross Blue Shield is doing to eliminate wasteful expenditures, reducing unwarranted variations in care across the network, choosing providers that are, you know, appropriate utilizers?

And I just want to reference the Axene report, since it came up in a little bit earlier in this testimony. On Exhibit 17, Page 38, there is a reference to care management effectiveness, and, I guess, Axene has done an abbreviated analysis of Blue Cross Blue Shield's care management effectiveness.

THE WITNESS: I'm sorry. Can you tell me what page you're on?

MS. HOLMES: Page 38 of Exhibit 17.

THE WITNESS: Thanks.

MS. HOLMES: And it just referenced Axene's abbreviated, so I understand, abbreviated analysis of Blue Cross Blue Shield's care management effectiveness

based upon only a few, but key, utilization metrics. It looked at inpatient days per thousand, ER utilization per thousand, and scripts per thousand, and they obviously could have done a more extensive analysis. They didn't here. But, based on that review, if you see in that last little paragraph there, they noted opportunities for improved measures.

So I'm wondering if there are, you know, internal assessments that you're doing about care management and effectiveness, utilization review that might, as a result of this study that suggests that there are opportunities for reductions in wasteful expenditures, do you benchmark against other Blues? Is this going to be a potential way in which you can reduce waste from the system?

THE WITNESS: The answer to that is obviously "yes". There's a number of programs, and I'll refer to Paul's testimony even. The lab benefit manager is a good example of one where, as we benchmarked against the spend on labs, we could see that we were very high relative to what you might expect looking at other industry measures. So we did set about looking at opportunities to, I'll call it, get the waste out of the lab part of the process. So the medical appointment needs some labs, but they don't always need

the whole lab markup, and so that's a good example of identifying a place where we had not previously been necessarily benchmarking lab against something else.

So in the Axene report they could see that we were reporting and measuring and benchmarking a number of items relative to care management and utilization review, but there are some other areas that we could do more measuring and comparing, and the lab benefit manager is a good example of one of those, and I expect that there will be other areas that we can look at and improve.

Of course, oftentimes, it takes more administrative cost to go after that, and so, to the extent that we'll be looking at the ROI on whether or not it costs us more money to go find those savings or waste, we're constantly looking at the ROI on each of those ideas as it comes along.

MS. HOLMES: Great. And then my final question actually relates to something that I think Blue Cross Blue Shield was relatively excited about last year. It was a new web-based tool that was going to engage customers in some sort of incentive campaigns around consumers, and there was no anticipation of savings in '19, but I think there was a hope, again, that this would be an initial investment and that you

would see savings later on, and so that, along with the price transparency tool for consumers, I'm wondering if either of these are translating into savings or changed consumer behavior that eliminates waste.

THE WITNESS: So you mentioned the, the web-based application. We remain excited about that. That has been rolled out, and that is a good example of something where we needed to find a more efficient way to engage with people, our members, on getting the right care at the right time. So, instead of having phone calls from nurses and spending relatively expensive resources on that, the tool allows us to engage at a level that's much more efficient.

I might invoke my colleague, Andrew, to speak a little bit more to our experience in using those tools, but that's a really good example of something that we knew we needed to reach more people, but to do it the way we had been doing it would be expensive. So we invested in a tool to be able to reach more people. We do know that it all depends on the uptake of these tools.

MS. HOLMES: Right.

THE WITNESS: Not everyone's into text messages and things about that, like that. So, in some ways, we can put those out there, but it's, it's up to

the members to use them and engage with us using those tools.

MS. HOLMES: So, I guess, in follow-up to that, maybe Mr. Garland will have the answer to that, but I am curious about the uptake in both the price transparency web tool and this tool to see if it's having any impact. I think it's been a slow progression in realizing that people have to be aware of it. There's an education process, but it could actually have a positive ROI.

THE WITNESS: Yeah. The current cost transparency tool, I know the uptake is quite low, and what we find is that people call our customer service folks and ask them and then together --

MS. HOLMES: They go to the website?

THE WITNESS: -- the member and the customer service rep will look and use the tool. So it's having an impact, but it's relatively small in terms of engagement with people who are actually using it.

MS. HOLMES: Okay. Thank you.

MR. BARBER: I'm going to interject here just to remind folks that we're behind where I thought we would be at this point. We're not through our second witness. We still have the Commissioner. Given the solvency discussion, I imagine that will go some time,

and then Dave Dillon. So, if we could just all be cognizant of time and pointed in our questioning, that would be appreciated.

MS. USIFER: Sure.

MR. BARBER: I wasn't speaking directly to you. I just --

MS. USIFER: Okay. I just want to touch on some of the changes that have occurred from RBC, and, looking at your five-year historical, which was on Page 68 of Exhibit 21 and the net underwriting loss of $15,492 in 2018, I just want to clarify something that I thought you said, but I wasn't sure. Was there to be, you said, another $7 million in risk transfer?

THE WITNESS: Yes, that's correct. So the final risk adjustment payment for 2018 turned out to be $8 million higher than what was recorded in these results.

MS. USIFER: Okay. So that would be about seven. And then in your, under Exhibit 10, Page 3, there was, there's discussion about the $7,200 from the cost-sharing reduction that you actually are trying to recoup.

THE WITNESS: Yes.

MS. USIFER: And two things there: One, I know, when you built your estimates for, for the, for

that year, they were assumed you would get that, and then in 2018, which is the bulk of this $7.2 million loss --

THE WITNESS: True.

MS. USIFER: -- that impacted your '18 --

THE WITNESS: Yes.

MS. USIFER: -- results, right? So I know we have a big loss. Not saying that. It's $15 million, but, when I look at it, you're going to get back about half of that due to the risk adjustment, and then the other half related somewhat to the CSR?

THE WITNESS: This is true. It contributed to that, yes.

MS. USIFER: Okay. And do we have any status on if you're going to get this CSR piece back?

THE WITNESS: The, the outline of the status was included, as you indicated, on exhibit, in Exhibit 10, Question 3, and it's in the legal process.

MS. USIFER: Okay. So I'm building kind of -- you're ending 2018 you have a 495 RBC.

THE WITNESS: Um-hum.

MS. USIFER: And, if those two things were adjusted, that's about a 16 RBC, which would bring you up to about 550, but, more importantly, if we look at on Exhibit 21, Page 6, and the two big drivers on that

page were referred to before, which were really the net deferred income tax and the change in nonadmitted assets.

THE WITNESS: I'm sorry. I just need to catch up with you. Page 6 of the annual statement?

MS. USIFER: Exhibit 21. Yeah, sorry.

THE WITNESS: That's all right. Yeah, I'm with you.

MS. USIFER: So in '17 and '18, and I kind of took them together to say, you know, there was pretty extraordinary change, and so in 2017 the net change was about $17 million reducing your surplus.

THE WITNESS: Which line items are you referring to?

MS. USIFER: Oh, I'm looking through the $29 million plus in net deferred income offset by the nonadmitted assets, $26 million.

THE WITNESS: Okay.

MS. USIFER: So that was a change of about $17 million, and carried forward to 2018, it's another $7 million, and I understand we're going to get those back somewhat when we get the credits.

THE WITNESS: Right.

MS. USIFER: But the reason I'm pointing that out is, you know, we've talked a lot about what's

happened over the last few years and what's gone on with RBC, and, specifically, in the past four years, it went 663, 590, 558, and 495.

And, if I look to 2017 to the 558 and I add back the 80 for those two things here, because those were, you know, fairly extraordinary for that specific year, that's going to bring that up to another, to about 640, and, if I carry that forward to the, to the next year, and we started at 495 and I add the 78 back, that brings us up to 583, and I add 31 million, 31 back for the 7 million and change that we're going to have that you took out in 2018, that brings us back to 614, and then we just talked about another 15 million 70, which would bring us up to 680.

And the reason -- let's take, forget the $15 million for right now. That 614 is kind of apples to apples to what we've looked at the past couple of years, because I'm just taking out those two things that you did for the tax, which will come back later. I'm not trying to say -- I know you're at 495, and that doesn't change, but there's been a lot of talk about the reason that your RBC has gone down so significantly is because of all the actions of the Green Mountain Care Board and we've done over the past few years, and that's certainly impacted. You've had losses, but,

when I look at those changes, you were at 663. In 2015 you went down to 590. This brings it back up to well over 600, which is, you know, now within the acceptable range.

THE WITNESS: The AMT credits?

MS. USIFER: Right.

THE WITNESS: Yeah.

MS. USIFER: And I know we are getting it back and you added it back in later, but I just wanted to really kind of bring that point, because that one change had nothing to do with anything that -- you know, it had to do with you guys going through and deciding these were nonadmitted and you had to change that, and it was in there before. I mean, the big change was in 2017.

THE WITNESS: A portion of it was in there, but not the entire amount.

MS. USIFER: But, I mean, in 2017 you reduced your surplus --

THE WITNESS: Yes.

MS. USIFER: -- by $19 million. Then you reduced it again by $7 million. So we had $26 million of reduction to surplus, not even touching on there was another $5 million reduction for changes in pension in 2018 as well as losses in 2018. But I just think it's

good to kind of put it in perspective --

THE WITNESS: Yeah.

MS. USIFER: -- that that change, which we will add back later which gets you off the 495, you know, certainly puts us well within the range of where we needed to be, you know, even with the new guidance.

THE WITNESS: And I agree, and it is a one-time change. So, when those AMT credits come through, thank goodness they are coming through, because we do need to have a plan to be within the ordered range. That's a one-time event. So the absolute critical thing for going forward is to have a fully funded premium rate.

MS. USIFER: Sure, but you took them out as a one-time event in 2017 and in 2018.

THE WITNESS: Right.

MS. USIFER: And they had been in there before. So, if we took them out every year from your RBC, the net change in your RBC would be significantly less. We could go back and say, Where were they in 2016 and '17? In '17 you made a big change. You took them out, and they had been your surplus.

THE WITNESS: So that only a, only $13 million had been in surplus prior, or sorry, only $4 million had been in surplus prior.

MS. USIFER: Right. So the net change is the 46 and the 29 in '17. I mean, is that something that was typical every year, to have those big adjustments?

THE WITNESS: That's true. It's not typical to have those big adjustments.

MS. USIFER: That's all. I'm not --

THE WITNESS: Yeah, I agree with you. I'm just trying to follow all the numbers to make sure I'm understanding the question that I am answering.

MS. USIFER: I think there's been a change in methodology. Things changed, brought your RBC way down, and things will adjust later, but those would have been in prior years as well.

THE WITNESS: I'm finding it difficult to agree with that, because the AMT credits have not been part of the surplus prior.

MS. USIFER: But those two lines, if we adjusted for those, it would get us into about the 600 range?

THE WITNESS: Yeah, I agree with that.

MS. USIFER: Because we are going to be talking about --

THE WITNESS: Thanks.

MS. USIFER: And the only other question I had was just on the cost-containment strategies and

how, as CFO, you know, in your role, how, what do you target specifically, trying to get more cost containment, what percentage? You know, how can we get a little bit more out of that year over year? And it's a never-ending process and --

THE WITNESS: It is a never-ending process. We have a group of folks inside the company who look at the qualified health plan or the individual small group segment and look at the different components of costs in that book of business, and they are constantly combing through and trying to find new opportunities, and, in fact, the lab benefit management initiative was one of those that we found, an opportunity that was both a cost-containment opportunity at an admin investment that was reasonable to go after, so to speak.

MS. USIFER: Thanks.

CHAIRMAN MULLIN: So earlier, much earlier in your testimony, you were asked by your attorney about the $110 million in reserves, and part of your response was that you said $550 per subscriber, and, basically, I just want to ask you: Do you think that's a little bit misleading, given the fact that a large portion of your book of business is TPA or ASO?

THE WITNESS: I don't believe it's

misleading. I take your point that, to the extent that the risk around the TPA and ASO business is more of a credit risk and whether or not, you know, we're paying that provider the money out and billing it back to the client. So, to the extent that it's a different kind of risk as opposed to the insured risk, I feel that it's an appropriate reflection of how to put our total reserves into context for people.

CHAIRMAN MULLIN: Okay. Can you remember what your percentage was for administrative costs in the last two years, not this year?

THE WITNESS: You mean for, not this year, meaning 2020?

CHAIRMAN MULLIN: In the last two rate filing years, so 2018 and 2019.

THE WITNESS: Off the top of my head, I don't know what they were. They were right around high 6-and-something percent or 7 percent.

CHAIRMAN MULLIN: So my recollection is that they were in the sixes, and so I'm just wondering if you would acknowledge that, by this year being at 7 percent, it's a trend in the wrong direction.

THE WITNESS: With the loss of membership, we have had a higher total cost, and it has gone up to 7 percent, but that 7 percent still compares very

favorably against industry averages of around 10 to 11 percent.

CHAIRMAN MULLIN: But it is a higher percentage than in the past?

THE WITNESS: Yes.

CHAIRMAN MULLIN: Okay. So I heard what the hearing officer said, so I'm just going to ask one final question, and it's only because I asked MVP yesterday this same question, and I'd like to get your response, and that is that, in your strategies trying to lower costs, one of the things that I hear feedback from providers, and I'll give you this example, they feel that, by the way things are treated, that they sometimes have to suggest more expensive care for their patients.

And the example I used yesterday is Cologuard, which is about 90 percent effective, probably a viable low-cost alternative for those that don't have a family history, and yet doctors are telling their patients, at least that's what they're telling me, that they should go straight for the colonoscopy, because, if the way Vermont law reads, a screening like a colonoscopy or a mammography is treated one way.

But what happens if the doctor goes with the Cologuard, even though it's less expensive to the

system, that it could be much more expensive to the patient, because, if anything does come up, then the colonoscopy then would be treated as a diagnostic, and so it would have much higher costs out-of-pocket to the patient.

So I'm wondering if you've had those discussions about trying to take away that incentive for the provider to suggest the higher cost methodology.

THE WITNESS: I can't personally speak to that. It would be our Chief Medical Director that would be best placed to answer that. I, I'd make a couple of notes and take it away and follow up on that question.

CHAIRMAN MULLIN: Okay. That's all I have.

MR. BARBER: Any redirect for this witness?

ATTORNEY ASAY: Just one question. Ms. Greene, if you could turn to Page 128 of Exhibit 1 again briefly.

CHAIRMAN MULLIN: Could you repeat what page it is?

ATTORNEY ASAY: Yes, Page 128 of Exhibit 1.

THE WITNESS: I'm there.

REDIRECT EXAMINATION BY ATTORNEY ASAY

Q. Okay. And does this page reflect that Blue Cross accounted for the AMT refunds in building the proposed

rate that's, that we're discussing today?
A. Yes.
ATTORNEY ASAY: Thank you. Nothing further at this time.
MR. BARBER: Okay. Any cross on that very limited inquiry?
ATTORNEY ANGOFF: None, thanks.
MR. BARBER: So I was hoping we could get -- so Andrew Garland is your next witness, correct?
ATTORNEY ASAY: That's right.
MR. BARBER: Yeah, I think we got to go to lunch. So why don't we take a 30-minute lunch break, come back here at 1:35?
(A recess was taken from 1:02 p.m. to 1:35 p.m.)
MR. BARBER: I'm going to call this meeting back to order. We are back on the record in GMCB Docket Number 006-19-rr. Sorry. That's wrong. I think we left off Blue Cross has yet to call their last witness. So, if you would like to call your next witness --
ATTORNEY ASAY: Yes. We call Andrew Garland.
THE WITNESS: Good afternoon.
DIRECT EXAMINATION BY ATTORNEY ASAY
Q. Mr. Garland, would you please state and spell your name?

A. It's Andrew Garland, A-N-D-R-E-W G-A-R-L-A-N-D.
Q. What is your position at Blue Cross?
A. I'm the Vice President of Client Relations and External Affairs.
Q. How long have you held that position?
A. For just over four years.
Q. And what was your position before then?
A. Before then I was the Vice President of Payment Reform and Enterprise Network Strategy for MVP and also the Vice President for Vermont, and that was for three years.
Q. And did you have another position at Blue Cross before you were at MVP?
A. Yes. I started with Blue Cross in 2002 and was with the plan until I went to MVP in 2012. I served in a number of roles, including the Director of Provider Contracting and the corporate Director of Network and Provider Affairs.
Q. As part of your work, are you familiar with Blue Cross Blue Shield of Vermont's participation in Vermont's accountable care organization?
A. Yes, I am.
Q. Is working with the accountable care organization, or ACO, part of your job responsibilities?
A. It is. I am the executive sponsor for engagement

with OneCare Vermont, and our Director of Health Care Reform, Kelly Lang, works directly for me.

Q. Would you please briefly explain what the ACO is and how it works?

A. Yes. The ACO is an administrative entity brought together by a group of participating providers to help them organize around payment reform so that, together, they can work toward creating a more efficient health care system, one that delivers lower cost, better quality of care, and improved access. Specifically, what the ACO does is marshal data and information and tries to get that information out into the provider system in organized way to help participating providers change their practices, better engage with their patients.

So the data can be very focused on, you know, which patients have the highest degree of illness or are carrying a lot of risk and need to be seen right away? It can also be more a systemic, which practice patterns seem to be yielding the best results, where are the best practices in the system, and how can we learn from them and have them more widely adopted?

They also administer the payment reform program on behalf all of those providers, trying to restructure payment incentives to support the work that they're

trying to do.
Q. And the ACO, it's called OneCare, right?
A. That's right, OneCare Vermont.
Q. Use those interchangeably? How many commercial payers participate in OneCare Vermont?
A. At this time, just one, Blue Cross Blue Shield of Vermont.
Q. So the payers are public payers?
A. That is right. Both Medicare and Medicaid participate.
Q. Is it voluntary for providers to participate in OneCare?
A. Yes, it is.
Q. And, if they choose to participate, do they have to participate across the board, or can they choose to participate only for some payers?
A. Yeah. It's the, as former Chairman Gobeille used to say, it's a coalition of the willing. At this point, providers do not have to participate with all the three payers. In fact, there are few that do. Most of those are hospitals. Today, only -- of all the providers in Vermont, only 8 hospitals, 2 federally qualified health centers, and about 50 percent of physicians are participating in the commercial program. Significantly more participate in both the Medicaid and

Medicare program.
Q. So the participation level for the commercial ACO is lower than the public payers?
A. Yes.
Q. Can you just briefly explain how the ACO financial arrangement works for the commercial payers?
A. Yes. Our program with them is a shared savings program. Again, the goal is to lower the cost of care while improving quality and maintaining or improving access. And, to do that, we share savings with providers. So the basic logic is they'll work at making the health care system more efficient. As a result, their fee for service revenues will decrease, but they will be made whole by sharing in the savings that they're creating.

So, in order to share savings with them, we need to be able to determine that savings were, in fact, accomplished. So an important component of the program is a projection of what we might call a baseline expense or a steady-state target. In other words, looking ahead a year, what would we expect the spend to be if the ACO didn't make any improvements? That's our baseline for measuring their performance, and then we measure the actual cost of care when the period is over.

If the actual cost of care is lower than that expected baseline, we know that the ACO generated savings, and we will share those savings with them, and, if the actual cost of care is higher than that baseline, then we assume that they were ineffective, and they will, in fact, because it's now a two-sided risk deal, they will, in fact, return some of that overspend to the health plan.

Q. How does the Board's premium rate setting affect the ACO financial arrangement for the commercial payer?

A. Directly. A critical component of the model is the premiums, and that baseline expenditure are tied to each other one for one. So any changes the Board makes to the premiums or any of the underlying assumptions will flow through directly to that projected expenditure for the ACO. So, if rates are cut or assumptions are lowered, those same cut rates or lowered assumptions will be reflected in that projected baseline for the ACO.

Q. Is there an example that you could provide the Board to illustrate is that point?

A. Yes. So, a concrete example, in 2018 I think our actuaries filed a 2 percent trend assumption, and the Board cut that assumption from 2 percent to 1 percent, which was not recommended by either our actuary or L&E.

We reflected that cut directly in the ACO's projected baseline.

So the numbers worked out this way: Their target was $530.91 per member per month with that 1 percent trend, you know, baked into the target setting. If, if we had gone with the 2 percent trend that Blue Cross Blue Shield of Vermont recommended, their target would have been $541.37. So that trend cut flowed through to their target at about $11 PMPM, or somewhere around there.

We just settled 2018 with the ACO a few weeks ago. They owe us $645,000. The expenses came in unfortunately above that target of $530.91, so their share of that $1.3 million, about $650,000. If we had left the trend at the 2 percent that we recommended, they would have owed us nothing. Their performance would have come in essentially exactly at projection.

Q. Are the rate setting decisions by the Board affecting the willingness of providers to participate in the commercial ACO?

A. Yes. Providers are very aware of this rate setting process, and they are aware that our rates have been cut, and they have concerns about participating with us when they believe there's a strong possibility that the rates are underfunded. The providers know

that the performance target is directly tied to the rates, and they also know that, if they choose to participate with us, they're taking a lot of risk that they will fail to achieve the shared savings target and that they are very likely to owe the plan money at the end of the year as a result of their participation.

I think, essentially, we could say that the bottom line for them is that, as long as the rates and the target are aspirational and not actuarial, there really isn't a realistic way for them to be successful.

Q. Are there other negative consequences to this dynamic that you haven't covered yet?

A. Yes. I think, in addition to the financial risk, there are a few other factors that really concern providers about this particular dynamic. One, their credibility and their brand, both as an ACO and as providers, they understandably do not want to sign up for a program that is likely to lead to failure and undermining their credibility.

I think they know, as we all do, that the all-payer model is in a very delicate stage, and it's important that we continue to build credibility and support for the program, and they're very concerned that the commercial portion of the all-payer model is going to undermine that credibility as they fail to

meet targets.

I think it's also worth noting that the providers that we work with, the physicians and nurses and other practitioners, are scientists, and, like actuaries, they have really serious problems working with data or financial models that they feel are fundamentally flawed or not representing the truth. So we get a lot of push-back, and we have had many, many long hours of conversation about how we would pass on a 1 percent trend when our actuaries believe that the actual result will be 2 percent. That's something that they really struggle with as professionals.

And then a third consequence, I think, both the ACO administration, although this is working well on, but many of the providers who participate in the ACO more specifically are concerned that Blue Cross Blue Shield of Vermont won't have the resources that we need to contribute to the success of the ACO. It's a collaborative effort in order to accomplish a real transformation in our system and really begin harvesting the kind of savings that we can by building a health care system.

We've all got to be at the table contributing resources, putting our programming together, sharing data, and the providers are concerned that we're not

going to be able to do that because we simply won't be funded.

Q. You indicated when you discussed the 2018 example that the Board's trend assumption was used, not Blue Cross Blue Shield's trend assumption. Could Blue Cross Blue Shield of Vermont have used the 2 percent trend assumption for the ACO?

A. No, we can't, we can't make the model work if the approved premiums and all the factors therein are not aligned with the target, and I think a hypothetical example helps to illustrate this. So the, the approved premium with a 1 percent trend for the members in the ACO is $530.91. If we had put in our target instead the $541.37 and went with two different numbers, not only would we have to explain why we sort of turned our noses up at the GMCB-approved trend, but, more importantly, we would have a real logistical problem.

So imagine that we have a target of $541 but premium coming in only at $530 and the actual performance ends up landing at $538. So we have spent considerably more than we've taken in. We've lost $8 per member per month, because the premium coming in is only $530. The actual expenditures are $538. But the ACO will also have earned shared savings, because their target is up at $541. So, in addition to the $8 of

actual losses, we would also have to fund 50 percent of that $3 difference between the ACO target and the performance. So we would be in a place where a successful all-payer model ironically would be further undermining the solvency of the commercial participant, making it frankly unsustainable for the long term.

Q. Based on your experience with the, with OneCare Vermont, in your view, if the Board, for 2020, relies on the lower trend estimate purported by L&E, will that have an impact on the commercial ACO?

A. Yes, I believe it will. I think providers will judge that it will be much more difficult to achieve any sort of savings, that they're likely to take a loss, and I think we'll see far fewer providers participate as a result of that. And I just know that our network with the ACO essentially did not grow at all between 2018 and 2019. We added almost no new providers to the commercial model. Despite the fact that we've been working quite well with the ACO on all other dimensions, there remain a lot of concerns about this financial component.

Q. Are there any other dynamics that you're aware of that might be limiting provider participation in the commercial ACO?

A. We do hear from a number of providers, and I

wouldn't go into too much detail in a public setting, but we hear from a number of providers that the Green Mountain Care Board pushes on them hard enough in the rate hearing process and the ACO cannot be used as a back-door methodology to lower their reimbursements still further.

Q. In the questions and testimony of earlier witnesses, there's been a fair amount of discussion of cost-containment and cost-control measures. Is there some insight on that point that you would like to add?

A. Sure, yeah. Like Ruth, I participate, you know, with the senior leadership team in strategy setting, and I think there's some further insight I can add, and, if folks have questions about specific programs, I can get into some of those as well. I can tell you, from my work with both clients and providers, these programs are extremely important to us but that we need to keep in mind a couple of limitations.

One is that, as hard as we work to develop cost-containment programs, there are major factors at work driving the cost of health care that we cannot directly impact. The health of the overall economy, real wage growth, these things are known to be tied to the amount of services that people use, and, obviously, we can't control them. The cost of new technologies,

new courses of treatments, the national pricing of prescription drugs, these things are all beyond our purview to affect through cost-management programs.

We work very hard to try to mitigate some of those factors or work counter to them, but, at the end of the day, as I think both Ruth and Paul have noted, it's our responsibility to pay for the health care that our members need, and we can't stop paying for that care simply because we've reached the limit of the, you know, the utilization trend that was approved in our premium. We keep paying as long as that health care occurs.

I think another point that's important to make is that OneCare and the work that we're all doing on the all-payer model will help us in the long-term change a profoundly difficult dynamic to deal with, and that is that, today, the provider system operates on a revenue basis. So I think a way to think about that is that, to the extent we're successful with cost-management programs, what we tend to do rather than profoundly change the cost picture is shift costs from one bucket to another.

So, if we save $1 million or $2 million through a cost-management program, the provider system is still out there managing to a revenue target, and, if we pull

revenue down $2 million over here, they will react and find ways to raise the revenue they need in other places.

Now, if we are good and we're persistent, that does mean creating value for our clients and customers, and sometimes we can see where it's going up and try to countermand it, but right now the core logic of our system is still revenue-based, and, to an extent, it will continue to be self-correcting until we fully effect the work that we're all trying to do through the all-payer model to get to a place where those revenue incentives are really, are gone, right, pulled out of the system.

Q. So I want to change direction slightly to talk about provider negotiations. As part of your work with Blue Cross Blue Shield of Vermont, are you familiar with its negotiations with providers?

A. Yes, I am.

Q. And is that part of your job responsibilities?

A. Yes, it is. I have directly overseen that work for the past four years. I oversaw similar work for MVP in Vermont when I worked for them and then for a number of years before moving to MVP, maybe four or five years, I was directly responsible for provider negotiations.

Q. Can you briefly identify in general terms the areas where Blue Cross negotiates with providers?
A. Yes. Our negotiations are primarily in the hospital space. We directly negotiate with all of the hospitals that are in our network. Most of the rest of our reimbursement is managed by nonnegotiable fee schedules, or our professional provider reimbursement is managed by a fee schedule that the plan sets, manages.
Q. Last year, you testified at some length regarding this work that Blue Cross does to try to achieve savings through these processes. Do you recall that testimony?
A. I do.
Q. Have those efforts continued with Blue Cross?
A. Yes, we've continued to use the same approach to collecting information and making sure that every hospital hears from us with an aggressive proposal.
Q. In general terms, how would you describe Blue Cross Blue Shield of Vermont's outcomes in negotiating with providers?
A. I think we're as successful as we can be given the constraints of our system.
Q. And what are those constraints?
A. There are two that are worth mentioning. One is

the rate approval, the hospital rate approval process. As I think I've mentioned before, many hospitals believe that the Green Mountain Care Board has taken everything that they need to give on the commercial side, and they're simply not going to negotiate with us.

The second is that we are a small, rural state with very little competition. So it's very hard for me to do what provider negotiating people do in other markets, which is to remove providers from the network in order to lower the cost of care or to really use our, our size as leverage.

Q. Mr. Garland, in your view, is it appropriate to further discuss the outcomes of Blue Cross Blue Shield of Vermont's negotiations with providers in a public session?

A. No.

Q. Why not?

A. For two reasons: One is because it's extremely important that we maintain a trusting relationship with our providers. There's a lot of things that we speak about in negotiations, and I think, if I were to speak about any of that publicly, it would erode that trust, and it would make it difficult for me to continue to have successful negotiations.

Secondly, I think a lot of the information we would discuss next is commercially and competitively sensitive, and I would not want to discuss it an open forum.

ATTORNEY ASAY: For the reasons that Mr. Garland just gave, Blue Cross Blue Shield of Vermont requests that the Board enter executive session to take further testimony on negotiations with providers, which is proprietary and commercially sensitive.

MR. BARBER: Okay. So there's been a request to go into executive session to discuss confidential trade secret information. This is the kind of information that we have granted confidentiality for throughout this process. Like yesterday, the procedure is that we would need to have a vote to go into executive session that specifically identifies the subject we will be discussing, and we would not be able to stray from that and discuss other matters, and there would need to be a motion and a two-thirds vote approving that.

CHAIRMAN MULLIN: Prior to a motion, Mr. Hearing Officer, might I suggest that, if we are to entertain this motion, that anyone that would have any questions, including the Board and the HCA, be able to do that during that period, rather than waiting until

afterwards when he's finished with all testimony.

MR. BARBER: Yes, I think that would be the procedure that we would like to follow. So, assuming that's agreeable, to both parties --

ATTORNEY ANGOFF: It is.

MR. BARBER: Is there a motion?

MS. LUNGE: I will move that the Board go into executive session to discuss confidential provider negotiations between the carrier and the providers they contract with.

MS. HOLMES: Seconded.

MR. BARBER: Okay. It's been moved and seconded. All in favor, please signify by saying "aye". Any opposed? Okay. The Board has voted to go into executive session to discuss provider negotiations. Before we go into executive session, I just wanted to say we are really -- I'm worried that we're not going to get to our actuaries, which I think would be a disservice to this process, because they've traveled here from Texas, and there's some points of disagreement between their actuaries and ours.

So I don't -- let's just all try and be quick through this, okay?

(An executive session was held. The testimony continues in a confidential transcript.)

MR. BARBER: So we are back into the public portion of this meeting. Ms. Asay, do you have any additional questions?

ATTORNEY ASAY: No.

MR. BARBER: Mr. Angoff, do you have any questions?

ATTORNEY ANGOFF: No.

MR. BARBER: Board members, do you have any remaining questions?

MS. LUNGE: I have a couple quick ones. Mr. Garland, could you talk to us a little bit about whatever you can say publicly about the ACO program in 2020?

THE WITNESS: Yes. We are pretty excited about the 2020 program. It doesn't look like the network is going to grow very much, but the ACO remains committed to the QHP line of business. They're ready, they think, to take on a little bit more risk. So I expect a large group pool will also go into the program in 2020, and, working together with them, we've made significant strides on a plan to bring self-funded clients into the program in a way that will be safe for the ACO and safe for the self-funded clients. So that's very exciting.

Also, we have a couple of really effective work

groups that the organizations are jointly sponsoring that have really gotten into some opportunities, we think, on the primary care side to both better educate about gaps in care and to do that in a way that really moves that information into a provider's work stream so that it's actionable and also a jointly sponsored program to get at the 5 or 6 percent of ACO members who have not seen a primary care physician at all in the last two years.

MS. LUNGE: Great. And are you expecting to move to a capitated payment methodology or an all-inclusive population payment?

THE WITNESS: We are. At this point, I think that will probably go into effect until April. A couple of the providers in the system have a pretty big technology transition. They're working on end-of-year, and they'd like to get that behind them. I do think the initial rollout will be a little bit smaller than we had hoped, because, apparently, there have been some payment issues on the Medicare side, and providers want to know that they've got that in their rearview mirror before they move to the fixed perspective payment with us.

So we may start with just a few hospitals in April. My expectation is, by the end of the year,

most, if not all, of the hospitals in the network will be joining. Whether that will happen all at once or one at a time is to be determined.

MS. LUNGE: And there's been some payment issues on your side as well in fee-for-service this year, haven't there?

THE WITNESS: Yes.

MS. LUNGE: Do you expect that that could also influence provider participation in growing the network?

THE WITNESS: I wouldn't think that that would affect our 2020 network. That's far enough behind us already, and we're a long way away from nailing down the 2020 network. So I think that will be safely in the rearview mirror.

MS. LUNGE: Thank you.

MR. BARBER: Anyone else?

MS. HOLMES: Thank you.

MR. BARBER: So I understand the Commissioner's been gracious enough to let our actuary come testify just to make sure that we get that in.

MR. PIECIAK: That's right.

MR. BARBER: Thanks.

DIRECT EXAMINATION BY ATTORNEY ABORJAILY

Q. Good afternoon.
A. Good afternoon.
Q. Would you please state your name and spell it for the record?
A. Dave Dillon, D-A-V-E D-I-L-L-O-N.
Q. What is your position with Lewis & Ellis?
A. So I am Senior Vice President and principal at Lewis & Ellis, the Dallas office. I have been there for slightly over 20 years now.
Q. And what work does Lewis & Ellis perform?
A. So Lewis & Ellis is primarily an actuarial consulting firm. That's how we started in 1968. But we do other areas of insurance work also, compliance, insurance compliance and insurance financial examination work also.
Q. You said that you've worked there for almost 20 years or over 20 years. Can you tell us a little bit more about your educational background and your experience as an actuary?
A. Sure. I got a bachelors degree in mathematics from Oklahoma State University and then a masters in statistics and actuarial science from the University of Iowa. I don't remember exactly when I got my credentials. I've been a credentialed actuary for

about probably 15, 16 years.
Q. And do you have any professional certifications?
A. Yeah, as part of that credentialing, I'm a member of the American Academy of Actuaries. That's primarily kind of the professionalism and standards organization. And then I'm a fellow of the Society of Actuaries, and that's primarily the education and research body.
Q. And what is your experience with the Vermont health insurance marketplace?
A. So I've been involved in Vermont since 2014 when we were engaged by the Green Mountain Care Board, and we have worked with approximately 65 filings across individual, small-group, merged market, and large-group filings.
Q. And to what extent have you done work in filings for other states?
A. So the bulk of my personal work is kind of -- I always joke I'm kind of a quasi-regulator. About three-fourths of my personal work is with states and jurisdictions governing health insurance. Since 2010 my staff has worked with over 20 states on health care reform issues, different aspects of it. Currently, Lewis & Ellis is advising twelve states on ACA rate review, and the four individuals that are primarily responsible for Vermont are working on nine states'

rate review this year.
Q. And, given that you've done some work with other states, what kind of comparative look do you get at the nationwide health insurance marketplace?
A. So, obviously, as everyone in here has commented and talked about, you know, Vermont is a little bit different. The market is different. It's community rated. It has a merged market. However, it is helpful that we work with other states, because, obviously, with the ACA there is a lot of issues that have impact everybody. May impact Vermont a little bit differently, but, but it definitely does help, you know, to have discussions with other states and other people in terms of how marketwide issues, you know, impact them and how they might impact in Vermont such as the individual mandate, such the AHP, issues like that.
Q. And are there other ways in which you keep up with changing health care reform issues and changes in the regulatory landscape?
A. Yeah. So, in addition to primarily working with states, Ms. Lee and I are both very active with the Society of Actuaries, and that keeps us very informed with health insurance issues. I currently serve on the Society of Actuaries Board of Directors. Ms. Lee is

the Vice Chair of the Society of Actuaries health section. We both were involved with a recent strategic initiative for the Society of Actuaries called, "Commercial health care, what's next?" So it's kind of, through those volunteer efforts, we definitely stay on top of things that we may or may not have also been addressed through work issues.

Q. And, for those who are not aware, could you explain who Ms. Lee is?

A. Jacqueline Lee, my coworker.

Q. And did she work on this filing also?

A. Yes. So the way -- I'll go ahead and maybe fast-forward a little bit to one of your next questions is, in terms of how we do the review, I mentioned earlier we primarily have a team of four actuaries that work in Vermont, and three are directly assigned to the Blue Cross filing. Kevin Ruthenberg, who is an associate of the Society of Actuaries, was the primary reviewer. I was the kind of next in line or the primary peer reviewer for the Blue Cross filing, and then Jacquie Lee is the secondary peer reviewer for Blue Cross, and she was also -- and we kind of, we both work on the MVP filings as well. So we kind of have different roles. She focused on MVP but kept an eye on Blue Cross to make sure we were consistent on certain

issues, and me with MVP. So, you know, I also was a secondary peer reviewer on MVP so that I can make sure that we were consistent with marketwide issues.

Q. And, speaking to the filing process generally, what is the process, and what sort of standards are you looking at?

A. Yeah, so in a rate filing so, you know, kind of mechanically everything is done through SERFF, the System for Electronic Rate Forms Filing, I think, is what it stands for. And that so, once the company submits the filing through that, there is a 60-day window, statutory window, that we have to meet to issue our report. So, as we review those, as we kind of dig in and review the filing, we will submit questions through SERFF, and the company will respond through SERFF, and that's how we communicate with the company for several reasons. One, it's kind of a standardized process, and it provides a kind of a record after the fact, after the fact of all the communication.

Q. And what happens at the conclusion of your 60-day review?

A. So we will issue a final report that we send to the Green Mountain Care Board, and it gets posted publicly for all parties to review, and that includes any recommendations we may have.

Q. And I believe that report is Exhibit 14 for this filing. Could you turn to Exhibit 14?
A. Okay.
Q. And I'm specifically looking at Page 2, the bottom of Page 2 where it says "Standard of Review".
A. Yes.
Q. Is this your standard of review, or is this the Board's standard?
A. So this is the Board's standard of review. That is the primary review that we are kind of beholden to. So we assist the Green Mountain Care Board with several of these issues, primarily kind of the terms excessive, inadequate, unfairly discriminatory, but I will also note that our review, there are, you know, other requirements as well that we have to look at. There are federal requirements, obviously, with the Affordable Care Act, and then we also -- it's been mentioned a couple times today, but Actuarial Standards of Practice help guide certain things that we have to review or have reviewed in a filing.
Q. And, per those standards, how is excessiveness defined?
A. So excessive, there are a couple definitions. I think kind of CMS has their own that they use when they review a filing, but kind of primarily for my review,

it is based on Actuarial Standards of Practice, and what we do is we review the claims piece, we review the admin piece, and we kind of make sure that all those issues are good, and then we compare it to the premium that's proposed and make sure that the premium, given the claims, given the admin, given those assumptions and a reasonable assumption for profit, that the premium charge for that is not excessive.

Q. And how about a definition for adequate?

A. So it's basically the other side of that coin. Once we've set that, kind of have reviewed the claims, reviewed the admin, reviewed the reasonable, I guess, kind of omitting the profit piece, we look to see if the premiums will cover those, and, obviously, if the premiums do not cover the admin or the claims, then we would say it's inadequate.

Q. And how about defining the term unfairly discriminatory?

A. Yeah. So unfairly discriminatory doesn't come into play too often in a review, especially in Vermont, but unfairly discriminatory is basically just confirming that a carrier doesn't charge two very similar people different rates. You know, they may live in certain geographies or have certain ages, and it's just to make sure that they're charging similar

people similar rates.
Q. And, at various points during your report, you may state that a given assumption is reasonable and appropriate. Could you explain a little bit about what that phrase means, reasonable and appropriate?
A. Yeah. Reasonable and appropriate is really just a synonym for not excessive, not inadequate, and they're not unfairly discriminatory.
Q. And, to be clear, do you review a filing for affordability?
A. Do not, no.
Q. And did you make any recommendations for this particular filing?
A. Yes, we did. I believe the -- let's see. I believe it starts on page, Exhibit 14, Page 24 of Exhibit 14. While there are kind of a few multiple recommendations within each of these bullets, we do have seven bullets, seven kind of high-level recommendations. Two of those do not impact rates as of the issue of this report. One may, which would be kind of what ultimately happens with the unit costs in the hospitals, but, as of the issue of this date, there were five recommendations that impact our assessment of the rate and two which did not.
Q. So, in the interest of time, rather than walking

through each of these individual recommendations, I would like you to turn to Exhibit 19 of Binder 1.
A. Okay.
Q. And have you seen this document and had a chance to review it?
A. Yes, I have.
Q. And were you present this morning when Mr. Schultz testified regarding this document?
A. Yes, I was.
Q. So I was wondering if you could just go line by line and tell us what L&E's recommendation is and whether that remains your recommendation after hearing testimony this morning from Mr. Schultz.
A. And do you want me to focus on each line or just the ones that there's still an open disagreement, or --
Q. Let's start with the ones in disagreement.
A. Okay, will do. So the first one is the medical utilization trend. When we reviewed that, you know, there are several -- you know, this is obviously a very key assumption. It is kind of one of the true, real kind of actuarial calculations in assessing, you know, what is an appropriate calculation for this. But there are some challenges this year. This is a very complex calculation, primarily centering around the dramatic enrollment shifts that we've seen between the two

carriers over the last couple of years.

Obviously, if, if no one moves and it's the same, you know, insurance company covers the same people every year, it's much easier to get a better understanding of what their costs are going to be next year, but it is challenging and complex to estimate what that increase is going to be when you're also losing people, and there, the people that are sticking around are sicker. You know, when did they become sicker? When did they decide -- you know, did they have a decision? Was it a personal decision to stay with Blue Cross because they were sick? You know, so there's a lot of underlying variables there.

Blue Cross, in their analysis, definitely did some controls to try to analyze, you know, and account. We might say normalize or standardize for those moving variables. However, as we look through it, we wanted to ask further questions just to make sure that all variables were controlled, because the market has changed so much over the last couple of years. And that did primarily center around kind of the health status of the company. The health status of the company has changed.

So we asked some questions about, if the data used for the trend had been normalized for health status,

and they provided some preliminary information, which led us to further questions, and it was still in our mind at that point that there might be still be some additional factors that may not have been controlled for in the data, primarily, again, centering around big enrollment decreases and increasing health status.

So, at that point, we kind of combined the analysis with MVP on a confidential basis. So this was information that both carriers -- we utilized this for both filings to help us assess both the trend in both filings. But one reason we thought that was helpful was, while MVP has growing enrollment shifts and is relatively healthy and Blue Cross has been losing membership, in the aggregate, the Vermont market has been relatively stable. And so, when you look at it in the aggregate, it does kind of mitigate those enrollment shifts and the moving around, because now we are a little bit more stable. There's still some issues going on in there, but it is still, again, kind of to the comment I made earlier, if something's more stable, it's easier to predict. So that's why we looked at the marketwide data.

So, when we looked at the marketwide data, it did help us get a little better sense of what the market was doing. Now, I will say that it is very clear that,

even after this analysis, Blue Cross's utilization is higher than the market average, and we do think that that is supported, and, and I believe it was mentioned that, you know, MVP's was lower than that. So, obviously, if you have one higher, one lower, you average it out to where that marketwide is.

But, after that aggregate analysis, we did feel that it kind of, it helped mitigate and control for some other factors, and so, based on that, we recommended a drop in the utilization from their kind of final 3.2 to our kind of final 2.5.

Q. And, after hearing the testimony this morning, have you changed your recommendation as to the recommendation to lowering to 2.5?

A. No, I have not. I completely understand Blue Cross's position about the coding. That was a big topic of discussion this morning, and I completely agree that is an issue to be taken into consideration. However, it's our position that it did not control for all of the variables in the underlying data. We do believe that there can be some antiselection, even in a closed cohort.

When you look over multiple years' time period, there can be someone two years ago that is still around that, at their last renewal, could make some

antiselective decisions. So we even, we believe there are some other variables kind of lurking in the data, and that's why we believe using the marketwide data does help inform that.

Q. Moving on to the next line, which is cost trend from 2019 to 2020, in L&E's report there was a recommendation about the Board considering updated 2020 hospital budget information, should it become available. Do you have any recommendation on that aspect as of today?

A. So, obviously, I have not had any opportunity to review their calculations for this estimate. However, based on our preliminary -- the narratives for this information has not been released too long, but our preliminary information is very consistent with Blue Cross's estimate. So, while I reserve the right to maybe have a slightly different opinion once we get an opportunity to review the data, this does appear to be a reasonable estimate and in line with our expectations.

Q. So I'm going to move down a couple lines to individual mandate morbidity impact. Could you explain a little bit about your recommendation for individual mandate morbidity impact and then maybe discuss whether that opinion has changed given the testimony this

morning?
A. Yeah, sure. So, with the mandate, you know, this has been a very tricky assumption that we've reviewed in multiple place, multiple states, and, and, you know, this was, there's a lot of different industry information on it, but, when we reviewed Blue Cross's assumption, we felt that they were just slightly too conservative in their assumption, and that was different by a couple things. One was the assumption that, if there was someone that did not receive a subsidy and did not have claims, that they would, they would leave.

We believe that is slightly too conservative, and we have seen experiences where that is not, not that case in data sets we have reviewed for other states and other analyses. So we just felt it was just slightly too conservative, and, you know, we don't believe that since -- yes, there had been some kind of ebbs and flows with the, you know, with, if the mandate was in place or not in Vermont and, you know, kind of the different timelines. We were not convinced that there would be that drop primarily, again, from the population that they assume that it would leave. So we are recommending that removal of that assumption.
Q. And that remains true even after this morning's

testimony?
A. Correct.
Q. Moving on to changes to risk adjustment, could you explain a little bit, could you explain a little about L&E's recommendation?
A. Yeah. So the risk adjustment is -- I'll try to keep it somewhat short, because we have had some discussion about it, but it is, this is a very significant factor, and it's very important, primarily because it is a zero-sum game between the market players. It's a very challenging assumption for the carriers to estimate, because they pretty much are doing it with one hand behind their back, because they don't know what the other carriers are doing, and, specifically in Vermont, the one other carrier.

So we started a couple of years ago to kind of help facilitate that process. You know, the filings have already come in, but we've requested additional data, and we kind of get a better number for the estimate that we deliver to both companies that help true up kind of the starting point for the risk adjustment calculation, because we did have access to both carriers.

One additional step we did this year was there was a change to the federal risk adjustment program. They

have continually tried to improve that process, and this year they made a relatively significant change with some coefficients, and so we took a look at that, and we did believe it would have an impact to the Vermont market.

Roughly speaking, it impacted kind of the bronze-platinum relationship, and that is an issue that was raised by Blue Cross last year. It's been mentioned again in this filing, and so, while I don't necessarily think the CMS change was necessarily designed for that specific issue, it does kind of help mitigate that, and so, once we ran those coefficient changes, we informed both carriers that their estimates should be modified, and that would be more money received by Blue Cross.

So those were kind of the two, the two main issues. The area of discrepancy or difference here that Blue Cross mentioned today was with regards to kind of the movement of the small, of some small groups. While I have not necessarily reviewed all of those calculations, I would advise the Board that that would be something that would be reasonable to consider, to further look at.

Q. It would be reasonable to, for the Board to further look at Blue Cross's calculations?

A. Yes.
Q. Okay, thank you. And, moving down to newborn morbidity adjustment, could you please explain L&E's recommendation there?
A. Yeah. So the newborn morbidity adjustment was somewhat similar to the previous time. That was one where kind of during the review process, for whatever reason, further questions were not asked, and further commentary was not provided for whatever reason, and Blue Cross has mentioned today that that was not included. So I would make the same recommendation that there should be, would be reasonable for the Board to review their calculations.
Q. Thank you. And I note, flipping back to, flipping back to exit, excuse me, Exhibit 14 --
A. Okay.
Q. -- I just wanted to confirm that there were a couple of recommendations on page -- I think we're on Page 24 and 25. I just wanted to confirm that. There was a recommendation listed impact of selection. I just wanted to confirm that this recommendation would have no impact on rates; is that correct?
A. Yes. The impact of selection goes to the issue I've raised or discussed earlier about Blue Cross's concerns about kind of relationship between the metal

tiers. They did some additional analysis this year and kind of modified their approach. We agreed with the modified approach.

However, we kind of felt it was maybe an above the line, below the line kind of issue. We just kind of made a recommendation where it should be included to better represent what we believe that adjustment was for, but it is so, while, if you look at a couple of the exhibits, you might see a couple of wide swings in two of the provisions, the net of those are zero for this issue.

Q. So, having quickly reviewed all of those recommendations, do you believe that the rates, if your recommendations are implemented, would be excessive?

A. No.

Q. Do you believe those rates would be adequate?

A. Yes.

Q. And do you believe those rates would be unfairly discriminatory?

A. No.

ATTORNEY ABORJAILY: No further questions.

MR. BARBER: Okay. I have a clarifying question. Changes to risk adjustment, newborn morbidity adjustment, will you be following up with an objection letter to Blue Cross on those issues?

THE WITNESS: I guess my question is, do you, is the typical protocol post-hearing on how we do that?

MR. BARBER: I'm not sure how we do it.

THE WITNESS: Okay. So I'll leave that open-ended.

MR. BARBER: Questions for Mr. Dillon?

ATTORNEY DONOFRIO: Yes.

CROSS-EXAMINATION BY ATTORNEY DONOFRIO

Q. Sorry. I can't see.

A. Here, I'll swing around here.

Q. I'm Mike Donofrio. I represent Blue Cross. Good afternoon.

A. Good afternoon.

Q. I'm going to try to be very brief given the hour. I want to focus your attention on the medical utilization trend. In particular, can you turn to Page 11 of Exhibit 14? And, in the middle of the page, do you see there are three bullet points --

A. Yes.

Q. -- which I believe you, L&E, has identified as the reasons why you recommended lowering the utilization trend; is that right?

A. Yes.

Q. Okay. And the first bullet there, so the first reason says, "L&E notes that the outpatient utilization

trend has oscillated in recent years and has leveled off in late 2018". So that's one of the reasons you gave for lowering the trend, right?

A. Yes.

Q. In doing whatever work you did to come up with that reason, did you compare the fourth quarter of 2018 to the third quarter of 2018 in terms of outpatient utilization trend?

A. Yes, we did. One thing that I did not mention earlier was 2018 definitely, there was definitely an uptick in utilization across all lines, and so we did try to further review that, and we did take that into consideration between different quarters and between different benefit categories in how we assessed what the appropriate trends were by those categories.

Q. Okay. And, as you just said, you did, you saw an uptick in outpatient utilization as you performed that analysis?

A. Yes.

Q. Moving to the second bullet, that one reads, "The reduced assumption is consistent with marketwide data". Do you see that?

A. Yes.

Q. And, if you look over on Page 10, the last sentence of the second paragraph reads, "L&E believes

that a reasonable range for marketwide utilization trend is 1 percent to 4 percent". Do you see that?
A. Yes.
Q. So, when you say that the reduced assumption is consistent -- oh, and I'm sorry. Does, that range emerged from your, the marketwide analysis that you described in your direct testimony, right?
A. Yes. The 1 to 4 percent is our range for the marketwide, yes.
Q. Okay. So, when you say that the reduced assumption is consistent with marketwide data, you mean that it falls inside that range, correct?
A. Yes, it seems reasonable based on that range we looked at, yes.
Q. And the reduced assumption that you're talking about here is 2.5 percent, right? Because here you were looking at the trend after having taken account of cost-containment activities, right?
A. Correct.
Q. And the comparable Blue Cross trend, the comparable Blue Cross number to that 2.5 percent is 3.2 percent, right?
A. Correct.
Q. And 3.2 percent lies between 1 and 4 percent, correct?

A. It does.
Q. So that, so Blue Cross's proposed trend here is also consistent with marketwide data, right?
A. Yes, it also falls within the range.
Q. And that is your definition for this purpose of what it means to be consistent with marketwide data, right, falls into that?
A. Yes, the word "consistent". I may not say it would be as reasonable, but consistent, yes.
Q. Okay. And the reason you gave here is that it was, is that the reduced assumption is consistent with marketwide data?
A. Correct.
Q. Okay, okay. At the top of Page 10, there's a small table. You see that?
A. Yes.
Q. And that's the results of your marketwide analysis shown for three different timeframes, right?
A. Correct.
Q. So, if you look at the first sentence under that table, you, L&E, stated that your 24-month marketwide estimate of 4.2 percent is substantially similar to Blue Cross's 2-year estimate of 4.1 percent, right?
A. Correct.
Q. And, just for the record, if you would flip to

Page 6, there's a table towards the bottom of Page 6, and that's where you got the Blue Cross 4.1 percent from, correct?
A. I believe so, yes.
Q. Flipping back to Page 10, I may make you do that, flip a few times.
A. That's fine.
Q. On Page 10 the next sentence under the, the table at the top, so the second sentence states that your 36-month marketwide estimate of 2.0 percent is materially lower than Blue Cross's comparable 3-year estimate of 3.1 percent, right?
A. Correct.
Q. And, again, that 3.1 percent, the Blue Cross figure, comes from the table on Page 6, right?
A. I believe so, yes.
Q. Okay. Now, the difference between -- go back to Page 6. I'm sorry.
A. Okay, sure.
Q. Thank you. The difference between the two Blue Cross numbers here, the 2-year average of 4.1 percent and the 3-year average of 3.1 percent, results from the inclusion of the time period 2015 to 2016 in the, in the calculation, right?
A. I believe so.

Q. I'm just kind of reading that right off of the table.
A. Yeah, that's fine.
Q. Okay. If you could return to Page 10, please.
A. Okay.
Q. Actually, I think this, I think my next question is not tied to any particular page. If, I just want to ask you a couple quick questions about risk adjustment. If risk adjustment results go up from year one to year two, that would indicate that the, the carrier's population in year two is higher risk than it was in year one, right?
A. Okay.
Q. And I'm sorry. By risk adjustment results, I mean the amount of a risk adjustment transfer.
A. Yes.
Q. So is that a correct statement?
A. Sure.
Q. And would that be indicative of durational antiselection?
A. That would be one measure of that, yes --
Q. Okay.
A. -- but not the only measure.
Q. Sure. If, on the other hand, risk adjustment results defined as I defined them a minute ago do not

increase from year one to year two, that would mean that the, the relevant population is, is not higher risk in year two than it was in year one, right?

A. Okay.

Q. And, in that second scenario, would that be indicative of durational antiselection?

A. Could you repeat the question, please?

Q. Sure. If from, if a, for a particular population, the risk adjustment result, meaning the amount of the risk adjustment transfer, did not increase from year one to year two, would that be indicative of the presence of durational antiselection in that population?

A. Not on the surface, no.

ATTORNEY DONOFRIO: If you'd give me one moment, I'm either done or very close to done. No further questions. Thank you.

MR. BARBER: Any questions for Mr. Dillon?

ATTORNEY ANGOFF: Yes.

CROSS-EXAMINATION BY ATTORNEY ANGOFF

Q. Good afternoon, Mr. Dillon.

A. Good afternoon.

Q. I'd like to ask you to join Mr. Schultz in my witnesses' hall of fame. Thank you.

A. I have never been accused of being a low talker,

so --
Q. Thank you for talking loud.
A. I always joke at my office they soundproofed my office so everyone else can have a quiet day.
Q. I don't have too many questions either. Could you turn to Page 11 of your report?
A. Okay.
Q. I think I'm going over some of the same material as Mr. Donofrio from a slightly different perspective. You say that, you recommend in the third paragraph that Blue Cross's trend assumption be reduced, utilization trend assumption be reduced to 2.5 percent a year, right?
A. Correct.
Q. And MVP used originally a zero percent utilization trend, right?
A. Correct.
Q. And you all raised it and said that 1 percent was more reasonable?
A. Correct.
Q. Why, tell me why, if I am wrong, why I'm wrong. It would seem to me that, Blue Cross being a bigger company than MVP, would have more capacity to control utilization trend and, therefore, that, at most, its utilization trend should be what MVP's is. What am I

missing?
A. So there are probably a couple different issues. It is, the data is very clear that Blue Cross does have more utilization than MVP. So, even though we have adjusted for things such as health status, my, my -- and this may be somewhat of a speculation, but, even after adjusting for health status, it has something to do with the relationship Blue Cross has with its consumers and the providers. We have definitely seen in other states where, you know, kind of the historical comment is that the Blues are kind of the carrier of last resort. When you've got something to have done, you go to a Blues, and they do tend to have higher utilization, even accounting for health status.
Q. Okay. So you're controlling for health status, controlling for morbidity?
A. Even at that case, yes. It's probably, I would probably liken it to kind of an induced utilization factor in a way where induced utilization, while very similar to health status, even if someone is healthy and they have a richer benefit, they're going to use it. It's somewhat similar to that argument.
Q. Okay. And, as an actuary, you don't look into the reason -- you don't make a judgment as to whether Blue Cross should be doing more to control utilization;

you're simply --
A. Typically, no. You are correct.
Q. Okay. Could you go down to the middle of that page? You see the, the bold headed headline. What do you call it? The line saying total, heading saying "Total allowed" --
A. Yes.
Q. -- "medical trend"? And then in the third line you say that L&E believes that actual allowed medical trend will likely fall in the range between 3.5 and 6.5 percent, right?
A. Correct.
Q. Okay. And then go down to the, the first bullet you see, third, third paragraph from the bottom. Using L&E's recommended change, it reduces the overall trend from the 5.9 to 5.2?
A. Yes.
Q. You see that? So 5.2 is within the range of 3.5 to 6.5, right?
A. Correct.
Q. Okay. But it's a little closer to the high end of the range, is there, right? It's a little closer to 6.5 than it is to 3.5.
A. Well, one thing to consider here is that the total allowed is, it's a combination of utilization and the

unit cost, and, you know, the unit cost is not really changing here. It's the utilization that has the variables.

Q. Okay. But you, you picked a number within that range that's, that's closer to the higher end than the lower end, correct?

A. That might be the result, but that is not how we went about picking that number.

Q. Oh, I'm not accusing you of deliberately erring toward the higher end. I'm just saying, objectively, that number is closer to the high end than the lower end, isn't it?

A. Yeah.

Q. Okay. Could you turn to the next page, Page 12? And in the, before the last paragraph you see a couple of lines above that you talk about the observed increase in utilization of nonspecialty drugs? Do you see that?

A. Yes.

Q. Okay. And in, in picking a number, did you consider whether there could be a downward trend rather than using an average?

A. So, yeah, it's always a, it is always tricky to, you know -- I kind of alluded to this earlier with the utilization trend in 2018 was higher. So, you know,

any time -- it kind of goes to the old saying. One time is an accident, twice is a coincidence, three times is a trend. When does it become a trend? At this point, you know, we definitely took all of the data into consideration, but we felt that the average was the most reasonable number for analysis for this, for this assumption.

Q. Could you turn to Page 13 and look at the first full paragraph, beginning in the middle? You see it says, "Blue Cross also considered several time series methods". You see that?

A. I'm sorry. Could you point to me which paragraph?

Q. Yeah. On Page 13, it would be the first full paragraph beginning with the word "specialty".

A. Okay.

Q. And then a little more than halfway down, you see the sentence beginning, "Blue Cross also considered several time series methods"?

A. Yes.

Q. Okay. And so the time series methods produced estimates ranging from 3.7 to 15.6, right?

A. Correct.

Q. Okay. But then you would, you elect to assume a 20 percent per year increase. How would you rationalize that?

A. So the time series methods are something that I believe I introduced to the, to this kind of situation a couple years ago. Blue Cross obviously knew that I liked looking at those time series methods, and so they have started to include that analysis, because they probably know I'm going to ask the question anyway. So they provided that information, which is informative, but, over the years, I would agree that, or my conclusion is those time series methods have not been as predictive as the other methods for the majority of the data analyzed. So I believe it was, it was reasonable to assume an assumption that is higher than what those methods calculated and picking an assumption more in line with the other methods.

Q. Do you think it would be unreasonable to assume a number within that range?

A. Yes, I do believe there are some numbers in that range that I would consider unreasonable.

Q. That wasn't exactly my question, though. Do you, do you believe that it would be unreasonable to consider any number within that range?

A. I can't answer that, because, if the answer is 3.7, it's a different answer than if it's 15.6.

Q. Okay. What is your answer if it's 15.6?

A. I would say I probably, if a company had submitted

15.6, it would probably be -- I would take that into consideration, and I'd be more likely to consider it reasonable. I don't know if I would necessarily say that, but it would be more reasonable than 3.7.

Q. Fair enough. How big does a company have to be in order to legitimately self-insure? That is, a group, obviously, a group of two, is not going to be able to self-insure, rights?

A. Correct.

Q. Okay. So, based on your experience over the years, what have you come to believe is the, is the what the minimum size?

A. So I don't know if there's a bright line. However, we do -- we don't typically see it historically much under 500 to 1,000 lives. It has gotten smaller with changes to the market. I mean, there are a few exceptions to the rule. I'll speak to Lewis & Ellis, we were 60 employees, and we self-insured. But we're also all actuaries, and we like to think we know how to, you know, use the self-insured, you know, utilize that process.

But it's pretty, it's not very likely for relatively small firms, you know, closer, you know, in that 50 to 100 range. It's a big risk for care for the companies.

Q. For a firm that's not at all actuaries, within 50 to 100 --
A. Correct.
Q. -- it would be a big risk?
A. Yes.
Q. You said that L&E is doing work this year in twelve states for state regulators?
A. Yes, and my team is working in nine.
Q. Okay. Is that in connection with exchange business?
A. It is primarily, I believe that nine is for the exchange business only, correct.
Q. Okay. And, in all the states -- I'm not going to ask you which state, all the states you're working in, but, in all the states you're working in, approximately how many carriers have filed for rate changes in all those states?
A. So we have a few states that have still not filed. I believe we have -- and, actually, I think, while I was sitting in the back row, we received a few. So my answer might change from a few minutes ago, but I believe we've received filings in seven states so far.
Q. And about how many carriers total in those states?
A. So it's roughly -- I'm trying to think. It's roughly -- there is one, one state with one individual

carrier, there's another state with two, And then everyone else is usually three to four.
Q. So approximately, like, 20, 25 carriers?
A. Yes.
Q. Okay. And, of those 20 to 25 carriers, how many are seeking a rate increase as high as Blue Cross's increase?
A. Well, I don't believe that that question is necessarily applicable, because their populations are so different, and they don't have community rate, and they don't have merged markets. So their rate increase requests are a dramatically different framework. I don't -- but, even at that, I don't, I don't recall even the range of the rate increases in the other states.
Q. Do you know of any carrier in any of those states that is seeking a rate increase that is equal to or higher than the rate increase Blue Cross is?
A. I believe so, yes.
Q. Could you name that carrier and the state?
A. I'm very hesitant, because I don't -- some of that work is not public, and I don't want to release a name if it's not considered public.
Q. Okay. In any of the states that you're working in, is the average rate increase -- don't name any

carriers -- but is the average rate increase sought by the carriers higher than the average rate increase sought by the carriers in Vermont in any of those states?

A. Again, I think this question is, is somewhat not valid, because those markets are so different because of the community rate and merged market, but I don't believe so.

Q. You don't believe what?

A. I don't believe there is an average higher this year than that.

Q. Are there any states in which L&E is advising health insurers this year?

A. I, ACA, I do not believe so, no.

Q. No? Any state in which, is there any state which L&E is advising health insurers this year?

A. There are some states where I, or some carriers that I do advise, but not with Affordable Care Act business.

Q. Okay. And what are those states?

A. I mean, most of my clients file in multiple states. So, I mean, I'd probably have to list them all.

Q. Okay. And how many clients?

A. I probably do work -- I personally probably have

-- I can think of two insurance companies that I have the most direct contact with.
Q. Okay. And are there any other L&E actuaries who are advising insurance companies in other states?
A. Yes.
Q. And about how many carriers are involved totally?
A. That, I cannot speak to. I cannot speak to how many insurance companies my business partners are consulting with.
Q. Would it be more than five?
A. Yes, probably.
Q. More than 10?
A. Probably.
Q. More than 20?
A. I don't know.
ATTORNEY ANGOFF: Okay. I have no other questions. Thank you, Mr. Dillon.
THE WITNESS: Thank you.
MR. BARBER: Board questions?
MS. LUNGE: I just have one question.
THE WITNESS: Yes.
MS. LUNGE: David, can you turn to your report, Page 15?
THE WITNESS: Okay.
MS. LUNGE: I, you were in the room earlier

when Mr. Schultz testified that the overall enrollment in the individual market had increased in 2019?

THE WITNESS: I'm sorry. Could you repeat that?

MS. LUNGE: Yes. Did you hear Mr. Schultz's testimony earlier that the overall enrollment in the individual market increased in 2019?

THE WITNESS: Yes.

MS. LUNGE: Could you then just explain in the, under "Changes in Pool Morbidity", your second paragraph, the last sentence talks about a decrease in QHP enrollment across individual and small group markets in 2019 and how that relates.

THE WITNESS: Yeah. So this may not be the best worded sentence, but I think our intention here was regarding the kind of the nonrecognition of the risk adjustment revenue, that was a reasonable assumption based on everything else.

MS. LUNGE: Thank you.

MR. PELHAM: Just one quick question.

THE WITNESS: Yes.

MR. PELHAM: So, as I look at these 16 factor categories on Page 26, there are -- and I, I guess I'll ask the question this way. It's kind of an awkward question, but, of these, which are the most salient in

terms of the, the purpose, the standard of review, the components affordable, unjust, unfair, inequitable misleading, which one of these should we look to to give the best insight into those issues?

And I ask that because this is the third place in my life where I've been involved in actuarial analysis. One was on the state employees retirement system. The other is for state revenue estimates, and there you had some kind of grounding in affordability. You had issues like gross state product, unemployment rates, inflation rates, consumer price index, personal income growth, and none of that is here. So, I guess, in your mind, are there any of these that are most relevant to those issues I just listed?

THE WITNESS: The short answer is probably "no". While, I mean, each of these are, each of these components broken out are all very important to the overall rate, I don't, you know, I don't really think any of them are necessarily any more important, because they are all interrelated, right? The morbidity impacts risk adjustment, which, you know, impacts the trend and things like that. So I think the short answer is "no".

MR. PELHAM: Thank you.

CHAIRMAN MULLIN: None.

MR. BARBER: Okay. Any redirect?

ATTORNEY ABORJAILY: Just very briefly, if I may.

REDIRECT EXAMINATION BY ATTORNEY ABORJAILY

Q. You received a couple of questions regarding the marketwide analysis that you did for utilization trend.

A. Yes.

Q. And I just wanted to be clear. And that range was 1 to 4 percent?

A. Correct.

Q. Okay. And, if Blue Cross had filed a 1 percent utilization trend, would you have found that to be reasonable?

A. No.

Q. And is your recommendation still 2.5 percent?

A. Yes.

Q. And one last question, just following up briefly from Mr. Angoff. So, to be clear, currently, you are not advising any health insurers on an ACA-related health insurance filing?

A. That is correct.

ATTORNEY ABORJAILY: Thank you.

MR. BARBER: Questions on that?

ATTORNEY DONOFRIO: No more questions. Thank you.

MR. BARBER: No questions on that? Thank you, Mr. Dillon.

THE WITNESS: Thank you.

MR. BARBER: I think we gained some time. So next on the list, I believe, Commissioner of Financial Regulation. So I think you missed the swearing in this morning.

THE WITNESS: That's right.

M I C H A E L P I E C I A K,

duly sworn to tell the truth, testifies as follows:

MR. BARBER: Okay. So whenever you're ready.

MR. PIECIAK: Great. Well, thank you very much, and thank you, Chair Mullin, and the Board for having the Department here. I was reviewing the testimony from last year, Chair Mullin, and you said at that time that the Yankees were the second best team in baseball with five games out of first place, and those were the days.

CHAIRMAN MULLIN: Little bit more than this year. It's a great year.

MR. PIECIAK: Yeah. So I do want to thank you for having me here. I do first want to thank the hard-working staff at the Department of Financial Relation for their good work in putting together the solvency opinion this year and for their general good

work in regulating Vermont's health insurance and insurance marketplaces.

As you probably know, the Department regulates a wide variety of financial entities, nearly 600 captive insurance companies, 16 traditional domestic insurance companies, 23 state-chartered banks, credit unions, trust companies, approximately 1,000 nondepository licensees, and 50 investment advisor firms. All together, these companies hold well in excess of $1 billion in total assets, and we work very closely to ensure Vermonters are well-protected and well-served by these firms and the individuals that work for them.

So we do this through stringent licensing requirements, consumer outreach and education, financial and market conduct examinations, reviewing and approving products prior to their introduction into the Vermont marketplace, and we also do this by responding to complaints, conducting investigations and enforcement actions as well.

Over the last five years, our Consumer Services Division handled approximately 18,000 inquiries, 2,200 complaints, and, combined with our market conduct actions, returned $11.4 million to Vermonters in restitution and $1.3 million in penalties. And I say all of this just to highlight the point that our

department is a consumer-focused organization, and I'm here to testify in that vein.

There's nothing more important to consumer protection than the solvency of a company that we regulate, all the more true in this case. An independent and financially sustainable Blue Cross Blue Shield of Vermont is good for consumers, because it certainly can pay its medical claims, regardless of the economic conditions that it might confront in the upcoming years. It can pay the medical claims regardless of unexpected events others that might occur due to illness, outbreak, other extreme conditions, and a financially sustainable Blue Cross Blue Shield will also have the capital it needs to invest in programs and people and in technologies that will improve the consumer experience and, more importantly, improve consumer outcomes as well.

So the Department is the primary regulator of Blue Cross Blue Shield. As the primary regulator, we engage in extensive oversight of the company. We do this through monitoring the company's quarterly and annual financial results, examining certain metrics in those results, including months of premium equivalency, surplus as a percentage of revenues, working capital ratios, the percentage of growth or decline in the

company's surplus, and we also continually monitor noninsurance risk factors including credit risk, investment risk, operational risk, liquidity risk, and reputational risk.

The Department also conducts periodic financial examinations. These exams are months-long processes. They involve being on site. They are extensive. We review the books and records of the company. We interview senior management, the boards of directors, and further examine any areas that we have identified as heightened risk. The Department also has regular and ongoing conversations with the company regarding its financial conditions, its operations, and any recent developments.

Another important regulatory tool that I think we've talked about a lot today is risk-based capital, or RBC. I think the Board knows that risk-based capital has two main components, the financial calculation itself and then also the model of law which we've implemented in Vermont and every other state across the country has implemented regarding when an insurance commissioner or department can take specific action based on the level of impairment on RBC. I think we've talked a lot about what goes into the RBC factor, so I will skip that, but, if you have any

questions about that, happy to take them.

So, as to our solvency opinion, we've talked in the past about how there's been some increased urgency as it relates to our solvency opinion. That urgency has repeated and also continues to this day, and the reasons for that are really fourfold. Blue Cross Blue Shield's risk-based capital ratio today remains at its lowest point since the establishment of the Green Mountain Care Board. Blue Cross Blue Shield's ratio is the lowest among its comparative companies across the country. In fact, its current RBC ratio is approximately half of the average RBC ratio for comparative companies across the country.

Blue Cross is the only comparative company whose RBC ratio has trended downward for each of the last 4 years, falling a total of 171 points or 26 percent of its total RBC score. Blue Cross Blue Shield has also fallen out of the company's recently approved targeted RBC range, and where they stand today would also be outside of the previously approved range as well.

So one of the shortcomings of RBC is the fact that it's a historical-looking formula. It does not look to the future. It does not look to things that might be company-specific as well. So there are some additional factors that I want to mention as it relates to our

solvency concerns or solvency impact, I should say.

First, Blue Cross Blue Shield, being a single-state Blues plan, this limits the company's ability to spread risk over a broad base geographically, thus making it more vulnerable to local risks such as epidemics, severe weather calamities, and other similar events. Blue Cross Blue Shield being a not-for-profit also limits the company's source for obtaining capital basically to that of generating gains through operations or rate increases. And then, further, there continues to be unpredictability surrounding federal health care policy and its corresponding impact on the Vermont health insurance marketplace. So it continues to be a very unstable federal landscape, for sure. So all of these factors add to our solvency opinion. These are outside of the RBC calculation, but the RBC status itself does also give us a pause for concern.

I think we also talked about AM Best credit rating agency. I think folks know them. They are a credit rating agency that focuses on the insurance industry. They rate many of the companies that we regulate, many of the captive insurance companies that we regulate as well.

As the Board knows, they revised their outlook for

Blue Cross Blue Shield's long-term issuer credit rating from stable to negative. They talked about the fact that they've had sharp underwriting losses and that there has been pressure on the company's performance the last four years, and some of that, I think, they used the words primarily some of that is attributable to the rate process and not receiving adequate rates over the past four years. So that's something else, certainly, that we take into account is the independent rating agencies that might rate our companies as well, and that certainly gives us a pause for concern.

Further, the Department also conceptualized risks in different ways. On Page 4 of our solvency opinion, you'll see a table that we created in last year's opinion, and we updated it for this year as well. This illustrates Blue Cross Blue Shield's net premiums earned. So these are the premiums, not the, the businesses that self-insure, but the premiums that are earned. That has grown 10 percent since 2014 while their surplus has declined over 20 percent during that same period while their membership has remained relatively flat.

All that means that Blue Cross Blue Shield's risk exposure has increased while, over the last five years, its corresponding surplus safety net has significantly

decreased. So there's more risk and less safety net, putting the company at further risk.

Other companies that we regulate that we've looked at for the last five years have seen similar premium revenue increases of approximately 36 percent, but, during that same time period, their surplus has kept up by increasing by approximately 38 percent. So Blue Cross stands alone as we look at some of the comparative companies that we regulate as well.

So I think the Board again also knows that the new RBC range order that we filed earlier this year requires Blue Cross Blue Shield to promptly file with the Department a plan to move back within its range if they ever do fall out of it. As I mentioned, at the end of 2018, Blue Cross's RBC sat at 495, considerably outside of its actuarially reviewed and approved range. They have submitted a plan to the Department that calls for $17.9 million in 2019 AMT refunds to go towards surplus, which will boost its RBC by approximately 78 points.

Similarly, in 2020 the AMT refund of $8.7 million will go toward surplus, increasing it by an additional 26 percentage points. This plan that Blue Cross has submitted to the Department would revise the four-year downward trend in RBC, would move the company into its

approved targeted RBC range, and would move it closer to its comparative companies across the country.

I view this and the Department views this as a unique opportunity to get Blue Cross Blue Shield trending in the right direction and safely back within its range without dramatically or really increasing at all its contributions to reserves that are normally filed.

I would note that it's estimated that a 7 percent contribution to reserve would be necessary to reflect the same impact that these alternative minimum tax credits would have. So I really do mention this as a unique opportunity. All the things that we've said are true in terms of the trending and some of the other solvency analyses that we do that give us some pause for concern, but there is a unique opportunity to really shift the company in a positive trajectory from an RBC perspective, from a solvency perspective, from a surplus perspective, and I do urge the Board to take advantage of that.

So, in conclusion, the Department does not expect the proposed rate will have a significant impact on their overall solvency assessment. However, the Department does caution the Board that any downward adjustments to the filing's rate components that are

not actuarially supported would continue to reduce Blue Cross's surplus and continue to negatively impact its solvency. Considering the circumstances described above, it's our opinion in our solvency letter that any departure from the rate filing should be made with great caution. So, with that, I'm happy to take any questions.

MR. BARBER: Thank you. Questions for the Commissioner?

ATTORNEY ASAY: No questions.

MR. BARBER: Questions for the Commissioner?

EXAMINATION BY ATTORNEY ANGOFF

Q. Yes. Good afternoon, Commissioner. You were nice enough to come over here and talk about your solvency opinion. I've got a couple questions about your solvency opinion. I'd like to ask you about some other things, too, if you're prepared. If you're not, I won't.

A. We're always prepared.

Q. Specifically, are you, would you mind answering a couple of questions about your permitted practice order that you put out on February 23rd 2018?

A. Sure.

ATTORNEY ANGOFF: Okay. So do you -- is it, is it in front -- does the Witness have --

MR. BARBER: Yeah, I think the binders are to your left right there.

ATTORNEY ANGOFF: That would be Exhibit 23 in Binder 2.

CHAIRMAN MULLIN: Just to confuse everything.

MR. PIECIAK: I have my own copy.

BY ATTORNEY ANGOFF:

Q. Oh, you brought, you happened to bring that with you?

A. Yes.

Q. Great, okay. So in that order you permit Blue Cross to nonadmit the entire AMT refund amount that it's getting under the Trump tax bill, correct?

A. That's correct.

Q. Okay. And in Paragraph 3 of this order, you note that income tax recoverables, like those AMT refunds, are generally considered admitted assets under SSAP Number 101 right?

A. Yeah, those that are expected to be recovered within the next calendar year.

Q. Correct. Okay. And so we're now in 2019, and so the amount of those refunds that would be expected to be recovered in the next calendar year are, aren't they, the $19.9 million for this year and then the additional amount for next year?

A. Yeah, I think it's 17.9, but the, but the point I think that you're making is, Are these amounts showing up on their financials? I think the broader point, just to cut to the chase, is that they have submitted a plan, they being Blue Cross Blue Shield, to the Department that it shows that they anticipate using the alternative minimum tax refunds to fund, to go to their surplus once received. That's part of their plan to get back within their range.

I think they've been transparent, also, in their financial statements. The first footnote to their financial statements mentions this permitted practice and the fact that it has been issued by the Department. So, you know, at this point, you know, I think that's all been very done in a straightforward and transparent way, and I think the Board and ourselves and others understand the position of Blue Cross Blue Shield and what they intend to do with those alternative minimum tax refunds.

Q. Isn't it true that, under your own standard, the standard which you set out in Paragraph 3 there, that these tax recoverables typically relate to amounts expected to be recovered within the next calendar year, that you shouldn't, that, based on that standard, there is no basis to nonadmit the amount this year, this

calendar year or the following year?

What, what is the standard? What is -- whether it's under SSAP Number 101 or anything else, what standard authorizes the nonadmission of a tax recoverable which is payable and, in this case, Blue Cross knows it's payable and has announced it's payable in a couple of months, and, clearly, next year it will also be? I mean, as a practical matter, there is nothing that's going to happen to prevent the payment of this money either this year or next year, and, given that, shouldn't this be an admitted asset that is now part of surplus?

A. So, to answer your question, first, this is a five-year payout period. So there's going to be five payments under this payment refund. So that's -- so it's a five-year refund schedule, so there's going to be five years in which there's going to be taxes owed to Blue Cross Blue Shield. We hope that those payments continue to come, that there are no changes in federal policy that impact them, but, certainly, even with the 2019 payment, it's uncertain when those are going to be collected, whether it's going to be in calendar year '19 or whether it's in early 2020.

So, certainly with the 2020 payment, that might not be received until well over a year from now, if not

longer than that. So the way that we approached this was to say that they would be admitted assets once they received the refunds, once they could go to the bank and take the refunds and pay claims and pay operational expenses for Blue Cross Blue Shield.

Q. That, that's what you've said under your permitted practice order, okay. But for that order, you agree that, that they would all be admitted now, correct?

A. I think that's correct, at least the payments in the current years.

Q. Okay. And Blue Cross itself, and I recognize that you put out this order last year in February of last year, but Blue Cross itself is now saying that, Yeah, we're getting the money in October of this year. Would you, assuming that your order was reasonable when issued, would you agree that, now that Blue Cross knows it's getting the money in October of this year, that at least the first $19.9 million should not be nonadmitted?

A. So, you know, I think, again, I'll go back to the statement I made that they've been very transparent with us about what they plan to do with those moneys. So we anticipate them going into surplus. Whether they're admitted or nonadmitted at this point, I think, is somewhat beside the point. We are confident that

that $17.9 million is going to go to surplus. That's the plan that they filed with our department. Whether they're admitted or not, you know, is not too much of a concern for us.

Q. Well, it is not beside the point, though, is it, if the absence of that $19.9 million makes a difference between an RBC ratio of 575 or so and 495?

A. I think that's correct, and that's why in my testimony I said what the anticipated RBC impact would be to those moneys flowing to the surplus. So that, I think, is important for the Board to know that that's going to be the impact. I think Blue Cross included it in their filings as well. So, again, just, you know, to reiterate, that's going to be a significant impact of somewhere around 78 percent for this year and about 36 percent for next year. So that is well-known to those that are making the decisions.

Q. Okay. In connection with your solvency opinion, you considered various factors, various risk factors. Did you also consider factors that mitigate risk? For example, did you consider the fact, did you consider the fact that Blue Cross's reserving practices, according to both their consultant, Axene, and your own, Oliver Wyman, were ultraconservative?

A. Well, I don't think they used the word

ultraconservative. I think they used the word conservative, and I talked to our actuary about that particular point, and he said, even though it was conservative, it was still reasonable. So, that, I remember having a conversation with him before the order was issued. So that, simply the fact that they were conservative on that point simply meant that there wasn't going to be an adjustment in their study that made that an additional risk factor.

Q. Could you turn to Exhibit 17, please? I'm sorry. Exhibit 17 in the first binder. Are you there?

A. Yes.

Q. Okay. Could you turn to Page 14 of the Axene report, which is Page 38 of Exhibit 17?

A. Yeah.

Q. Okay. And could you read the first full paragraph on that page beginning with "based on"?

A. Could you say that one more time, the page?

Q. I'm sorry?

A. Which page is it again?

Q. It's Exhibit 17, Page 38, which is Page 14 of the Axene report.

A. 38?

CHAIRMAN MULLIN: 38 in the red type in the bottom.

MR. PIECIAK: Thank you.
CHAIRMAN MULLIN: It gets very confusing.
MR. PIECIAK: Care management and effectiveness?
CHAIRMAN MULLIN: Just above that, I think he is --
BY ATTORNEY ANGOFF:
Q. The paragraph beginning with "based on", do you see that?
A. Yeah. So based on --
Q. Okay. Could you read just the last, I'm sorry, before, the last sentence before that "based on", the, the sentence that begins "AHP consultants".
A. "AHP consultants believe that Blue Cross Blue Shield could potentially lower its explicit level of provisions for adverse deviations which result in both higher surplus level and higher HRBC ratio".
And I believe Blue Cross Blue Shield testified earlier, they said they took that under advisement and did just that.
Q. Do you agree with statement that you just read?
A. So I agree with understanding that Blue Cross effectuated it. I can't speak to it, because I didn't prepare that report, but it sounds like a reasonable recommendation. It sounds like one that was taken into

account and acted on.
Q. Well, whether or not it was taken into account or acted on, the fact that Blue Cross has this 15 percent provision for adverse deviation, Blue Cross's own consultant concluded that it could potentially lower that amount, and, if it did so, that would result in both a higher surplus level and a higher HRBC level, and all I'm asking you is, Do you agree or disagree with that statement?
A. Well, you know, it sounds like a reasonable recommendation. There's a lot of things that can be done to inflate, potentially, an RBC ratio. So I --
Q. I'm sorry. I missed that. To what?
A. I said a company can do a lot of things to impact its RBC ratio.
Q. To impact its RBC ratio?
A. Yeah. I said inflate, but impact, to make it go up. So, you know, those aren't always the wisest things to do, but this sounds like a reasonable recommendation and, again, one that it sounds like Blue Cross Blue Shield acted on.
Q. Okay, good. And you agree, don't you, that Vermont is not a hypercompetitive environment?
A. Well, we're fortunate. I heard earlier that there are some states with only one carrier. So the fact

that we have two is good.
Q. It's not hypercompetitive, though, is it?
A. They're pretty competitive with each other, but yeah.
Q. Okay, all right. Could you turn back to Exhibit 17, please? And go to Page 10 of the Oliver Wyman report, which is Page 15 of the exhibit. Okay. And go to the fourth bullet up that's starting with "competitive environment".
A. Yeah.
Q. Could you read that, please?
A. So it says, "The competitive environment considers the threat of a new entrant into the Vermont marketplace. Axene did not include an additional charge for competitive environment risk". So, in that case, they don't anticipate new carriers entering space.
Q. Do you know how Axene and Oliver Wyman came up with its calculation that, in the bullet right above that that's saying regulatory environment that its RBC ratio, I'm sorry, that its target should be increased by 73 percent because of the regulatory environment? Do you know how they came up with that 73 number?
A. Well, just to clarify, that wasn't Oliver Wyman coming up with that. That was Oliver Wyman opining on

determinations that were made by Blue Cross Blue Shield's consultant. So I can't talk about how they came up with that, and I probably couldn't talk about how Oliver Wyman did as well.

Q. Fair enough.

A. Yeah.

Q. And, in developing your solvency opinion, did you also consider Blue Cross's statutory duty to ensure that subscriber benefits are provided at minimum cost under efficient and economical management?

A. So, yes, I would -- whenever we review a filing, whether it's a Blue Cross Blue Shield filing, a long-term care filing, a worker compensation filing, our department balances considerations like those against considerations about pricing, affordability, availability of products. So that's something that we consider when reviewing a filing or reviewing the operations of a company.

ATTORNEY ANGOFF: Thank you very much, Commissioner. I have no further questions.

MR. PIECIAK: Thank you.

MR. BARBER: Thank you. Questions from the Board?

MS. LUNGE: I think I'm going to pass for now. I may have a follow-up, but I'm going to let

other people have more time.

MR. PELHAM: I don't.

MS. HOLMES: I just have a quick one. As a consumer-focused agency, as you referenced, I'm sure you recognize the tension in particular the Board faces but the tension that exists between the need for consumer protection as seen through solvency with the consumer concerns associated with the affordability of rising premiums, right? That is effectively the tension that we face, and you're a consumer-focused agency focused on solvency.

And, as we've heard testimony today, as these Blue Cross Blue Shield premiums rise relative to competitors, we've heard testimony that enrollments will fall, average health risk rises, and, as a result of that, Blue Cross Blue Shield will face even higher administrative costs per capita with low enrollments, and the fact that their average health risk goes up means that their adverse claims experience is going to grow, and it's not going to be mitigated by the risk transfer, because it's not fully one-to-one on that.

That, of course, is going to affect solvency going forward. The solution to that is ever-rising premiums to cover the higher administration costs and the higher risk and, presumably, higher CTRs to cover this.

So my question to you is, There's going to be a cycle here that I'm concerned about. How does the current competitive position of Blue Cross Blue Shield in this QHP market affect your assessment of Blue Cross Blue Shield's ability to reach the target range of the RBC that's set forth in your order? You know, what are the CTRs that are going to be expected, what are the premium growth rates that are going to be expected to achieve that target range given the competitive position of Blue Cross Blue Shield?

MR. PIECIAK: Yeah. So the one point I'll make at first is that, you know, as members leave a company, in this case, Blue Cross Blue Shield, all else being equal, you're likely to see their RBC score go up, because there's the same amount of reserving or same amount of surplus, I should say, but there's less lives to be covered. So you would actually see their RBC go up, but, certainly, then there becomes a question at some point about scaling. Like, how big does a company need to be to achieve the scaling that's necessary to ensure that its administrative costs aren't too high as a percentage of premium and that they're getting the right types of agreements and contracts in place, to your point.

So, in terms of a contribution to reserves, I

mean, Blue Cross Blue Shield for a long time has had a 2 percent contribution to reserve revised down to 1.5 percent after the federal tax went away, and that is something that we find to be reasonable, that the Department can agree with, that, if that 1.5 percent is funded year in and year out, there will be some times where that might not be needed fully. There might be some times where a much higher contribution to reserve might be needed, but, if that is consistently provided for, then the surplus should be in a range that, you know, is sound.

In this particular instance, the contribution to reserves wouldn't help it catch up to the degree that it needs to, because you would need something like a 7 percent contribution to reserve to get it closer to that new RBC range, but for the alternative minimum tax refunds. So, again, that's a unique opportunity to get it within its range, and, if, if the Care Board does fund that contribution to reserve and, you know, of course, if you fund the contribution to reserve but there's other areas that are cut that are not actuarially supported, it's the same as cutting to that component.

So something to be mindful of all the way around in the rate filing, but, if they're getting that to

their, to their baseline, then they should be in a sound financial position regardless of potential, you know, competitive environment.

MS. HOLMES: So let me just follow up quickly. You mentioned that the RBC is, will be, needs will be lower if they have fewer members. So does that mean that, if their enrollments continue to decline, there should be a new target range?

MR. PIECIAK: Yeah. So, I mean, like we talked about, I think, in the previous meeting, if there are certain factors that impact the company, that a range needs to be examined, then that's something worth looking at. Now, I think you might find also that some of the higher risk potentially individuals in groups might be staying with the Blue Cross Blue Shield company, so that might cut against the range changing.

MS. HOLMES: That's what I meant by that, folks that are staying are higher risk. So, in effect, I'm worried that they're needing to be higher reserves, which is going to require higher premiums, which is going to fuel that cycle. So just trying to figure out where this ends.

MR. PIECIAK: Yeah. Well, you know, unfortunately, I don't think the answer is in the rate process. I think the answer is the work that the Green

Mountain Care Board is doing outside of that and I know Blue Cross and other Vermont stakeholders have been a part of as well. I think that's probably where the answer lies, not so much in the rate filing process, but, certainly --

MS. HOLMES: Are you referring to the all-payer model?

MR. PIECIAK: Yeah, exactly right. But, certainly, those efforts will be stymied if Blue Cross Blue Shield, even in the short-term, doesn't have the capital that it needs to, you know, have sufficient reserves, make investments in technology and processes and people to help in those, you know, help with those innovations.

MS. HOLMES: Thank you.

MS. USIFER: I just want to go through some of the RBC calculations and some of the discussions.

MR. PIECIAK: Yeah.

MS. USIFER: Agree that they're at 495 right now, but looking at what the biggest impact has been over the past five years, could you venture to guess what that is?

MR. PIECIAK: So, if you look at our solvency opinion, we had our outside actuary, Oliver Wyman, prepare a financial analysis, and on Page 3 of their

report, you see the last five years, and, certainly, the thing that catches my eye is underwriting losses and gains for the last three years. Certainly, not all of those years did they have a loss, because other things in terms of investments and whatnot may have picked up the slack, but that's certainly something that catches my eye.

MS. USIFER: Yeah. When I look through it, I actually see it a little different, see it a little differently. Over the past five years, the underwriting loss has been a $20 million loss, and the net, the net investment gain has been plus 35. So there's actually been about a $15 million contribution for those two categories. The biggest change that I see that's gone on is, prior to a couple years ago, they had these admitted assets in their surplus. So the past two years they've taken those out, and that was based on the chart, if you look on Exhibit 21, Page 6 in Book 1. So what I did is, if I did a bridge -- like, this only bridges for two years. So, if I did a bridge from the 590 that we were in 2016 to the 495 --

MR. BARBER: Can we get to the exhibit? Which exhibit are we on?

MS. USIFER: So it's Exhibit 21, Page 6.

MR. BARBER: Of binder?

MS. USIFER: Binder 1.

MR. PIECIAK: Is it their financial statement?

MS. USIFER: Oh, sorry, sorry. It's their financial statement.

MR. BARBER: So what page again?

MS. USIFER: It's in the second book, Exhibit 21, Page 6. And we can go back and do it basically time, but, if we looked at these, you know, these two years, the net income has been about a wash. The change in unrealized gain, about a wash. The change in net deferred income tax and the change in nonadmitted assets has been a $24 million change, $17 million in 2017, $7 million in 2018. That combines for 110 RBC points. So that's really what's driven the biggest change.

It used to be in their numbers. Now, as you say, we have this unique opportunity that it's going to come back, but it was there. Now it's going to come back, which is great, but I think the point we're missing is that, over the past five years, barring that, there hasn't been a lot of change. The other negatives, if you go down, are, you know, their gains, their loss in surplus was due to their pension being down.

So I just wanted to make sure we're realizing that. You know, there's been a lot of focus that what

the Green Mountain Care Board has done has detrimentally impacted their RBC, is what put them into a 495, and, respectfully, I don't agree with that. I would say those assets used to be in their numbers. They're now out of their numbers. They're going to come back in their numbers.

MR. PIECIAK: So I just want to -- if I can just clarify one thing. So in 2017 with the tax cut bill, it passed in, like, December of '17, I think, and Blue Cross Blue Shield paid in a federal alternative minimum tax for corporations, not for individuals. That was a deal that was struck in the 80s, and Blue Cross certainly can tell you more about that, but those were payments that were never expected to come back to Blue Cross because they're a nonprofit.

It just so happened that, because that alternative minimum tax for corporations went away, that they got these tax credits. So they wouldn't have been on their financials prior to 2017, rather, because they never would have been owed -- they never would have anticipated getting those deferred tax payments back due to their nonprofit status.

Because the, the alternative minimum tax went away, that's what created the admitted assets to come onto their balance sheet, which would have been in 2018

but for our February 2018 order that said, you know, when they filed with us in March of that year, that they could treat them as nonadmitted assets.

And, again, the reason we did that was not to deflate or to mess their RBC score, but, simply, we thought it would be misrepresenting if they did it the other way, because they didn't have that money, you know, in the bank. They didn't have that money to go get and pay claims with. So we thought it was a more appropriate representation to hold those assets back, so just treat them as nonadmitted, I should say.

MS. USIFER: And I'm okay with that. I'm just saying, if I look at what's happened, if you look at what changed in RBC over the past two years, the biggest driver was those two lines, and the actual operations were about break even, and the operations over five years actually were favorable. So, you know, we are where we are. We're at 495, and we're going to get back up, but I just really want to be on the record that, barring some of that in and out, that's what's created a lot of the noise in the RBC, and we would have been quite a bit higher had those been in there. On top of that, there are small adjustments like the $7 million that they knew they were supposed to get back from risk. That's 30. You know, so that brings them

from 495 up again by 30, the CSR adjustment that they might get back.

So I just wanted to, you know, kind of really point that out, because a lot of the documentation really points just to what the Green Mountain Care Board has done as far as rates, and, when I look at, you know, the net operating income loss, because you do expect to have some gains on your portfolio out of reserve --

MR. PIECIAK: Yeah, sure.

MS. USIFER: -- that should offset and help you in your RBC. Those have been a wash for the past five years. So I just wanted to get that point out there. And just another topic, on ACO risk, and, you know, right now the ACO in Vermont is holding about, estimating a potential overall risk of $30 million, very small amount for commercial, about $3 million. Most of it's in Medicare.

But the hospitals are now taking on that risk, and that shift over time, should we be 100 percent in, you know, there's was a very small move in the RBC range for Blue Cross relative to that. I just want to get your perspective on, you know, where the risks should reside, you know, when we have, you know, if we had a fully populated ACO and, if, in fact, you know, 3

percent or, of a risk of up to 6 percent, 50 percent was going to be borne by the ACO on commercial, how would that impact?

MR. PIECIAK: Yeah. So, I mean, the risk doesn't disappear, right? I mean, it gets shifted to some degree. So, certainly, I think my perspective would be you'd want to think about what are ways to measure the risk that might be residing in new places that we haven't, you know, thought about or sort of measured in ways in the past and coming up with something that I think was universally agreed to as a solid indication of, you know, I would say solvency, but solvency or ability to pay or ability to manage that risk, you know, coming up with a new way of measuring that is probably going to be critical as this continues to go forward.

MS. USIFER: Okay. And just one last thing. You talked about not adjusting rates if they're not actuarially supported.

MR. PIECIAK: Um-hum.

MS. USIFER: And would you support that what L&E has put forward is actuarially supported?

MR. PIECIAK: Yeah. So we, you know, did a somewhat, you know, unusual in the sense that we don't ask our actuary to get involved in the rate process in

a general term, but, because of the rate that was requested, it being high, I mean, higher, as high as I've ever been Commissioner and also the RBC being at the lowest point since I've been Commissioner, we did ask our actuary to both look at the financial status on top of our analysis and also to take a look at the rates.

As it relates to the two major points of disagreement, I think our actuary said on the individual mandate that they had seen more conservative, I guess you would call it, filings that, that included a number that was even greater than Blue Cross Blue Shield's. So she and Oliver Wyman -- it was not an actuarial opinion. I don't want to say that she gave me an actuarial opinion, but this was her thoughts on the filing, that she agreed with Blue Cross Blue Shield's perspective as it relates to the trend.

They said that there was some room of reasonableness there on both sides. So they saw that as a range instead of one being more right or one being less right. So I will just caution or just mention that, when you do have a range to consider, whether you want to take the low end of the range every time considering the financial status of a company, there might very well be times where you do want to do that

to balance affordability, but there's also probably times where you want to be cautious of that because of where a company might reside in their overall financial status.

MS. USIFER: Thank you.

CHAIRMAN MULLIN: No questions.

MR. BARBER: Robin, did you have one?

MS. LUNGE: I do. So the opinion that you just gave is not your actuary's opinion; is that what you said?

MR. PIECIAK: That's correct.

MS. LUNGE: Okay, thank you. And, in terms of risks and reserves, would you agree with the statement that reserves should reside appropriate to the risk taken on by whichever party?

MR. PIECIAK: I believe that's correct, yes.

MS. LUNGE: Thank you. Thanks, Mike.

MR. BARBER: Thanks. All right. Thank you for your testimony.

THE WITNESS: Yeah, thank you.

MR. BARBER: I think we have -- so we're, we're one minute away from 4:00. Do we have a little bit of a --

MR. FISHER: I am Mike Fisher. I am the Health Care Advocate, and I will indeed be brief. So I

think we all know that affordability concerns for Vermonters are real, and I think we all know, and I think Vermonters know that what it means. I think, you know, I don't believe there's a Vermonter who would say that affordability means some kind of measure of what MLR means or that affordability means something that that's within the parameters of an actuarial analysis, that affordability is measure of consumers' experience.

I don't want to get into a ridiculous debate about what is the found, right, appropriate foundation, what comes first, whether affordability comes first or an actuarial analysis. Predictably, the actuary will say, Hey, you got to be actuarially sound first, and, predictably, the Health Care Advocate is going to say, Hey, affordability is of primary concern. I don't know what's first. Both are important.

400 commenters have commented, over 400 commenters have commented, and that's an impressive number, and I was going to go into a little detail there, but I'll skip it. Blue Cross told us today that any reduction in the rate on nonactuarial grounds will cut into the reserves or won't reduce the cost of care. In a few weeks, you're going to hear from hospitals who are going to make a similar kind of argument from their side, that you can't possibly put downward pressure on

their business because of their own pressures.

So I, I end up with this just very basic. Both of those things can't be true. There, there has to be an ability for you, the Board, to put downward pressure on this, on this health care financing system. Otherwise, I guess we should all just go home, which I don't believe. I believe that there is something we can do.

Just a very quick review of a few things. Higher rates lead to more people being forced into higher out-of-pocket plans. The underinsured rate is growing. Went from 27 percent in 2014 to 40 percent in 2018. Out-of-pocket, according to the Household Health Insurance Survey from last year, out-of-pocket costs for the underinsured Vermonters was an average of $4,072, and 18 percent of those people were contacted by a collection agency. It's real. It's real, and it's impacting people's ability to get the care they need.

I don't want to offend the Board, but I do want to speak to the urgency of it from my perspective and from what I think we're hearing from consumers. From my perspective, the crisis that's happening in Vermont families when they need care and can't afford it is like the urgency of a community hospital going bankrupt, and I know, you know, really important things

have happened in the last couple of months around Springfield, appropriate things. Injections of cash, a lot of meetings, and probably a lot more than that I know about, have happened, and those are the right things to do to save a community hospital that's in trouble.

I just want to say that we have a very similar crisis that's happening in a much more private way. Vermonters are proud. People are proud. They don't want to speak out loud about what's going on for their financial crisis. They don't want to talk about it. But it's impacting the ability of people to get the care they need, and, and thank you, Board, for taking on this task of balancing these two really, really big pressures.

MR. BARBER: Thank you. Questions?

MR. DONOFRIO: No questions.

MR. ANGOFF: No questions.

MR. BARBER: Questions from the Board? Okay, thank you.

MR. FISHER: See you down the road.

MR. BARBER: So I would propose we skip closings, but is that, is that reasonable, or would you like to make a closing statement?

ATTORNEY ASAY: Could we have one second?

MR. BARBER: We have until 4:15, so --
ATTORNEY ASAY: How about a two-minute closing?
ATTORNEY ANGOFF: Two minutes? Okay.
MR. BARBER: Okay, go ahead.
ATTORNEY ASAY: All right. So I'll just go back quickly to the beginning of this hearing where the Health Care Advocate suggested that the theme would be overreaching, and I want to respond to that directly and just say that, based on the evidence that we've heard, there is no overreaching in this request. Blue Cross has no incentive to overreach. As we've heard, they're a nonprofit with a mission to serve Vermonters, and they have every competitive incentive in the marketplace to make their rates as low as possible, and the testimony that we've heard about their administrative costs, essential need for a CTR contribution, and, given their solvency and the actuarial building of the rates, makes it very clear there is no padding in this rate request.

There's some disagreement among the actuaries, but I think and I'll make this point brief. As the Commissioner indicated on the trend piece, it's a range. There's a reasonable route. Blue Cross's proposal is reasonable, it's within the range, and,

given the solvency concern, the circumstances here, given the evidence about the uptick in utilization, this is a very risky time to go to the low end of the range.

There's, there are two overarching points that I think we want to close the hearing on. One is, as has come through the witnesses, the premiums have to be funded to pay for the cost of health care. There's no padding in the rates. A cut to those does not make health care cost less. It does not make health care more affordable. It just underfunds the premium, puts the solvency of the insurer at risk, and puts strain on the system. Underfunding the rates is not the way to reduce the cost of health care. As you heard from Mr. Garland, fully funding the rates supports the ACO, which is the payment reform effort that's going to show results down the road.

And the other overarching point is that solvency is a critical issue. It's the most important element of consumer protection, and, if the rates are underfunded, it's going to put further strain on Blue Cross's reserves, and it's going to threaten their solvency, which will ultimately threaten those factors that the Board must consider, access to care, access to quality care, and, ultimately, affordability.

MR. BARBER: Thank you.

ATTORNEY ANGOFF: That was probably pretty close to two minutes. I'll try to do the same. We'll file our brief, and we'll go through all the actuarial issues, but the big issue, obviously, to me and, I think, to most, to many people, anyway, is the whole issue of the tax refunds. Blue Cross understandably wants to use that money to build up its surplus. Surplus in Vermont of the Blue Cross plan has traditionally been among the lowest in the country. It always has.

And they see, and I see it from their perspective, a unique opportunity to take this windfall and to build up their surplus. From the Commissioner's perspective, I also see, from the Commissioner's side, I also see his perspective. The worst -- I was Commissioner in Missouri for six years. The worst thing that can happen to a Commissioner is to have a company go bankrupt, go insolvent under your watch.

If people have to pay rates, pay high rates, you get a lot of complaints, but it's not catastrophic. If a company goes insolvent, the Commissioner personally is the one who feels it. So I get it from his perspective, although I don't think there's a realistic chance of that happening in Vermont for obviously

reasons discussed here.

I do think, though, that, as I said originally, Blue Cross overreaches in trying to blame the rate increase and the second step back, blame the Board, really, for what's happened to its surplus. There are a lot of other reasons that its surplus has declined. This year, for example, 10 million bucks was due to their losses in the stock market. You can question whether they should have had that much in stock and, if they did have that much in stock, why did they lose $10 million, but, yeah, they lost $6 million on their insurance business, but they lost $10 million in the stock market. So they can't blame the rate, the rate regulation system for what's happened to their surplus to the extent that they're trying to.

For me the tiebreaker is this: If this were another state where the standard was excessive, inadequate, or unfairly discriminatory, I might have more sympathy to Blue Cross's arguments than in this state where you have to consider affordability, and we all like to have maximum solvency, but you can't have maximum solvency if you've got to consider affordability. So I'd ask the Board to err on the side of, within reason, making the rate as affordable as possible.

MR. BARBER: Thank you. Before we adjourn, there were some questions that the Board asked that required some follow-up from Blue Cross. We will try and get those to you in writing so they're clear with a date for a response. In addition, I think there will likely be some questions from L&E on those two points of disagreement on the actuarial piece. So we'll include those as well and get that out this week.

ATTORNEY DONOFRIO: Thank you.

MR. BARBER: Okay. Anything else before we adjourn? No? Okay. So we are adjourned.

(Whereupon at 4:11 p.m. the hearing was adjourned.)

C E R T I F I C A T E

I, Sunnie Donath, RPR, do hereby certify that I recorded by stenographic means the hearing re: GMCB Docket No. 006-19-rr, at the Vermont State House, Room 11, 115 State Street, Montpelier, Vermont, on July 23, 2019, beginning at 8:00 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 330 pages are a transcript of the stenographic notes taken by me of the evidence and the proceedings to the best of my ability.

I further certify that I am not related to any of the parties thereto or their counsel, and I am in no way interested in the outcome of said cause.

Dated at Westminster, Vermont, this 25th day of July, 2019.

//Sunnie Donath, RPR