STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB 018-14

VERMONT HEALTH CONNECT RATE HEARINGS: BLUE CROSS AND BLUE SHIELD OF VERMONT'S PROPOSED 9.8% INCREASE

August 12, 2014
9 a.m.

State House
Montpelier, Vermont

Hearing held before the Green Mountain Care Board, at Room 11 of the Vermont State House, State Street, Montpelier, Vermont, on August 12, 2014, beginning at 9 a.m.

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1 MR. GOBEILLE: Good morning everyone.
2 Thank you to all the parties for coming. I
3 will officially call this hearing of the
4 Green Mountain Care Board to order. I'm
5 going to be turning this over to Judy Henkin
6 who will be the Hearing Officer for today.
7 Judy.
8 MS. HENKIN: Thanks, Al. Good morning
9 everybody. I am Hearing Officer by
10 designation of the Chair, Al Gobeille.
11 This -- today is the 12th of August,
12 2014. We are here in the matter of Blue
13 Cross Blue Shield Vermont 2015 Vermont
14 Health Connect rate filing. This Docket
15 GMCB 018-14. And this is being conducted
16 under Title 8 of the Vermont Statutes
17 Annotated Section 4062(a). And this hearing
18 -- please first things first. Everyone's
19 cell phones off. This is a hearing.
20 Thanks. And I didn't correct that, and I'm
21 going to talk a little bit about the process
22 that we are going to go through for this
23 hearing.
24 This is an administrative hearing in
25 accordance with the Vermont Administrative

1 Procedures Act. We do have a rule that
2 governs the hearing procedure. It is Rule
3 2.000, and section 2.307 guides the hearing
4 process. We are going to have witnesses
5 today, first from Blue Cross Blue Shield of
6 Vermont, then the Department of Financial
7 Regulation will present some testimony. Our
8 -- the Board's actuaries are here. They
9 will go after the Department. And we do
10 have David Dillon who will be testifying
11 today.
12 And the Health Care -- the Health Care
13 Advocates' office, sitting over on this side
14 will also be presenting a witness. This
15 hearing also allows for public comment under
16 Section 2.307(b). If anyone is here from
17 the public that wishes to comment, not ask
18 questions of the Board or any witnesses,
19 they may sign up. We will reserve time at
20 the end. There is a sign-up sheet that is
21 on the table by the door on this end of the
22 room that I'm pointing to. Please sign up.
23 We will give a limited period at the end of
24 all testimony for witnesses to comment
25 specifically on this particular rate filing.

1 As I said, it is public comment. You do
2 not have to speak in public. If you want to
3 comment, we do have a process by which you
4 can comment through the Web site. The
5 Vermont -- if you go to the Green Mountain
6 Care Board's Web site there is a link in the
7 right-hand corner to the rate review Web
8 site. You can send it by U.S. mail, or give
9 a call to the Board and leave a comment that
10 way. We have comments running through the
11 18th of this month.
12 And as I said, if you're going to
13 comment and you want to sign up, please do
14 so now so we can reserve time. In this
15 hearing please all cell phones off. I'll
16 say it once more.
17 MEMBER OF THE PUBLIC: Sorry.
18 MS. HENKIN: That's okay. You missed
19 the first reminder. In this hearing there
20 are some documents that are confidential,
21 and I am going to just remind the parties
22 and remind the witnesses that if you are
23 going to reference anything that may be
24 confidential, I would like you to please
25 bring our attention to it first. Because we

1 would have to close the hearing to the
2 public for a very short, limited amount of
3 time, during which time that would be
4 discussed.
5 So I know that the HCA's office and Blue
6 Cross are aware of what documents they are,
7 but I'm also going to remind the Board that
8 that may be what we need to do.
9 We have exhibits that were stipulated
10 to, and I guess what we will do first is
11 just go through the housekeeping on that.
12 Everyone who is on the Board should have
13 this nice binder in front of them. And do
14 you want to tell me about this document,
15 Lila?
16 MS. RICHARDSON: Yes. In addition to
17 the documents that we had stipulated to at
18 the prehearing conference, there is an
19 additional Exhibit 10A which is a supplement
20 with the opinion from Donna Novak, our
21 expert. The parties agree that that can be
22 part of the record also as a stipulated
23 exhibit.
24 MS. HENKIN: And this was stipulated to?
25 MS. HUGHES: Yes, it was.

1 (Exhibits marked 1 through 13, including
2 10A, were admitted into the record.)
3 MS. HENKIN: Okay. Anything else
4 preliminary that we should get out of the
5 way now? I would like -- if anyone who is
6 going to testify -- I would like to swear
7 everyone in at once if I can. If you are
8 going to be a potential witness, who would
9 that be?
10 MS. HUGHES: For Blue Cross and Blue
11 Shield we have Ruth Greene and we have Paul
12 Schultz.
13 MS. HENKIN: Okay.
14 MS. RICHARDSON: And for the Health Care
15 Advocate, Donna Novak.
16 MS. HENKIN: Okay. And we have for L&E
17 -- we have for the Department over here, Mr.
18 Cassetty, Attorney Cassetty would be and
19 over here, potentially two witnesses, but at
20 least one.
21 Okay. Could everyone raise your
22 right-hand?
23
24
25

1 DAVID CASSETTY
2 PAUL SCHULTZ
3 RUTH GREENE
4 DAVID DILLON
5 DONNA NOVAK
6 Having been duly sworn, testified
7 as follows:
8 THE GROUP OF WITNESSES: Yes.
9 MS. HENKIN: Okay. Everyone has
10 affirmatively answered. With that, I would
11 like to give the parties a minute or two for
12 an opening statement before we get going.
13 And then we would go into testimony from
14 Blue Cross's witnesses.
15 MS. HUGHES: Thank you. I'll be very
16 brief. My name is Jackie Hughes, and I'm
17 here on behalf of Blue Cross and Blue Shield
18 of Vermont today. And we are very pleased
19 to be here to present our 2015 exchange rate
20 filing. You all have the filing in your
21 binders. It is Exhibit 1. And it is part
22 of the agreed evidence that the parties have
23 reached earlier.
24 Our purpose today is to make our filing
25 clear to you, the Board, to explore the

1 issues raised by the Board's contract
2 actuary as well as the Department of
3 Financial Regulation and the Health Care
4 Advocates' actuary and to answer any
5 questions you may have about the filing.
6 Like last year's filing our goal in this
7 filing is to get it right. It is to get the
8 right rate to fully fund the delivery of
9 benefits to exchange participants. And as
10 you will see, Blue Cross has priced its
11 product so that it can compete vigorously in
12 the exchange market without jeopardizing its
13 financial strength. Lewis & Ellis's review
14 of the filing was rigorous, and we thank
15 them for their courtesies and their
16 attention to turning this to you in a timely
17 fashion. And although the disagreement that
18 we had with the filing is fairly limited, we
19 believe that any further reductions to our
20 proposed rate would not be prudent. So we
21 are asking you, the Board, to adopt the rate
22 as filed. And with that, if the HCA has an
23 opening.
24 MS. RICHARDSON: Thank you. My name is
25 Lila Richardson. I'm appearing on behalf of

1 the office of the Health Care Advocate which
2 was formerly known as the office of Health
3 Care Ombudsman. The office of the Health
4 Care Advocate is a party in this case
5 appearing to represent Vermont ratepayers
6 who will be enrolling in plans offered by
7 Blue Cross Blue Shield of Vermont in the
8 Vermont exchange marketplace beginning in
9 January, 2015.
10 This rate filing is a very important
11 one. According to the filing documents in
12 Exhibit 1, almost 58,000 Vermonters are
13 currently enrolled with Blue Cross Blue
14 Shield of Vermont and the qualified health
15 plans through the Vermont Health Connect
16 exchange marketplace. This obviously
17 represents a very large percentage of the
18 total number of Vermonters enrolled in plans
19 under the health care exchange.
20 Our goal is to ensure that Blue Cross
21 Blue Shield of Vermont's rates for the
22 products and the exchange are both
23 reasonable and as affordable as possible.
24 Blue Cross Blue Shield of Vermont is
25 requesting a 9.8 percent increase for 2015.

1 The HCA's concerned about the affordability
2 of premiums if this rate increase is
3 approved as proposed. Although lower income
4 Vermonters do receive subsidies to help pay
5 for the cost of their premiums, other
6 Vermonters must pay the full price for non-
7 group coverage. In addition, small
8 employers purchasing plans on the exchange
9 would experience the full impact of any rate
10 increase, and many employers will be passing
11 the initial cost on to their employees,
12 other individual Vermonters.
13 The Board has already received many
14 public comments expressing concern about the
15 affordability of plans on Vermont Health
16 Connect. Lewis & Ellis, the actuarial firm
17 hired by the Board has, as Jackie just
18 indicated, reviewed the filing and has
19 recommended a number of modifications to the
20 rate request from Blue Cross Blue Shield.
21 The Health Care Advocate office agrees with
22 these proposed modifications from L&E.
23 Our primary area of disagreement with
24 the filing involves the assumptions that
25 Blue Cross Blue Shield has made about

1 something called the attachment point for
2 federal transitional reinsurance which is
3 provided to carriers in the exchange. There
4 will be evidence from an independent
5 actuary, Donna Novak, who has reviewed the
6 filing, and this would show that the Blue
7 Cross Blue Shield rates can be reduced as a
8 result of an expected change in transitional
9 reinsurance attachment point from $70,000 to
10 $45,000. And this recommendation from our
11 actuary is consistent with one of the
12 recommendations from Lewis & Ellis in their
13 report.
14 And in summary we are asking the Board
15 to reduce Blue Cross Blue Shield's proposed
16 rate in order to achieve rates that are as
17 reasonable and affordable as possible in the
18 exchange.
19 MS. HENKIN: Thank you. You can call
20 your first witness.
21 MS. HUGHES: Thank you. I will call
22 Ruth Greene.
23
24
25

1 RUTH GREENE
2 Having been previously duly sworn,
3 testified as follows:
4 THE WITNESS: Morning.
5 MR. GOBEILLE: How are you?
6 DIRECT EXAMINATION
7 BY MS. HUGHES:
8 Q. Good morning. Could you state your full name
9 for the record?
10 A. Ruth Greene.
11 Q. And although the Board has your CV, as Exhibit
12 13 in the binder, could you tell us what your position is
13 with Blue Cross Blue Shield?
14 A. I am currently CFO and Treasurer of Blue Cross
15 Blue Shield Vermont, and in that capacity I'm responsible
16 for all the financial management responsibilities for the
17 company. And as part of that I'm also overseeing and
18 responsible for the premium rate filing for all of our
19 products.
20 Q. And are you an executive with Blue Cross?
21 A. Yeah. I'm a senior executive on the executive
22 team. Yeah.
23 Q. Can you describe Blue Cross's role in health
24 care reform efforts here in Vermont?
25 A. Blue Cross Blue Shield of Vermont's role is

1 integral in -- with respect to health care reform in
2 Vermont. In fact, if you look at our mission and vision
3 as we publish them on our Web site or as employees come in
4 to work every day, we -- our mission is that we are
5 committed to the health of Vermonters, and outstanding
6 member experience and responsible cost management for all
7 the people whose lives we touch. And more importantly our
8 vision is a transformed health care system in which every
9 Vermonter has health care coverage and receives timely,
10 effective and affordable care.
11 So we feel that our mission and vision is very
12 much tied up in the long-term benefit of Vermonters as
13 Vermont finds its way through the health care reform
14 efforts. In fact, we can't achieve our vision unless
15 health care reform happens, because our vision is for a
16 transformed health care system.
17 The other thing I would like to emphasize is
18 that we -- on an ongoing basis we demonstrate our
19 commitment to that vision in health care reform in Vermont
20 by partnering with various entities in the state, the
21 Board, members of the various working groups that the
22 state has formed in terms of delivery system reform,
23 payment reform. And we also are very committed to the
24 success of Vermont Health Connect. We have been a very
25 committed partner as we have worked through several

1 contingency plans, as we have worked people through the
2 transition to the new exchange and avoided any gaps in
3 coverage as people had to switch over from their old plans
4 to the new.
5 So we feel that we are very, very committed
6 and view the Vermont Health Connect and the exchange and
7 the qualified health plans and those rates as an integral
8 part of health care reform.
9 Finally on that point, I would just like to
10 emphasize that Blue Cross Blue Shield of Vermont really
11 can only succeed in all of this and be an effective
12 partner if we have solid financial foundation to build on
13 and make sure that the exchange itself is funded and we
14 can pay all the claims that are incurred by the members on
15 the exchange.
16 Q. So is this filing and Blue Cross's
17 participation in the exchange part of those efforts?
18 A. Absolutely. The 2015 exchange rate filing
19 itself is an integral part of all of these efforts. It is
20 the second year of the first years of a new program,
21 important state program, as the state moves forward in its
22 health care reform efforts. And again, just want to
23 emphasize how important it is that we get the rate right.
24 We have an obligation to get the rates as right as
25 possible given that we have a lot of estimates that we are

1 making. We are committed to that goal and believe that
2 the Board has that obligation to make sure that the rates
3 on the exchange are adequate to fund the claims that the
4 members will incur plus small administrative cost, six
5 percent of our administrative costs which is very
6 competitive and lowest in the industry as well as the
7 contribution to reserve. So really that is a key piece of
8 the success of the exchange both now and in the future.
9 Q. So is the exchange market a material part of
10 your business?
11 A. Yes. As the Health Care Advocate opening
12 statement said, that there is close to 58,000 members in
13 our estimates for 2015 for the rates on the exchange. And
14 that is clearly a majority, about 90 percent of the
15 commercial members on the exchange, and it also is a
16 significant segment to Blue Cross Blue Shield of Vermont.
17 It's a significant portion of our business.
18 So all of those things make this an important
19 piece of our ongoing efforts to make sure that the
20 exchange and plans on the exchange are successful.
21 Q. And so what was Blue Cross's approach in
22 putting this filing together?
23 A. Blue Cross Blue Shield of Vermont in overall
24 approach to this exchange as always, I mentioned earlier,
25 we have an obligation to try and get the rates as accurate

1 as possible. And in some ways, I hesitate to use the word
2 accurate because we are talking about trying to estimate
3 what will happen in 2015, what will the medical costs be,
4 et cetera. But we have done our level best. We have a
5 lot of experience with the Vermont health care products,
6 and so we -- like we did last year and we do each time we
7 make a filing, make our best estimates.
8 That said, we have done everything we can. We
9 are very sensitive to the need for the rates on the
10 exchange to be consistent and affordable. But we also
11 recognize that they need to be adequate to cover the
12 claims that the members will incur. So we have done
13 everything we can as we go through, and I thought I would
14 mention a few things in that category.
15 As we go through our rate filing, the experts
16 and the actuaries looking through the filing, there is no
17 conservative, conservatism. We have no implicit margins.
18 We requested a minimum level of CTR, one percent, which is
19 the minimum level required just to sustain the member
20 reserves as medical costs increase. There is no
21 additional contribution to members' reserves for any sort
22 of significant adverse events.
23 We also have no sort of topping up or
24 additional administrative costs included in the exchange.
25 We took a view -- we took a long view of our rates that

1 all of our members should benefit from the ongoing cost
2 containment and cost efficiency improvements that Blue
3 Cross Blue Shield has been able to achieve over the last
4 few years. And so we have included six percent on average
5 of premiums for administrative costs, and so for 2015 and
6 2014 we have not included any additional administrative
7 costs that might be attached to the various contingency
8 plans or the outreach that we had felt like was an
9 important piece of getting the exchange launched.
10 So just wanted to emphasize that as we submit
11 our rate filing, it's important to recognize that we are
12 not adding anything in for that.
13 The other thing is just wanted to mention the
14 transitional reinsurance, Health Care Advocate had brought
15 that up in the opening statements. And that is one of the
16 areas that is going to be discussed at length as the
17 various witnesses come through. Paul Schultz from Blue
18 Cross Blue Shield of Vermont will walk through in detail
19 what our assumptions were on the transitional reinsurance.
20 But I think it is important to recognize that we believe
21 that to assume anything other than what the current ACA
22 regulations require for the attachment point, which is
23 you'll have an explanation a little bit later on, how they
24 -- the attachment point affects the rates, but you'll see
25 later on that there is a recommendation to anticipate what

1 might happen with those attachment points in the future.
2 And we feel very strongly and believe strongly that that
3 would be imprudent.
4 The idea that we are going to artificially
5 assume that subsidization is going to come into our
6 exchange rates that hasn't been approved yet by the
7 federal CMS folks is really mortgaging the future. We
8 believe that if those subsidies do not come through, then
9 what will happen is in 2016 and in future years, the rates
10 will have to be increased even further. So although you
11 might feel that the rates are kept lower in 2015, it
12 really just digs a hole, if you will, that it will be a
13 steep hill to climb. If I can just explain in another way
14 to be clear --
15 MS. RICHARDSON: Objection. The
16 testimony is not responsive to the question
17 which was asking about how the rates are
18 developed.
19 MS. HENKIN: I'm going to allow her to
20 go on with this.
21 THE WITNESS: Okay, thanks. The rates
22 being developed were very much in alignment
23 with the rules in place at that time. So I
24 think that the way to think about our 2014
25 rates and 2015 rates, and as we look to the

1 future, we are recognizing that the
2 increases over time were designed through
3 the transitional reinsurance to phase out
4 over three years, and we have incorporated
5 that program as it was intended.
6 Lastly, I would like to just point out
7 that the Department of Financial Regulation
8 has commented that the higher subsidies
9 would dig a hole and require higher rate
10 increases later. So I just want to
11 emphasize when we pull these rates together
12 we did our best for Vermonters to get the
13 rates right both now and in the future.
14 BY MS. HUGHES:
15 Q. So are you familiar with the standards for
16 approval of rate requests?
17 A. Yes.
18 Q. And can you tell us how does Blue Cross
19 promote quality care for its members?
20 A. Blue Cross has very, very broad and deep focus
21 on quality. We have a lot of monthly metrics and things
22 that we use to measure our customer service results.
23 We also provide for very comprehensive
24 products that focus on health and wellness. We also have
25 preventative services as required by ACA, but even in our

1 other products we have a very strong focus on the
2 importance of preventative services.
3 And we also have something called our Quality
4 Management Program. And this is a very broad program that
5 goes from care management, utilization management, as well
6 as disease management. It looks at health and wellness
7 programs. We have a Better Beginnings program which
8 focuses on the health of expectant moms and their babies
9 and afterwards.
10 So there is a lot of focus at Blue Cross Blue
11 Shield of Vermont to make sure that we are delivering
12 coverage that allows people to have quality care. Another
13 example of the quality that we are looking for is the --
14 and the exchange was being rolled out, we recognized that
15 there was some benefit translation services that were
16 needed, so we sent some folks out to the community to make
17 sure that those things were taken care of.
18 So we are constantly looking at ways to ensure
19 that things are delivered in a quality way.
20 Q. And how does Blue Cross promote access to
21 health care in Vermont?
22 A. The Blue Cross Blue Shield Vermont has a very
23 comprehensive provider network, that's sort of what I
24 think of first and foremost when we talk about access to
25 care. It's a very comprehensive across the State of

1 Vermont. It's also through our Blue Card mechanism. Goes
2 nationwide, and it also has access to health care
3 globally. We have access to our provider network
4 globally.
5 As a case in point, we just in the last couple
6 of weeks had had a couple of members who were traveling
7 this summer and one in eastern Europe and one in Asia who
8 were utilizing our Blue Card network and brought the
9 services that come to bear with that on getting the
10 quality care that they needed. So it's very much a part
11 of our operating.
12 We do not limit our network in any way. The
13 network that we use for our exchange quality -- qualified
14 health plans is very comprehensive. The other thing I
15 would point to on access is that we are offering products
16 across the full gamut on the exchange for individuals and
17 small employers, we have both -- all the standard plans as
18 well as several non-standard plans. So we are providing
19 choices for people to access the health care coverage that
20 they need.
21 Q. So how does Blue Cross ensure that its
22 exchange and other products are affordable?
23 A. So the affordability of any health care
24 coverage really needs to be taken into context with the
25 other requirements for rate reviews. So the standards of

1 rate review include affordability. It also includes
2 quality, access for members. And in order to ensure that
3 you have quality and the access it requires that all of
4 the services and capabilities and provider network is
5 included in those rates.
6 So we believe that Blue Cross Blue Shield of
7 Vermont in providing our quality -- very high quality
8 products on the exchange with very low administrative
9 costs and minimum required CTR is doing our level best to
10 get the high standards that Vermont expects to Vermonters
11 on the exchange for as low price as possible. But we do,
12 as I said earlier, have an obligation to ensure that the
13 premium rates are adequate to cover the claims that the
14 members are going to incur on the exchange or through the
15 exchange.
16 Q. And the exchange products, they are a form of
17 insurance. Could you explore the function of insurance
18 relative to affordability?
19 A. Yes. The -- fundamentally Blue Cross Blue
20 Shield of Vermont's role in the exchange and filing these
21 rates is to protect all of the individuals that come on to
22 the exchange from their individual risk that they could
23 potentially have an unaffordable health care event or
24 potentially ruinous health care costs related to a
25 significant illness or injury.

1 So what we do as the payor in the exchange is
2 we pool all those individuals together, individuals and
3 the employees of the small groups on the exchange, and we
4 bear that risk and make the entire coverage on the
5 exchange affordable. So really there's a very big role.
6 We also, as I mentioned earlier, if you look at the
7 exchange premiums we are obligated to make sure that there
8 is premiums to cover the claims. And 91 to 92 percent of
9 the premium charged on the Vermont Health Connect exchange
10 is related to claims. We have six percent of admin and
11 other one percent of CTR, and the balance is the taxes and
12 the fees.
13 So really the fundamental way to attack
14 affordability long term is to make sure that the delivery
15 system and the payment reform initiatives are accomplished
16 really with 92 percent -- close to 92 percent of the
17 premiums on the exchange driven solely by the claims.
18 That's really the biggest way to address affordability
19 long term.
20 Q. So the standards that you just explored, are
21 they consistent with Blue Cross's vision?
22 A. Yes. The vision that I outlined earlier
23 specifically talks about a vision for a transformed health
24 care system where all Vermonters have health care
25 coverage, and so in reviewing these rates for the 2015

1 exchange, we really are very much aligned. We will
2 promote access. The word quality is in both the rate
3 review standard and our vision. And in terms of our focus
4 on timely and effective care, and making sure that the
5 affordability is there, is key.
6 Q. So the 91 to 92 percent claims cost that you
7 referenced earlier, are those costs solely within Blue
8 Cross's control?
9 A. No. They are not. Blue Cross of Vermont has
10 some influence over the 92 percent of claims that are on
11 the exchange through our quality management program. And
12 also through the contract negotiation and contract design
13 that we do with the providers. But clearly, the providers
14 and the various payment reform efforts and looking for
15 ways to ensure quality at a lower cost is key.
16 In fact, the -- another important role of the
17 Green Mountain Care Board being the hospital budget
18 review, that plays a role in the medical costs in our
19 premium. It is clear that with hospital budgets looking
20 for three percent target or maximum for the net patient
21 revenue increases each year, if they have a mix of
22 Medicaid, Medicare, and commercial business, and the
23 Medicaid and the Medicare rates only go up one to two
24 percent or in the case of yesterday's news, Medicaid might
25 not go up at all, probably won't go up at all, it really

1 shifts the rate of increase to the commercial payors.
2 And it's a well-known dynamic called the cost
3 shift that does come into play with our exchange rate
4 filing, and in some of the summaries and rate filing you
5 can see that the medical cost trend is in the four to five
6 percent range. L&E and the other actuaries commented that
7 that was reasonable, but it is something that is -- will
8 feel a lot of pressure as the Medicaid rates are not
9 allowed to go up.
10 So I feel that we have -- we do what we can,
11 and we work very hard to partner with the providers to
12 find new payment mechanisms to reduce the health care
13 costs, but really the influence we have over that is very
14 much indirect.
15 Q. Thank you.
16 MS. HENKIN: You're done, Jackie?
17 MS. HUGHES: I am.
18 MS. HENKIN: Ms. Richardson.
19 CROSS EXAMINATION
20 BY MS. RICHARDSON:
21 Q. Good morning. Has the financial strength of
22 Blue Cross Blue Shield of Vermont changed substantially
23 since you testified last year in connection with the
24 Vermont Health Connect filing, for the 2014 rates?
25 A. Our financial strength stays within the range

1 that we manage to. I believe that since the
2 implementation of the exchange and several contingency
3 plans that we put into place introduced more uncertainty
4 around our financial outlook, we are continuously
5 monitoring results. And again as we put our rate filing
6 together, we are always working to get the rates as
7 correct as possible.
8 Q. Okay. Does Blue Cross Blue Shield Association
9 -- you're part of the Blue Cross Blue Shield Association?
10 A. We are a licensee of the Association. Yeah.
11 Q. And does that Association have a target range
12 for determining risk-based capital?
13 A. They don't have a target.
14 Q. Do they -- does Blue Cross Blue Shield Vermont
15 itself have a range of risk-based capital that you're
16 trying to achieve?
17 A. I understand what you're getting at. Blue
18 Cross Blue Shield Association has a minimum level. It's
19 not a target, but a minimum level of risk-based capital
20 that they expect all of their licensees to maintain, or
21 else they would come in and increase monitoring and
22 review. The idea being that to sustain the Blue Cross
23 Blue Shield brand and access to the Blue Card network and
24 be able to operate as part of that national and global
25 network they want to make sure that the participants in

1 that Association is -- are financially solid. So that's
2 what the Association has.
3 Q. And what is that minimum amount that the
4 Association recommends? Without asking for specific RBC
5 information from Blue Cross, what is the minimum that the
6 Association requires?
7 A. I guess I'm -- I find it difficult to answer
8 that question without sharing a number which is that
9 something --
10 Q. I'm asking for the number that is the minimum
11 amount. Not a number that is related to Blue Cross Blue
12 Shield' own --
13 A. I don't have that with me. But I think it's
14 375 percent RBC.
15 Q. And is there an upper limit to the amount that
16 Blue Cross Blue Shield of Vermont tries to set in its RBC?
17 A. I can give you a little bit of context. So --
18 MS. HUGHES: And I would just like to
19 interpose that we are prohibited by law from
20 revealing what the RBC level of any insurer
21 is. And so I would caution the witness not
22 to be specific about Blue Cross's RBC
23 itself.
24 THE WITNESS: Sure. Sure. But in
25 answer to the question about how we look at

1 what an appropriate amount would be, we do a
2 fair amount of sensitivity testing as we
3 look at our blocks of business, and we look
4 at the risks that our business could have.
5 And this is something that the National
6 Association of Insurance Commissioners and a
7 lot of the industry experts will do.
8 Most companies, including Blue Cross
9 Blue Shield of Vermont, have what we call an
10 enterprise risk management program, which is
11 we look at all of the risks that might come
12 to bear on our business, and it's through
13 that lens that we have a look at how much
14 risk-based capital we are required to hold
15 in order to protect all of our membership
16 against any sort of adverse event.
17 So as I said, we do some modeling which
18 looks at, you know, what would happen if we
19 had a flu epidemic. Looks at what would
20 happen if the medical trend rate suddenly
21 doubled or shot up a few percentage points.
22 We also look at what would happen in the
23 case that just we had an aberration -- sort
24 of statistical aberration in claims in any
25 one year. And when we complete that

1 modeling we determine how much risk-based
2 capital we need to keep in order to weather
3 those types of storms.
4 And must be kept in mind that if we had
5 a significant event and we are required to
6 pay out a number of claims unexpectedly, it
7 would take several years to replenish that.
8 So all of that analysis is taken into
9 account when we determine the appropriate
10 range for our risk-based capital.
11 BY MS. RICHARDSON:
12 Q. And what is the appropriate upper limit of the
13 range that Blue Cross has determined?
14 A. We manage to a range of between 500 and 700
15 percent.
16 Q. Thank you. The attachment for transitional
17 reinsurance was changed in 1914 (sic) from the attachment
18 point that was originally assumed in the Blue Cross Blue
19 Shield 2014 filing last year; is that correct?
20 A. Yes.
21 Q. And do -- would you describe what the change
22 was?
23 A. If it's okay, I'll have Paul Schultz, the
24 senior actuary from Blue Cross Blue Shield Vermont, go
25 into the details behind that. I can give you a high level

1 response.

2 The implementation of the 2014 exchange both
3 nationally and in Vermont included several transition
4 programs where people were either not signing up early
5 enough or the systems were preventing people from signing
6 up when they wanted to. So the CMS recognized that the
7 attachment points that were built into this three-year
8 transitional reinsurance program would not be hit very
9 easily in 2014 because it took people longer to get into
10 their new qualified health plans.

11 So the way the attachment point works is that
12 someone might be a high cost claimant who incurs a lot of
13 claims, and once it gets to a level at the attachment
14 point then the federal government will subsidize the
15 claims above that. Well they understood that if people
16 came into the exchange in January, February or March or in
17 our case many people signed up April 1st because we
18 offered people to extend their plans, that that mechanism
19 wouldn't be hit as quickly because they only have nine
20 months left of the year to hit that attachment point.

21 So the attachment point was reduced to take
22 into account that dynamic, and we do view that as a
23 one-time thing. There is not going to be another
24 transition to the exchange in 2014. And Paul Schultz when
25 he walks through his testimony can explain in some detail

1 what the specific impacts are.
2 Q. But Blue Cross Blue Shield did benefit
3 financially from the change that occurred last year in
4 2014?
5 A. In fact, no. I think Paul will be able to
6 show you that's not the case.
7 Q. But the attachment point was lowered from what
8 was anticipated?
9 A. Yes.
10 MS. RICHARDSON: No further questions.
11 MS. HUGHES: I have a few follow-up
12 questions.
13 REDIRECT EXAMINATION
14 BY MS. HUGHES:
15 Q. Ms. Greene, you testified that the minimum
16 level of risk-based capital for the Blue Cross Association
17 in order to retain your marks, your Blue Cross & Blue
18 Shield is 375. If you were to hit 375 what would happen?
19 A. Well in fact the wheels start turning before
20 you hit 375. There's trend tests that are run every
21 quarter and every year that says that if your risk-based
22 capital is reducing and approaching a lower level, the
23 Blue Cross Blue Shield Association will begin coming in
24 and reviewing and requiring certain reports around issues
25 that might be affecting the company. Once something

1 happens that 375, or once something the RBC gets to 375,
2 there is a very formal program of monitoring and control
3 that take place.
4 By that time though don't forget that the
5 Department of Financial Regulation, the question earlier
6 was about the Association. But so my answer is around the
7 Association. But the Department of Financial Regulation
8 would be well involved at that point as well.
9 Q. And you testified earlier that your modeling
10 would try to pinpoint what would happen if there is
11 significant events. With a CTR, a contribution in reserve
12 at one percent, would you be able to sustain any
13 significant unusual events and maintain your position?
14 A. The CTR at one percent is really the minimum
15 level required to sustain the level of member reserves as
16 medical costs increase. If we were to have a significant
17 adverse event that reduced significantly our surplus, that
18 one percent does not replace it. It would require a
19 significant increase to our CTR, and it would take
20 potentially many years to recoup, if you will, that
21 position.
22 Q. Thank you.
23 MS. HENKIN: Does the Board have
24 questions of this witness? Dr. Ramsay?
25 DR. RAMSAY: Yes. I have a comment

1 first. And then just a couple of
2 observations. The comment being having --
3 going through this process for the second
4 time, I would like to publicly commend Blue
5 Cross Blue Shield for the thoroughness, and
6 I guess thoughtfulness of how you presented
7 the data about these exchange rates.
8 As you might expect we get an enormous
9 number of public comments about any
10 increase. And that's what makes our job so
11 difficult. But I would like to say that
12 first and foremost compared to last year
13 this has been a different process for the
14 Board. So thank you.
15 The second thing is, you know, I'm a
16 family doctor. And so I focus on a couple
17 of issues that are so important to people
18 that we all take care of, the medical trends
19 and the pharmacy trend. I feel like the way
20 you develop the medical trend in terms of
21 morbidity, potential morbidities, and your
22 experience which is very limited at this
23 point, was very reasonable. And the
24 pharmacy trend also raised in my mind some
25 questions, not necessarily on the liberal

1 aspect, but I know there are drugs that are
2 for a very small number of Blue Cross Blue
3 Shield enrollees are going to cost you
4 millions of dollars coming up. I know that.
5 And I know that some of those costs are not
6 only in providing the drug but in how you
7 contract with your pharmacy benefit
8 managers.
9 So do you find there is some -- there
10 may be some opportunity for Blue Cross Blue
11 Shield or any payor to deal more directly
12 with their pharmacy benefit managers about
13 reducing the burden of those costs for
14 Vermonters?
15 THE WITNESS: Thanks. First I'll just
16 respond by saying that the pharmacy benefit
17 management function and integrating the
18 medical care and the pharmacy care to make
19 sure that members are getting the right care
20 and the right medications is first and
21 foremost in our goals.
22 We are -- we do contract with pharmacy
23 benefit manager, and we negotiate rates with
24 them like we do other providers each year.
25 We are constantly looking to improve on

1 that. We do also work with our pharmacy
2 benefit manager to focus on those high-cost
3 drugs that you mention to make sure that
4 best practices are being used in terms of
5 determining whether or not those are going
6 to be effective and doing followups to make
7 sure that they are being effective.
8 So we are, you know, very focused on
9 what members need and the safety of members.
10 But also bringing to bear some of the best
11 practices as a way of -- I wouldn't say
12 managing that trend -- but doing what we can
13 to reduce the impact of that trend on our
14 members' costs.
15 DR. RAMSAY: I guess in light of that, I
16 also want to say because I won't -- I don't
17 have the opportunity to say this in public,
18 and I'll say the same thing tomorrow, that
19 the Green Mountain Care Board appreciates
20 Blue Cross Blue Shield and all the payors'
21 willingness to work to reduce the burden of
22 prior authorization and administrative costs
23 to every insurer, particularly primary care
24 practitioners in the state. And I know that
25 you all are working together to make that

1 happen. And I know it's difficult.
2 You each have your own policies and
3 procedures for how you establish your prior
4 authorization plan. But I also say I
5 believe it is a real opportunity for us to
6 improve on our generic prescribing ratio
7 throughout the state. And I believe our
8 primary care doctors will take that on.
9 So I thank you for your willingness, and
10 I will thank all payors to work on that very
11 difficult issue. But I think there is a
12 vision that that can really improve and
13 reduce some of these pharmacy trends over
14 time in the State of Vermont.
15 MS. HENKIN: Dr. Hein?
16 DR. RAMSAY: I have a question about
17 transition arrangements, but I'm going to
18 wait for Paul.
19 THE WITNESS: Okay. That's good. He's
20 the one to ask it to.
21 MS. HEIN: Just by way of introductory
22 remarks I want to thank you both for the
23 introduction into what will be a very
24 vigorous look today at a number of issues.
25 For me there are three words I'll be trying

1 to understand your definition and others'
2 definition of; they are reasonable,
3 affordable and adequate. Adequate refers
4 mostly to the ability for Blue Cross Blue
5 Shield to cover claims. So that's really a
6 Blue Cross word. Reasonable I would say to
7 whom and for what? And particularly on the
8 word affordable, really comes down to
9 Vermonters. So though your mission is to
10 improve the health and rate costs to
11 Vermonters, our job is truly to be sure that
12 the issues for Vermonters are well
13 understood around affordability.
14 So in addition to definitions of
15 adequate and reasonable, which in a sense is
16 what a lot of the testimony will be, I think
17 our job is to really define and understand
18 what is truly affordable for Vermonters.
19 And your thoughts on how to think about that
20 are most welcome.
21 THE WITNESS: And it's a challenging
22 question, and as my comments earlier
23 indicated, it sort of from my perspective
24 needs to take into account the quality and
25 the access. And Vermont has very, very high

1 standards when it comes to what is expected
2 to be covered with the premiums on the
3 exchange. And for years Vermont has had
4 community ratings so the individuals and
5 small groups and the older people and the
6 younger people and the smokers and the
7 non-smokers, everyone is paying the same
8 rate.
9 And so one thing that does come up from
10 time to time, and I'm sure the Board gets
11 these questions about, you know, the high
12 cost of health care in Vermont, or the high
13 cost of the high premium rates in Vermont,
14 and you know, there is two things I would
15 look to for that. Is that in many ways
16 Vermont wants everyone to have access to the
17 same quality health care. And so there are
18 no cheaper rates for non-smokers. There are
19 no cheaper rates for 40 year olds. So
20 everyone is paying the same rate.
21 So it's a difficult balance, because
22 some of those mechanisms raise the bar in a
23 good way in terms of what people are
24 expected to get from the health care
25 coverage, but it also makes it challenging

1 for some folks, and the subsidies through
2 the federal programs are helping with that a
3 lot.
4 But as the Health Care Advocate
5 mentioned, not everyone is in the situation
6 where they have the subsidy. So I don't
7 know if that helps with that challenge. I
8 think it is probably one of the more
9 challenging aspects of what the Board has to
10 consider.
11 MS. HEIN: Thank you.
12 MR. HOGAN: Yeah. I would like to --
13 and this may take a few moments, Madam.
14 MS. HENKIN: I want to remind everyone
15 first of all there is some people here I
16 don't know. If you're going to want to make
17 a public comment at the end of this, there
18 is a sign-up sheet by the door, and I'll
19 repeat that right now. But I am
20 anticipating that each witness is about an
21 hour and we are getting towards that. So we
22 will get going on these.
23 MR. HOGAN: I want to spend a few
24 minutes trying to understand better the
25 overall financial condition of the company,

1 without treading into proprietary issues.
2 And to do that, using page 29 of the five-
3 year historical data, which I believe was
4 stipulated and is public information.
5 MS. HENKIN: Exhibit what number?
6 MR. HOGAN: 11.
7 MS. HENKIN: Page?
8 MR. HOGAN: 29. So that is public
9 information at this point.
10 THE WITNESS: Yes, that is our public
11 annual statement.
12 MR. HOGAN: All of my remarks for the
13 next few minutes are going to be connected
14 to this information. And so for example,
15 these are where my eye took me. This is not
16 a thorough review. This is what jumped off
17 the page.
18 In 2009 company's assets were 136
19 million. In 2013 they were 214 million.
20 That's an increase of almost 53 percent over
21 that period. Now this is my arithmetic.
22 You may want to go back and check it. For
23 liabilities in '09 you were at 54.9 million.
24 And in 2013 you were at 81.7. That's an
25 increase of less than the asset increase.

1 Significantly less. And it was an increase
2 of almost 49 percent.
3 The capital and surplus numbers in 2009
4 you were at 81 million. By 2013 you were at
5 133 million. I'm rounding off. That's an
6 increase of 64 percent.
7 On the revenue side in 2009 you were at
8 287 million, and by 2013 you were at 421
9 million. That's an increase of 46 percent
10 over that four years.
11 So and that's another way to look at it,
12 is just take these numbers and divide by
13 four, it gives you a sense of the size of
14 the increases. One that caused me real
15 concern because I don't know enough about it
16 is the medical and hospital expenses. These
17 were flat for a number of years. In 2009
18 they were 250 million, by 2013 they were at
19 393 million. That's an increase of 57
20 percent in hospital and medical expenses
21 over a mere four years. So that's one that
22 caused me pause.
23 One -- on the reverse, on your total
24 administration expenses, in '09 you were at
25 13.6 million. And in 2013 you were at 15

1 million. That's a very small increase over
2 that period over those four years of 10.9
3 percent. You deserve a lot of credit for
4 that. And a little -- as I get into this a
5 little more, you deserve even more credit
6 for it. Excuse me. My fingers aren't
7 working here. And I needed some help on
8 that one.
9 But total adjusted capital, could you
10 give me a definition for that?
11 THE WITNESS: Total adjusted capital is
12 really similar to the capital in surplus,
13 but the NAIC requires that we make certain
14 adjustments to it before we then have a look
15 at it relative to the risk surplus which is
16 the -- the authorized control level
17 risk-based capital.
18 So as you can see, in our case, the
19 adjustments that are required are zero. So
20 it is in fact the same as the capital
21 surplus.
22 MR. HOGAN: Okay. That's helpful. In
23 2009 you were at 81 million. And 2013, 133
24 million. That's a 63 percent increase over
25 four years in adjusted capital. Total

1 members I won't do the exact numbers, but
2 total members increased by only 25 percent
3 during this same period.
4 And another interesting one that jumped
5 out at me were unpaid claims after the prior
6 year, that it's been very flat and very
7 solid. Only 3.9 percent increase from '09
8 to 2013. So you know, that's terrific
9 performance.
10 And my last question before I continue,
11 would you give me a definition for
12 affiliated common stock?
13 THE WITNESS: Affiliated common stock is
14 the value of our wholly-owned subsidiaries.
15 So we have a couple of legal entities that
16 make up the membership of both Blue Cross
17 Blue Shield Vermont and the Vermont Health
18 Plan. And so the Vermont Health Plan their
19 financial information is reflected, and we
20 have some other wholly-owned subsidiaries as
21 well.
22 MR. HOGAN: That's helpful. In 2009 you
23 were at 531 -- excuse me, you were at 31.6
24 million. And in 2013 you were at 58
25 million. That's an 84 percent increase in

1 that very important factor.
2 At this point those are interesting
3 numbers, but they just stand alone as
4 numbers. But I began to put a few of them
5 together. And -- to form some important
6 ratios which I'm sure you have all kinds of
7 ratios, but for example, if you divide the
8 assets by the liabilities in 2009 you have
9 two and-a-half times the assets than you did
10 liabilities. And as you look at that over
11 time, that number stays remarkably solid.
12 2.4 percent in '10, 2.6 in '13. 2.5 in '12
13 and 2.6 in '13. That is a very, very strong
14 performance at the highest level as you look
15 at it.
16 I then took the capital and surplus and
17 divided it by the total members. So it
18 would give me a value per member of the
19 capital surplus. And in '09 that value was
20 646. And in '10 it was 834. And in '11 it
21 was 925. And in '12 it was 890. And then
22 in '13 it took a tiny step back to 841.
23 Very strong.
24 I also did the same with revenue.
25 Divided by total members to see what the

1 revenue per member would look like. And it
2 works out that in '09 the revenue per member
3 was 2,286; '10, 2,354; '11, 2,361; '12,
4 2,702; and '13, 2,728. Solid, careful
5 increases.
6 I also then took -- and this is where
7 you really should get some credit. The
8 total administrative expenses divided by the
9 members shows an even amazingly better
10 picture than just the pure numbers. Because
11 in '09 the administrative cost per member
12 was 109 bucks. I'm rounding off. In 2010
13 it was 109. And 2011 it dropped to 105.
14 And 2012 it dropped to 99. And in 2013 it
15 dropped to 98. I'm just about done. Those
16 are the items that kind of jumped off the
17 page at me as I began to put these numbers
18 together.
19 And by the way, I did not get help from
20 L&E on this. This was my own analysis. So
21 if there is faults with it, they are my
22 faults. But when I look at the ones I
23 selected, it gives me the sense of a company
24 that is strong and getting stronger. I go
25 back far enough that I remember when Blue

1 Cross was on the ropes. And I really think
2 that you have done an amazing job, your
3 leadership, of putting this back together.
4 And also I want to redouble the comments
5 that Allan made regarding work that you're
6 doing on the health care reform and stepping
7 in when the administration struggled on the
8 exchange, the whole business. You have been
9 there. You've done it well.
10 So my question to you is, what did I
11 miss? As you look at these kinds of -- at
12 this sheet, what are the combinations of
13 data that tell you you may not be as strong
14 as I think you are?
15 THE WITNESS: Well thanks for the run
16 through. That was a very good way when you
17 say it's just what caught your eye, it's a
18 good way to use the historical exhibit. And
19 I can go through and talk about each item.
20 But what you see here is a story about
21 growth, and as the company has grown in
22 membership, you mentioned that the 25
23 percent growth in membership and the growth
24 in some of the other line items, claims in
25 particular, going up, I think you got the

1 same number I did. 64 percent.

2 So what you see is both the growth in
3 the membership itself which is a good story
4 because we maintain our efficiency and have
5 some scales that affects and shows in the
6 strong administrative cost per member. But
7 the claims growth also is growing because of
8 the medical trends, so those members even if
9 we have all the same members, the revenue
10 line and the asset line and the surplus line
11 are all going to have to grow to reflect
12 both the growth in membership and the growth
13 in claims.

14 So if you look at the 64 percent growth
15 in capital surplus and the 57 percent growth
16 in medical claims, that's a good way to sort
17 of show that the capital surplus growth is
18 really required to support that increase
19 throughput of claims, and so you have growth
20 in members, but those members are also
21 incurring higher cost, higher claims over
22 time. So that's kind of the theme that you
23 see through all of those numbers.

24 The asset-to-liability ratio bears that
25 out. That as you have certain amount of

1 assets and liabilities to sustain a
2 membership, the ratio of those two things
3 are not going to need to change a lot over
4 the life of the company. So as you noted
5 that one was level. So that's very
6 consistent with that story.
7 MR. HOGAN: Did you comment specifically
8 on the hospital and medical expenses? That
9 is a very, very large increase, and if that
10 increase were more normal, as these other
11 increases, you would even be in better
12 shape.
13 THE WITNESS: Right. So the claims
14 line, if you look at it both in relation to
15 the membership growth, and what the medical
16 trend has been over, you know, if -- it's
17 come down in recent years, but even if you
18 assume it's four, five, six or, you know,
19 mid single digit range, the combination of
20 the membership growth and that growth has
21 caused the large growth over the last five
22 years. If our membership was to stay the
23 same, those memberships would grow more
24 consistently with the medical trend and
25 pharmacy trends.

1 MR. HOGAN: As claims increased by 84
2 percent, membership increased by 24 percent?
3 THE WITNESS: Right. So five percent
4 over five years would give you the
5 additional claims growth.
6 MR. HOGAN: Okay.
7 THE WITNESS: Just to emphasize the
8 point about the surplus, the surplus growth
9 needs to take care of the risk around that
10 higher claims volume. So the surplus growth
11 in order to sustain our financial strength
12 would have to grow at a similar pace.
13 MR. HOGAN: But you haven't answered my
14 question yet.
15 THE WITNESS: Sorry.
16 MR. HOGAN: Which was what indicators on
17 this sheet would, if you drew them out and
18 combined them in different ways, would tell
19 you that you're not as strong as I think you
20 are.
21 THE WITNESS: Thank you. Thank you for
22 the reminder. So yes, the thing about our
23 business is the future and the past
24 sometimes don't line up. And you mentioned
25 that you go back to a period where the

1 company was on the ropes. The process of
2 building that financial strength is a slow
3 process, and as you see over the last five
4 years, we have been able to take that
5 stronger financial position, combined with
6 membership growth, and as I would also
7 indicate we shared with the Board when we
8 visited a couple months ago now, I guess
9 that at the same time our member customer
10 service metrics were going up as well.
11 So we have been able to improve the
12 member service and our quality scores at the
13 same time as reducing expenses and growing.
14 So it has been a good run. The last five
15 years is, I would say, very strong.
16 The issue is that as we have
17 consolidated a large part of our business on
18 to the exchange, we have got 58,000 members
19 on the exchange, the uncertainties around
20 what's going to happen with the subsidies
21 and the claims experience on the exchange,
22 my -- what I would put forward to Green
23 Mountain Care Board here is that the future
24 won't be like the past unless we make sure
25 that the rate filings are allowed to have

1 the adequate premiums on the exchange. So
2 when I think about operating our company
3 right in the sort of middle of our desired
4 range for RBC and financial strength, I'm
5 also looking to the future with higher
6 claims costs and the uncertainties and the
7 money that we have incurred to transition
8 people to the exchange.
9 I think that's where the risk to my
10 concern comes into the future.
11 MR. HOGAN: So it's a future concern
12 more than a current concern.
13 THE WITNESS: Right. I believe so.
14 MR. GOBEILLE: Can I piggyback a couple
15 questions?
16 MR. HOGAN: Sure.
17 MR. GOBEILLE: When I look at this page
18 the line that my eye goes to is line nine.
19 And I'm not sure I know what it means. But
20 it's titled "Net Underwriting Gain, Loss,"
21 in parentheses. Could you tell me what that
22 definition means?
23 THE WITNESS: Sure.
24 MR. GOBEILLE: Or what the definition of
25 that is.

1 THE WITNESS: The net underwriting gain,
2 and I'll draw your attention to the net
3 income line, line 12, the net underwriting
4 gain is the -- in any one year how we think
5 we have -- across all of our products. So
6 --
7 MR. GOBEILLE: This is the whole
8 company.
9 THE WITNESS: All of Blue Cross Blue
10 Shield products when we are making estimates
11 about pricing for a particular year, that
12 underwriting gain reflects how well we did
13 in making those estimates. And as you can
14 see some years --
15 MR. GOBEILLE: You're two in three.
16 THE WITNESS: Some years it's a positive
17 number.
18 MR. GOBEILLE: You're two in three.
19 THE WITNESS: Sometimes it's a negative
20 number.
21 MR. GOBEILLE: So you made it up on
22 investments.
23 THE WITNESS: Yeah. Investments is in
24 there. And when we look at the range that
25 we are managing our surplus to, that

1 investment income comes into play when we
2 look at that.
3 MR. GOBEILLE: Yes.
4 THE WITNESS: If you look at the net
5 income line, the net income line is what
6 actually goes through to the surplus line.
7 So but you can see that that still has a
8 wide variability to it as well.
9 In the last couple of years we have
10 been, you know, just a small percent of
11 revenue above the profit line, and in --
12 let's see --
13 MR. HOGAN: But that's still a pretty
14 predictable path. It's a reasonably narrow
15 --
16 THE WITNESS: I think as a non-profit
17 company we are not trying to have a big
18 profit on that line. We target one to two
19 percent. It's a small number relative to
20 the large claims numbers that are going
21 through the financial statements that will
22 tend to be a little bit more volatile.
23 MR. GOBEILLE: What I see when I look at
24 this is that three out of five years the
25 adequacy of the rate was not enough to meet

1 expenses, but the investment income -- the
2 gain was enough and other income was
3 enough --
4 MR. HOGAN: To cover it.
5 MR. GOBEILLE: -- to allow the company
6 to be profitable, for lack of a better word.
7 I know it's not the right word in a non
8 profit, but profitable four out of five
9 years. So they are -- they lost on
10 underwriting three out of five years and
11 were negative one out of five years. And so
12 when we think of adequacy, I look to the net
13 underwriting gain, loss, in parentheses,
14 line, as an indicator of were the rates of
15 their total company adequate, and what is
16 the effect on the cash position of the
17 company after that.
18 And so that's what I think is -- that's
19 the peril of this. As we look at any one
20 product, all products build to the aggregate
21 company. So what's -- and my question is
22 what I didn't do first was compliment you
23 like everyone else did. So I failed because
24 you deserve praise. Don George, I want to
25 thank you for your leadership the last year.

1 It's been tough.
2 Vermont Health Connect did not go well.
3 You stepped in, and your company was
4 unbelievably flexible, tolerant, at times
5 patient, just a great performance. I'll say
6 the same thing tomorrow to MVP. So from me
7 as a purchaser of health insurance as a
8 business owner, thank you for your work in
9 the small group market and all of your work
10 on the payment reform and the small group
11 that you lead. So I will compliment you.
12 But when we get into these numbers it
13 gets really dry. And I don't really like
14 doing that for too long. Because I'm
15 supposed to work stochastic modeling into
16 something that I say today.
17 THE WITNESS: I'll bring Paul in on that
18 one.
19 MR. GOBEILLE: So I want to know about
20 that later. Thank you.
21 MS. RAMBUR: Can I ask a question?
22 MR. GOBEILLE: Is it about stochastic
23 modeling?
24 MS. RAMBUR: Of course. I had a very
25 small micro question. I'm curious about the

1 extent to which the uncertainty around the
2 Medicaid rates were built into this, or did
3 yesterday's announcement bring new
4 uncertainty?
5 THE WITNESS: Yesterday's announcement
6 did bring new uncertainty. We were
7 developing the rates, we -- as we said in a
8 rate filing -- we go through and really
9 carefully look at all the provider
10 contracting rates that we include and make
11 estimates as to what might happen in 2015
12 for those contracts. And our basic
13 assumptions in the filing was that we would
14 achieve similar rate increases that we had
15 in the past.
16 Right out of the gate though, 1.6 for
17 Medicaid was going to put pressure on that
18 set of assumptions. By moving 1.6 to
19 something lower or zero as the case may be,
20 it's going to put tremendous pressure on the
21 -- connecting the hospital revenue to the
22 medical trend assumption in the rate filing.
23 MS. RAMBUR: Thank you. And my kudos
24 also for the clarity. Thank you.
25 MS. HENKIN: Do you have anything else

1 at this point?

2 MS. RAMBUR: It can wait. I have

3 questions about some other things, but we

4 can have more testimony.

5 MS. HENKIN: Okay. And Chair Gobeille,

6 do you have any other questions?

7 MR. GOBEILLE: I'm good.

8 MS. HENKIN: I had a request that we

9 take a 10-minute bathroom break at this

10 point. Is there going to be anything else

11 from this witness?

12 MS. HUGHES: Actually I would like to

13 reserve the opportunity to recall Ms. Greene

14 because I don't know what the Department is

15 going to have on its plate, for example. So

16 I would like the opportunity to recall her.

17 MS. HENKIN: We have this room today

18 until -- we should have this hearing done by

19 2. I'm hoping we can break for lunch. We

20 might run through. Hopefully not all the

21 witnesses will take as long, and it's

22 getting that first witness over with. And

23 you don't have to apologize. That's fine.

24 So we will take a quick break. Please

25 be back at 10:30, and we will commence again

1 then.

2 (Recess was taken.)

3 MS. HENKIN: Thanks everyone. We are

4 back on the record now. We have completed

5 this witness for now. We are going to

6 continue with Blue Cross's next witness.

7 MS. HUGHES: Yes. I call Paul Schultz.

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1 PAUL SCHULTZ
2 Having been previously duly sworn,
3 testified as follows:
4 DIRECT EXAMINATION
5 BY MS. HUGHES:
6 Q. Can you state your full name for the record?
7 A. Paul Schultz.
8 Q. And where do you work?
9 A. Blue Cross Blue Shield of Vermont.
10 Q. And although the Board has your CV as Exhibit
11 13 in the binder, could you briefly describe your position
12 with the company?
13 A. I'm Actuarial Director at Blue Cross Blue
14 Shield of Vermont. So as part of that I have oversight
15 over all pricing and filing that the company does
16 including the exchange.
17 Q. And are you familiar with the filing of --
18 that's under consideration today that's Exhibit 1 in the
19 binder?
20 A. Yes. I supervised its preparation.
21 Q. And can you review for us how that filing was
22 prepared?
23 A. Yes. As with any filing, there are a number
24 of component parts. By far the largest is the projection
25 of paid claims. So to perform that projection we started

1 with the 2013 experience of members who enrolled with us
2 on the exchange. So those are members who are with us on
3 the exchange and were with us in 2013 as well in a small
4 group or an individual product.
5 Starting with that experience we adjusted it
6 for the EPO network, which is the network supporting the
7 exchange. We then trended it forward to 2015. We made
8 certain adjustments for changes in population that were
9 anticipated. So we had about 15,000 new members as well
10 on the exchange that we were not able to identify as
11 having them with us in 2013. So we made adjustments to
12 the projected claims for that. And we then applied a paid
13 to allowed ratio to take us from allowed claims which is
14 our basis of the projection to paid claims which is our
15 liability on the exchange.
16 So claims costs, as Ms. Greene alluded to,
17 represent about 91 and-a-half percent of the total premium
18 on the exchange. To that, we added administrative costs.
19 We used a similar approach here. We started with our
20 actual 2013 experience across the company. We did not
21 trend that forward because of ongoing membership growth.
22 We have a broader base across which to spread our fixed
23 costs. And we assumed that that would offset any sort of
24 inflation or wage increases that would lead to a higher
25 total admin, so we did not trend our admin forward.

1 We also excluded from the 2013 admin any one-
2 time costs for the exchange. So in terms of member
3 outreach, in terms of the introduction of Vermont Health
4 Connect, those we considered to be one-time costs and we
5 did not include those in our projections. So admin costs
6 come to about 6.1 percent of the premium dollar. To that
7 we then added federal taxes and fees, state taxes and
8 fees, that came to a total of about four and-a-half
9 percent. And that is then offset by the subsidy that's
10 provided by the federal government through transitional
11 reinsurance which is a topic we will discuss extensively a
12 little while later.
13 And finally we added a one percent
14 contribution to reserve. We did not add any profit, we
15 are a local Vermont non-profit company. There is zero
16 profit.
17 Q. And the CTR figure, does that take investment
18 income into account?
19 A. It does. A one percent target for CTR does
20 take the investment income projection into account. So
21 when we are establishing that target we would -- we are
22 looking to get one percent contribution reserve out of the
23 rates. That supplemented with the investment income
24 allows us to maintain the surplus position that we need to
25 maintain with our target range.

1 MR. HOGAN: So excuse me, I have a
2 question. That's in addition to the CTR?
3 Or is it included in the CTR?
4 THE WITNESS: That is not included in
5 the CTR.
6 MR. HOGAN: Not included.
7 THE WITNESS: The CTR is separate. But
8 the one percent target for CTR we take the
9 investment account income into account in
10 setting that target for what we need to get.
11 BY MS. HUGHES:
12 Q. So as the rate filing was developed, what were
13 Blue Cross's objectives?
14 A. We have a mandate to develop rates that are
15 neither excessive nor inadequate. So if you look at those
16 two things together we need to develop rates that are
17 accurate. As part of that development there are a number
18 of assumptions. And those assumption may have a range of
19 possible results.
20 The direction we were given by senior
21 management, and that we pursued as our goal, was to when
22 we look at those assumptions to develop rates that are as
23 affordable as possible while still using assumptions that
24 are reasonable both individually and in the aggregate.
25 Q. And so would it be fair to say that part of

1 your objective was to cover all the claims expense that
2 would be incurred in the exchange?
3 A. Yes. That's correct.
4 Q. So can you give us an overview of the
5 assumptions that went into the filing? And I think before
6 you list them, I would like you to focus first on trend,
7 because I think that is the biggest element.
8 A. I would agree that trend is the most important
9 assumption in the filing, has the greatest impact. The
10 way we developed our trend was to look at it in two
11 different components. Trend consists of utilization which
12 is the frequency with which members utilize service,
13 whether that be a hospital admission or a pharmacy -- a
14 fill of a pharmacy prescription, and then increases to
15 costs, the amounts providers are paid.
16 So if you take the combination of the two;
17 utilization, and the increase in payments, you come up
18 with a total trend. We looked at the two components
19 separately, and we looked at it separately for medical
20 costs and pharmacy costs. So kind of a total of four
21 different viewpoints. First looking at utilization, we
22 examined -- on the medical side we examined three years of
23 claims' experience for the products that were exchange
24 eligible. In other words, all of our individual and small
25 group products, exclusive of Medicare supplement-type

1 products.

2 So in reviewing that trend we didn't do a

3 stochastic model, but we did do some regression analysis.

4 And we looked at that for a number of different benefit

5 components looking at the hospital utilization separately

6 from physician and so forth. And in doing so, we

7 concluded that we would be able to use a trend rate of

8 zero percent. So zero utilization trend, which means that

9 we expect that the number of services used in 2015 will be

10 the same as what folks used in 2013. We did something

11 similar on the pharmacy side looking only at pharmacy

12 claims. And we did note an upward trend in pharmacy

13 utilization over time. So we used an assumption there of

14 just shy of two percent.

15 On the unit cost side again, first with

16 medical, we observed the results of the most recent round

17 of contracting. So the results of hospital budget

18 negotiations with the Green Mountain Care Board which then

19 led into our own negotiations with providers. We worked

20 with provider contracting to note any instances -- well

21 first we established that what happened in the most recent

22 round of negotiations would be the same increase, same

23 level of increase as what would happen in future rounds.

24 So in other words, the results of last year's hospital

25 budget process and the subsequent negotiations we would

1 see the same sort of result in 2014, and then again in
2 2015 which will impact the last bit of our projection
3 period.
4 Once we established that assumption, we worked
5 with provider contracting to note any specific providers
6 with whom the negotiation might go a little bit
7 differently than it had in the past. So we put all that
8 information together and developed our unit cost
9 assumption, our medical unit cost assumption in that way.
10 We ended up with a trend of 4.4 percent on the medical
11 side, and as I mentioned earlier, zero percent
12 utilization.
13 For pharmacy we also did a more specific
14 analysis. We received a list of brand drugs that are
15 expected to go generic from our experience period out to
16 the projection period, and we accounted for all of those
17 explicitly. So as we think about GDR increasing over
18 time, the generic dispensing rate increasing over time, we
19 did take that into account, and we did it in a very
20 explicit way in looking at brands that are expected to go
21 generic over time.
22 We also looked historically at how brands and
23 how separately generic costs have increased over time, and
24 we looked specifically at specialty medications, those
25 very, very high cost medications that a few number of

1 members would be taking. But specialty meds do drive a
2 fairly decent proportion of the pharmacy trend.
3 So in looking at all of that we developed a
4 pharmacy trend of 8.4 percent in total. So the medical
5 and pharmacy combined is about 5.1 percent.
6 Q. And before you move on to the other
7 assumptions, can you tell us whether the Board's actuary,
8 Lewis & Ellis, weighed in on your medical trend?
9 A. They did, yes.
10 Q. What was their opinion on it?
11 A. Their opinion was our trend rates were
12 reasonable and appropriate.
13 Q. So what were the other assumptions besides
14 trend that went into the filing?
15 A. Other assumptions -- one of the bigger ones
16 was an assumption we made for changes in population. So I
17 mentioned earlier the 15,000 new enrollees. We looked at
18 those new enrollees in a few different segments. Small
19 group, individual subsidized, individual non subsidized,
20 and we noted for each of those segments within each
21 segment the new members were younger on average than the
22 continuing members. So we made a downward adjustment to
23 our rate -- our claim cost projection to account for the
24 fact that we have these younger members within each of
25 those segments.

1 There were a few other demographic adjustments
2 as well. Looking at the overall total exchange population
3 we projected versus the population in the experience
4 period, and we adjusted demographically for that as well.
5 We made a contract conversion type of adjustment. When we
6 develop rates we do so on a per-member basis. Those need
7 to be translated into tier rates, single, couple, family.
8 So one member does not equal a single rate. We have
9 children in there that are lower cost. You need to
10 translate from one to the other. So we did that as part
11 of the projection.
12 We also -- we also developed an estimate of
13 the impact of transitional reinsurance, which again we
14 will talk about a bit more, but in terms of how we did the
15 projection, we took a look at the projected experience by
16 member and modeled out how those members would hit the
17 attachment point that we talked about, and what kind of
18 recoveries we might expect by the attachment points that
19 have been established by the Department of Health and
20 Human Services. So we did that modeling explicitly, and
21 that was offset with the contribution rate that's also
22 been established by HHS which is basically another fee
23 that's part of the exchange.
24 Q. And did you take into account any changes in
25 benefits?

1 A. We did. We did that in a few different ways.
2 One, there were a few benefits that are added as part of
3 qualified health plans that are not part of the 2013
4 experience; specifically dental and vision benefits. We
5 also took into account the concept of induced utilization.
6 That says that the richer a plan a member has, the more
7 they tend to utilize the benefit. So we made an
8 adjustment from the experience period to the projection
9 period based on the relative richness of the plans to
10 account for the fact that members will utilize a little
11 bit differently based on the plans that we projected they
12 will have.
13 Q. And did you make any special adjustments for
14 the catastrophic plan?
15 A. We did. There are some adjustments that are
16 required for the catastrophic plan to take into account
17 the population that are eligible for that plan. That's
18 only folks who are under 30 years old who are in a very
19 specific income bracket. So we did make those assumptions
20 as required.
21 Q. And how about paid to allowed ratios? Did you
22 take that into account?
23 A. Yes. As mentioned earlier to go from allowed
24 costs to paid costs we need to use something called a
25 paid-to-allowed ratio, which is a portion of the allowed

1 cost that we the insurer are liable for, as opposed to
2 costs that are paid by members out of pocket. So that's
3 part of going from the overall projection of member per
4 month allowed cost to specifically what's paid for each
5 plan on the exchange.
6 Q. So as a result of the work that you did what
7 was the average rate increase contemplated by the filing?
8 A. The average rate increase is 9.8 percent.
9 Q. And can you describe for us what the
10 components of the 9.8 percent rate increase consisted of?
11 A. I can. The largest component of that increase
12 are increases in the amount that are paid to providers.
13 And that consisted of a few parts.
14 In the 2014 filing we made a similar
15 assumption or an analogous assumption for the amounts that
16 providers would be paid. In fact, we have observed to
17 date that the actual increases in provider payments have
18 outpaced that assumption. Now we haven't made up that
19 shortfall in these rates, but we do need to start with the
20 right baseline. And that drives an increase in rate.
21 Beyond that, I spoke earlier about the unit
22 cost trend. It's 4.4 percent on the medical side. Higher
23 than that on the pharmacy side. So those items combined
24 both the difference between what was in our 2014 rates and
25 what's actually happened thus far, and then the projection

1 forward to 2015 combined for about a seven percent
2 increase in rate.
3 Beyond that, we have changes in federal fees
4 and subsidies. Transitional reinsurance keeps coming up
5 as part of this conversation. That's essentially a
6 federal subsidy to the rates. It's a transitional
7 program, as the title would imply, that had its highest
8 subsidy in 2014. And it gradually decreases to no subsidy
9 in 2017. So that was -- as part of the Affordable Care
10 Act it was anticipated that that federal subsidy would
11 decrease. That means then that the premium rates need to
12 go up to get to the same total. You have the same total
13 cost and the federal subsidy decreases, premiums have to
14 go up to compensate for that.
15 Also there is a federal insurer fee that goes
16 up from 2014 to '15. This is a fee that the federal
17 government uses to provide subsidies for low-income folks
18 to be -- to be able to afford the exchange products. It's
19 a total industry-wide assessment. And that industry
20 assessment increased from 8 billion dollars in 2014 to
21 11.3 billion dollars in 2015. So a very sizeable
22 increase. And that's reflected in the rates as well.
23 Those items -- those changes in federal fees
24 drove about a five percent increase on the rates.
25 A third item that drove an increase were

1 benefit changes. This was only about a one percent
2 increase. And a couple flavors, the Green Mountain Care
3 Board approved a change to enhanced pediatric dental
4 benefits, so we needed to factor that into our paid
5 claims. Also most of the deductibles and out-of-pocket
6 maximum remain the same from 2014 to 2015. So as the
7 total cost of care increases due to provider increases,
8 and the member out of pocket stays the same, the
9 difference needs again to go into the premium rate so the
10 exchange is adequately funded.
11 So again those items combined for a little bit
12 of a percent. We are well above 9.8 percent now if anyone
13 is doing the math. So there were a couple offsets to
14 that. We talked about the assumptions we made for new
15 members. Those decreased the rate by about two and-a-half
16 percent. And then kind of everything else also drove
17 another couple points of decrease on the rate. Our
18 administrative costs are a little bit lower in '15 than
19 they were in '14 on a per member basis, so that helped to
20 drive the exchange -- I'm sorry helped to drive the
21 decrease on the exchange rate.
22 The CTR is part of that. Our utilization
23 trend, zero percent on the medical side is also lower than
24 our 2014 assumptions, so that helped to lower the rate of
25 increase from '14 to '15 in our rate.

1 Q. Are you familiar with Vermont's statutory
2 standards for rate approval?
3 A. Yes, I am.
4 Q. And in your professional opinion is the rate
5 as filed excessive?
6 A. It is not.
7 Q. Is it inadequate?
8 A. No.
9 Q. Is it unfairly discriminatory?
10 A. No.
11 Q. Is it reasonable in relation to the benefits?
12 A. Yes, it is.
13 Q. And do the rates as filed meet the statutory
14 standards as you understand them?
15 A. Yes, they do.
16 Q. So are you familiar with the recommendations
17 prepared by the Board's actuary Lewis & Ellis?
18 A. Yes, I am.
19 Q. And is that found in Exhibit 8 of the binder?
20 A. It is.
21 Q. And how many recommendations -- and I'll just
22 with permission of the Chair, refer to Lewis & Ellis as
23 L&E?
24 MS. HENKIN: That is just fine.
25 MS. HUGHES: It's easier.

1 MS. HENKIN: They refer to themselves as
2 L&E.
3 MS. HUGHES: Okay.
4 BY MS. HUGHES:
5 Q. So how many recommendations did L&E make to
6 the Board?
7 A. There are four recommendations.
8 Q. And are you also familiar with the report by
9 NovaRest, the HCA's actuary which is Exhibit 10?
10 A. Yes, I am.
11 Q. And did NovaRest address all of the issues L&E
12 did?
13 A. They did not. They addressed three of the
14 four.
15 Q. And of the L&E recommendations that NovaRest
16 did address, was the NovaRest report consistent with the
17 L&E recommendations?
18 A. Yes, it was.
19 Q. Did NovaRest contain any additional
20 recommendations beyond what L&E recommended?
21 A. No. It did not.
22 Q. So I'd like to go over each of L&E's
23 recommendations. Can you briefly describe for the Board
24 what the first recommendation was that L&E made?
25 A. Yes. They recommended that in place of the

1 induced utilization factors that we developed that we use
2 induced utilization factors that HHS developed as part of
3 their risk adjustment mechanism.
4 Q. And what did L&E estimate the impact of this
5 change would have on the filing?
6 A. They estimated the overall impact would be a
7 0.2 percent decrease in the rates.
8 Q. And if this change were made using the HHS
9 factors, how would that affect plan relativities?
10 A. This would disproportionally impact the bronze
11 plan, so it would make the bronze plans relatively more
12 expensive. It would add to those rates. It would
13 decrease rates for the gold and platinum plans.
14 Q. And as far as you know has HHS made public how
15 it derived its factors?
16 A. Not as far as I'm aware.
17 Q. And what were your factors based on?
18 A. Our factors were based on group experience,
19 our own group experience in Vermont. By using group
20 experience we feel that we mitigated to the extent
21 possible any impact of selection or morbidity. And
22 further, we used the Vermont factors because it's specific
23 to the people who are going to be on the exchange. We
24 felt that they would best reflect what actual experience
25 will look like on the exchange.

1 Q. And did HHS require that you use their
2 factors?
3 A. They did not require we use their factors.
4 No.
5 Q. Okay. So why did you use Vermont-specific
6 factors?
7 A. Again we used them because we felt it would
8 best reflect the experience that would take place on the
9 exchange. And we felt that by using group experience we
10 were able to mitigate any impact of health status or
11 morbidity.
12 Q. What was L&E's second recommendation?
13 A. L&E recommended that the changes in family
14 tiering be moved from the development of the index rate to
15 plan-specific adjustments.
16 Q. And what are your thoughts on that
17 recommendation?
18 A. We are in agreement with that recommendation.
19 The reason we developed the rates in the way we did is
20 that we were required by the reviewing actuary in 2014 to
21 do it that way. So we maintained that development into
22 2015. There is no rate impact here. It's a matter of
23 where we apply these factors, and we are in agreement they
24 are more appropriately applied after development of the
25 index rate.

1 Q. And how about the third recommendation?
2 A. The third recommendation is that we reduce our
3 assumption for the federal insurer fee to two and-a-half
4 percent.
5 Q. And did NovaRest comment on this
6 recommendation?
7 A. They did not. Well their comment was that
8 they didn't have sufficient information to make a
9 recommendation.
10 Q. Can you describe for the Board how the federal
11 insurer fee works?
12 A. Yes. This is an amount of money that federal
13 government is raising again to pay for low-income
14 subsidies on the exchange. It's an overall industry
15 assessment. So the federal government was raising eight
16 billion dollars in 2014. 11.3 billion dollars in 2015.
17 That total amount is divvied up among all the different
18 insurance companies across the country. So such that, for
19 example, the 2015 amount that they raise will be based on
20 2014 premiums.
21 Q. So you say it's an overall industry
22 assessment. It's my understanding that some employers
23 self insure. Are those employers responsible to pay this
24 fee?
25 A. No. They are not. This is a premium-based

1 assessment, so it applies only to fully insured business.
2 Q. And is there an anticipated end date for this
3 fee?
4 A. There is not.
5 Q. And how much was the fee in the approved Blue
6 Cross 2014 filing?
7 A. Two percent of premium was approved in the
8 2014 filing.
9 Q. So you testified earlier that you supervised
10 the filing. And without divulging any proprietary or
11 confidential information, can you describe your approach
12 to calculating the fee?
13 A. Yes. We -- so as part of the 2014 development
14 we received an estimate from the Blue Cross Blue Shield --
15 Blue Cross Blue Shield Association of our portion of the
16 eight billion dollar industry fee. We compared that to
17 premiums. We did all this on the 2011 basis. And
18 dividing the two things together results in a percentage
19 of premium.
20 Because the federal insurer fee is not a
21 deductible expense, we need to gross that up for taxes.
22 Our anticipated tax rate is 20 percent, federal income tax
23 rate is 20 percent. So by dividing by one minus 20
24 percent, we gross up that percentage for taxes. We then
25 needed to make adjustment, because as mentioned earlier,

1 this does not apply to self-insured business. So as large
2 groups are motivated by the Affordable Care Act to move
3 towards self insurance as a means to -- well, potentially
4 as a means to avoid some of the fees and so forth, that
5 impacts how we need to raise the money.
6 Again the premium that's the basis of our --
7 of our assessment is one year prior to the year in which
8 we need to raise the funds. So as companies move to self
9 insurance, we are unable to raise those funds from those
10 companies even though they were part of the prior year
11 premium. So we need to again inflate our calculation to
12 adjust for that difference, to adjust for that change. In
13 2014 we did that. We weren't able to make a precise
14 estimate of this impact. It involves very far-reaching
15 assumptions about what large employers are going to do.
16 So in lieu of the specific estimate, we
17 rounded the answer up to two percent. So to move forward
18 then to the 2015 result, we started with that same
19 analysis, and then we know that the total industry
20 assessment is going from eight billion to 11.3 billion,
21 that's a 41 and a quarter percent increase. So we
22 multiplied our two percent by 41 and a quarter percent to
23 get to 2.83 percent.
24 Q. And what does L&E estimate the impact this
25 change would have on the rates filed?

1 A. The change to two and-a-half percent they
2 estimate as having a 0.4 percent downward impact on rates.
3 Q. And L&E characterizes what Blue Cross did as
4 simply rounding up, is that a fair characterization?
5 A. It's probably a poor choice of words. We
6 needed to craft an assumption for how groups would move to
7 self insurance. So again, in the absence of having
8 specific information that would allow us to calculate an
9 explicit assumption, we made an estimate that resulted in
10 an answer of two percent in 2014.
11 Q. So since the filing was made, have you
12 received independent confirmation that your approach is
13 reasonable?
14 A. We have. We received a preliminary bill from
15 the IRS for 2014.
16 Q. And I'm going to distribute what we labeled
17 Exhibit A. So Mr. Schultz, do you recognize Exhibit A?
18 A. I do.
19 Q. And can you tell us briefly what that is?
20 A. Yes. This is -- based on the preliminary bill
21 that we received from the IRS after the date of the
22 filing, we were able to quantify support for our insurer
23 fee assumption.
24 Q. And who prepared this exhibit?
25 A. I prepared it.

1 Q. And can you please describe for the Board what
2 this exhibit tells us?
3 A. I can. So I'll just go down through the
4 information on the page. So we did receive the
5 preliminary bill from the IRS. And that annual fee was
6 provided to us as 7.9 million dollars. From our most
7 recent forecast of 2014 premium, much of which is of
8 course known at this point, but projecting the rest of the
9 year as well, we believe that 2014 premiums will be 511
10 million dollars. So if you divide those two quantities,
11 the result is 1.55 percent.
12 As discussed earlier, we need to gross that up
13 for federal income taxes. Our anticipated tax rate is 20
14 percent. So dividing 1.55 percent by 0.8, results in 1.94
15 percent. That is close to our 2014 estimate of two
16 percent but a little bit short of that estimate. The
17 following row provides for the incremental increase of the
18 insurer fee which is the 41 and a quarter percent that I
19 mentioned earlier in terms of the total industry
20 assessment. So if we take the 1.94 percent, that we are
21 calculating based on our preliminary bill, and apply the
22 increase we get to 2.74 percent as the fee that we would
23 need to charge on 2015 business in order to raise money to
24 pay the 2015 assessment.
25 Q. So can you go down the second column labeled

1 original filing for us.
2 A. I'll do that. So originally we estimated that
3 the 2014 required charge would be two percent. In fact,
4 1.94 looks like the actual number. So again applying the
5 overall increase we got to 2.83 percent which is what we
6 filed. The L&E opinion was that we should use 2.5
7 percent. If we back off the 41 and a quarter percent that
8 we know that the assessment increases from '14 to '15, we
9 get 1.77 percent which is quite a bit lower than the 1.94
10 that we have seen based on the bill that we have received.
11 Q. So the incremental increase of the insurer fee
12 of 141.25 percent, did L&E agree with you on that
13 calculation of the percentage increase for the 2014
14 assessment over the 2015 assessment?
15 A. Yes, they did.
16 Q. So is it your testimony that the expected
17 federal insurer fee for 2015 as a percentage of premium,
18 and that's without taking into account those market
19 changes that you were talking about earlier, can you tell
20 us what that percentage is?
21 A. Our best estimate of that fee is 2.74 percent.
22 Q. So in your professional opinion what
23 percentage should the Board approve to fully fund the
24 expense of the health insurer fee in 2015?
25 A. 2.74 percent.

1 Q. And if the Board's does not do that, will the
2 rate be adequate?
3 A. If they approved the 2.5 percent the rate
4 would be slightly inadequate.
5 Q. And can you tell us what the subject matter of
6 the fourth recommendation in the L&E report was?
7 A. Yes. They recommended that we reduce --
8 excuse me, reduce the attachment point for transitional
9 reinsurance to $45,000.
10 Q. And before we get into the actual details, can
11 you describe what the federal transitional reinsurance
12 program is for the Board?
13 A. Yes. So this is a way for the federal
14 government -- the federal government assesses a
15 contribution to all business in a per member per month
16 contribution amount to raise a certain amount of money,
17 that was 10 billion dollars in 2014, goes down to six
18 billion dollars in 2015, to be redistributed to individual
19 plans on the exchange through a mechanism called
20 transitional reinsurance.
21 So the way the subsidy works is that they
22 define attachment point which is basically a floor, above
23 which a certain percentage of claims are reinversed to
24 insurers. That's the coinsurance percentage up to a
25 reinsurance cap. And all of those parameters including

1 the contribution rate, the attachment point, the
2 coinsurance, the cap, are all established by the
3 Department of Health and Human Services on a year-by-year
4 basis.
5 Q. And where is that guidance found from HHS?
6 A. That's found in the Final Rule on Benefit and
7 Payment Parameters which is in your binder. Portions of
8 it, I should say, are in the binder in section 12. That
9 was published on March 14, 2014.
10 Q. Is that March 14 -- I'm sorry.
11 A. March 11, 2014.
12 Q. And so can you briefly describe what those
13 parameters are related to the transitional reinsurance
14 program?
15 A. Yes. They established attachment point of
16 $70,000. A coinsurance percentage of 50 percent. And a
17 reinsurance cap of $250,000.
18 Q. And is the March 11, 2014 final rule a
19 directive to health plans on how they are to -- sorry, how
20 they are to apply the transitional reinsurance program?
21 A. As far as I'm aware it establishes the payment
22 parameters. One could conclude that insurers should use
23 those payment parameters to calculate their rates.
24 Q. So were these the parameters that you used in
25 your pricing?

1 A. They were.
2 Q. And how do L&E and NovaRest characterize your
3 assumption regarding the transitional reinsurance program?
4 A. They both state we did not use the proposed
5 parameters.
6 Q. And which proposed parameters were they
7 referring to?
8 A. They were referring to information that was
9 included in the Preamble to the Final Rule for Exchange
10 and Insurance Market Standards for 2015. That final rule
11 was published on May 27, 2014. It's also in section 12,
12 excerpts of it are. And I can read the quote that they
13 used. It reads: We intend to propose changes to the
14 reinsurance parameters for 2015 generally consistent with
15 these recommendations." I will editorialize those were
16 recommendations to keep the attachment point at 45
17 thousand dollars. It goes on to read: "Specifically in
18 the proposed 2016 payment notice we intend to propose to
19 lower the 2015 attachment point from 70,000 to 45,000. We
20 may also propose to modify the target 2015 coinsurance
21 rate, based on estimates of rollover funding from 2014 and
22 estimates of collections and payments for 2015. These
23 proposals will be subject to notice and comment
24 rulemaking."
25 Q. So has HHS made a formal proposal to decrease

1 the attachment point for 2015 of $45,000?
2 A. No, they have not.
3 Q. So the statements then in the L&E report and
4 NovaRest report, are they accurate statements?
5 A. They are misleading. We did use the proposed
6 and in fact the final parameters.
7 Q. So what reasons do L&E and NovaRest give for
8 using the assumption of $45,000 as the attachment point?
9 A. NovaRest gives three reasons. L&E-- well
10 those three reasons are at the bottom of page 7 and on the
11 top of page 8 of their report which is section 10 of the
12 binder. So the first is that CMS made the proposal
13 publicly and therefore appears committed to implement the
14 decrease.
15 The second, I'll paraphrase, has to do with
16 the fact that they did make a change to the attachment
17 point in 2014, and therefore you might reasonably conclude
18 they will do the same in 2015.
19 And third, there is a statement that Blue
20 Cross Blue Shield of Vermont benefited from the lower
21 attachment point in 2014. So even if the 2015 proposal is
22 not implemented, we can use the benefit from 2014 to
23 essentially fund the shortfall in 2015. L&E was not as
24 explicit in their rationale. They did comment they felt
25 the change was likely. A footnote seems to attribute

1 their rationale for that to the change that was made in
2 2014. In other words, the footnote agrees with the second
3 NovaRest point.
4 Q. And are these positions persuasive in your
5 mind?
6 A. I don't feel that they are. And I would like
7 to go through each in turn. In terms of the --
8 MS. RICHARDSON: Non-responsive.
9 BY MS. HUGHES:
10 Q. So can you address the first NovaRest
11 rationale?
12 A. I can. First HHS has not proposed a reduction
13 in the attachment point. They have stated an intention to
14 propose. Along with that, they stated that they may
15 change the coinsurance percentage as well.
16 Now the thorough reading of the Preamble to
17 the Benefit and Payment Parameter Rules sheds some more
18 light on the way HHS intends to operate transitional
19 reinsurance.
20 So again, referring to Exhibit 12, there is
21 some text in here starting at the bottom of the first
22 column of page 13779 in the Federal Register. It reads:
23 Section 1341-B3B3 of the Affordable Care Act directs HHS
24 to collect six billion dollars for reinsurance payments in
25 2015. This is four billion dollars less than will be

1 collected in 2014 for reinsurance payments. We believe
2 that the lower coinsurance rate and higher attachment
3 point we have proposed appropriately accounts for this
4 smaller reinsurance pool.
5 Now it's also true in reading these rules that
6 HHS is to do this in such a way that total payments are
7 equal to total contributions, their outflow and inflow are
8 supposed to be the same. And that is on -- it's on page
9 13777 which was not included, I don't think, in the
10 binder. But I believe we have copies of it.
11 Q. I believe that's true. And I would ask that
12 this be marked Exhibit C.
13 A. So I'll read as part of that; "We are
14 finalizing our modification in section 153.230D, to
15 provide that if HHS determines that the amount of
16 reinsurance payments requested under the uniform payment
17 parameters will not be equal to the amount of reinsurance
18 contributions collected for reinsurance payments, HHS will
19 determine a uniform adjustment up or down to be applied to
20 our requests for reinsurance payments."
21 So this language, I believe, makes it clear
22 that the intention of HHS is to pay out the amount of
23 money that they take in through the contributions. Their
24 mechanism for doing that is to adjust the coinsurance up
25 or down. From the first quote that I read, from the final

1 rule on payment parameters, HHS established parameters,
2 and they did so based upon some intensive modeling that
3 they did. They have something called the Affordable Care
4 Act health insurance model. They used that to create a
5 projection of all of the contributions that they would
6 receive in 2015 and a projection of all of the reinsurance
7 requests that they would receive as well. And they set
8 the parameters such that the amount they take in through
9 contributions equals the amount they pay out through
10 payments.
11 So given that they established these
12 parameters in March, any change to the attachment point in
13 order to maintain contributions and payouts being equal,
14 would need to be accompanied by a change in the
15 coinsurance percentage as well. So by applying just the
16 decrease in the attachment point with no change to
17 coinsurance, my conclusion is that this will result in
18 payments, payments out that are greater than the
19 contributions they receive. So if we were to change the
20 $45,000 for the attachment point, we would need to do so
21 in conjunction with an assumed change in coinsurance to
22 provide the same amount of outflow. So for me, this first
23 argument is not persuasive because it only looks at half
24 of that equation and results in a situation that HHS is
25 clearly trying to avoid as they establish this language.

1 Q. And the second point that NovaRest made, can
2 you explore that with us?
3 A. Yes, I can. So they -- that statement is that
4 because this happened in 2014 it's precedent for it
5 happening again in 2015. And the situations are very
6 different.
7 I would like to refer you to the central
8 column, kind of right in the middle of the page of 13779,
9 in the Federal Register under heading E, Adjustment
10 Options. That first paragraph, the second sentence reads;
11 "However, updated information including the actual
12 premiums for reinsurance eligible plans as well as recent
13 policy changes, suggests that our prior estimates of the
14 uniform reinsurance payment parameters overestimated the
15 total covered claims cost of individuals enrolled in
16 reinsurance eligible plans in 2014. To account for this
17 we propose to decrease the 2014 attachment point to
18 $45,000." That's the 2014 change that in fact did happen.
19 They refer to recent policy changes. Later on in this
20 document they specify that that refers to the transitional
21 policy announced in November 2013.
22 Again, as Ms. Greene testified, the delays in
23 enrollment on the exchange changed the HHS estimate of
24 what their payouts would need to be. When folks aren't on
25 the exchange for 12 months they are only on the exchange

1 for maybe nine months, they have less time to reach the
2 attachment point, therefore payments, all else being
3 equal, would be lower which is why HHS was able to lower
4 that attachment point.
5 There is no analogous change in 2015.
6 Transition policies nationwide have been extended to 2016.
7 But that was already known at the time that HHS developed
8 their 2015 payment parameters. So there is no similar
9 unknown quantity in 2015 that we would anticipate would
10 result in an overestimation on HHS's part of what the
11 payments would be.
12 Q. And how about NovaRest's third rationale,
13 could you briefly go over that?
14 A. I could. The third rationale is that we can
15 use the windfall, if you will, from 2014 to pay for the
16 shortfall in 2015. And as Ms. Greene again alluded to
17 earlier, that's not the case. There was no windfall in
18 2014.
19 Q. So we are going to hand out what we have
20 labeled Exhibit B. Can you identify this exhibit for the
21 record?
22 A. I can. This is a summary exhibit showing
23 expected 2014 transitional reinsurance recoveries.
24 Q. And who prepared this exhibit?
25 A. I prepared the exhibit.

1 Q. And can you walk the Board through this
2 exhibit?
3 A. I can. So again this is a look at 2014. We
4 have three columns of information. The first looks at the
5 2014 filing assumptions. This is what we put together
6 last year. This is what our 2014 premiums are based upon.
7 As was pointed out by both of the opinions,
8 there were changes to those parameters. The changes were
9 made by HHS actually during 2014 to lower the attachment
10 point from $60,000 to $45,000. At the same time,
11 individual enrollment on the exchange was delayed due to
12 the transitional policy, so those two regulatory changes
13 taken together were the subject of a question that we
14 received. Specifically there was question one from the
15 July 8, 2014 L&E interrogatories, can be found in tab five
16 of the binder. And it specifically asked for the impact
17 of regulatory changes on our transitional reinsurance
18 estimate. So that middle column is what we prepared in
19 response to that question. We were not asked that
20 question about what the final projection is.
21 And so as we move to the final column what
22 changes is the percentage of the population that has
23 individual coverage. As mentioned, transitional
24 reinsurance applies to the individual market. In Vermont
25 we have a combined market. So the recoveries that we

1 receive for the individuals need to be spread over the
2 entire exchange population. Our assumption in 2014 filing
3 was that almost 57 percent of the exchange population
4 would be individuals. In fact, only about 40 percent of
5 the exchange population are individuals in Vermont.
6 The reason for the discrepancy may have to do
7 with small group employers, for example, who were
8 unwilling to put their employees out on to the exchange
9 given some of the issues that we have had with Vermont
10 Health Connect. So when we do the math, the parameters in
11 our filing assumptions led to a projected individual
12 recovery of almost 55 dollars. Spreading that -- using an
13 assumption of almost 57 percent individual, we got a total
14 expected recovery per member per month of 31 dollars.
15 The information that Ms. Novak alludes to
16 correctly in her report is that because of regulatory
17 changes that per member per month figure increases to 40
18 dollars and 49 cents. But that accounts only for the
19 regulatory changes. When we also account for the actual
20 enrollment on the exchange we can see that the same 71
21 dollars and 29 cents that was calculated based upon the
22 revised parameters, when we apply 40.43 percent of the
23 exchange population to it, we are left with just shy of 29
24 dollars of expected recoveries. So that in fact is a
25 seven percent decrease from what we filed and what is in

1 our 2014 rates.
2 So the point that we can use a windfall to pay
3 for a subsequent shortfall is not valid. There is no
4 windfall in 2014.
5 Q. So in other words, does Blue Cross expect to
6 collect the full amount that was approved in the 2014
7 filing?
8 A. We do not. We expect to collect an amount
9 that's about seven percent less than that amount.
10 Q. And so in your professional opinion how would
11 you characterize changing the assumed attachment point to
12 $45,000 at this point in time?
13 A. I would agree that it's within a range of
14 possible outcomes. But I consider it to be highly
15 unlikely. That a change would be made to the attachment
16 point without an associated change to coinsurance that
17 would offset it in such a way that again total amount that
18 HHS takes in equals the total amount that they pay out. I
19 would therefore conclude that it would be imprudent for us
20 to lower the attachment point to $45,000 independent of
21 any other adjustments.
22 Q. And did NovaRest or L&E take into account any
23 changes in coinsurance?
24 A. They did not.
25 Q. So why did you use the final attachment point

1 from the -- I'm sorry, the attachment point from the final
2 rules on benefit of parameters in the development --
3 A. First of all, it is the final rule. I think
4 it speaks for itself these are the parameters that have
5 been established by HHS. Secondly, again I feel in my
6 opinion it is highly unlikely that a change would be made
7 to the attachment point independent of any other changes
8 to these parameters. And therefore, it would be imprudent
9 for us to assume that that change would take place.
10 Q. And what percentage of the health insurance
11 exchange market is Blue Cross products?
12 A. As Ms. Greene alluded to earlier, over 90
13 percent of the exchange is with Blue Cross Blue Shield of
14 Vermont. And this represents a significant portion of our
15 own business as well.
16 Q. And are you aware of how issuers nationally
17 are approaching this?
18 A. Yes. Through our own research and through our
19 contacts with the Blue Cross Blue Shield Association, we
20 found that insurers who have a significant presence on the
21 exchange nationally are using the 70 thousand dollar
22 attachment point. It would be imprudent to do otherwise
23 when you have a lot of skin in the game.
24 Q. So at 90 percent of the market would you say
25 you have a significant presence in Vermont?

1 A. I would say that. Yes.
2 Q. And what is the practical effect of a reduced
3 attachment point?
4 A. L&E estimates that the effect would be a two
5 percent decrease in rates.
6 Q. And do they make any statements about CTR in
7 connection with transitional reinsurance?
8 A. They do. So within the L&E opinion they make
9 a statement if HHS does not ultimately adopt these
10 proposed reinsurance parameters, the CTR would be
11 negatively impacted.
12 Q. Is that on page six of their opinion?
13 A. That is on page six of their opinion. Yes.
14 Q. And did DFR weigh in on this issue?
15 A. They did. They made a couple of different
16 comments.
17 MS. RICHARDSON: Objection. We have
18 testimony from all of these parties.
19 MS. HENKIN: Let me just say we do have
20 these people here to testify. I would like
21 you to make this brief at this point. I'm
22 going to allow the question, but I would
23 like you to finish up with this witness.
24 Because much of this will be covered or is
25 repetitive. Continue.

1 THE WITNESS: Okay. So DFR opines in
2 their original opinion because the
3 contribution to surplus is dwarfed by all
4 other components of the rate increase, it is
5 easy to see that underestimating the other
6 components can quickly eliminate any
7 protection offered by the contribution to
8 surplus. In their supplemental opinion they
9 indicate that if the lower attachment point
10 is not ultimately adopted, there will be a
11 need to substantially increase the
12 contribution to surplus for 2016.
13 So with respect to practical
14 applications, based on the DFR opinion, a
15 significant increase to contribution to
16 surplus would lead to a substantially higher
17 rate increase in 2016 as well due to the
18 underfunding on the exchange. And I would
19 furthermore agree with the other comments as
20 well, and I would say our rates would be
21 inadequate if this change is made. And in
22 fact HHS does not adopt the parameters.
23 BY MS. HUGHES:
24 Q. So if those parameters are not adopted,
25 specifically the reduction to $45,000, as the attachment

1 point, can you tell us in dollar terms what impact that
2 would have on this rate filing?
3 A. It's approximately six million dollars.
4 Q. And if the 70 thousand dollar attachment point
5 is adopted by the Board, and HHS does adopt a 45 thousand
6 dollar attachment point with no other changes, how would
7 Blue Cross handle any excess funds?
8 A. We would proactively work with the Green
9 Mountain Care Board to determine the best way to get those
10 excess funds back in the hands of policyholders.
11 MS. HUGHES: So I would move to admit
12 exhibits A, B and C as presented during Mr.
13 Schultz's testimony.
14 MS. HENKIN: Is there an objection to
15 the admission of Exhibits A, B and C?
16 MS. RICHARDSON: No.
17 MS. HUGHES: C is the Federal Register
18 page.
19 MR. GOBEILLE: Oh.
20 MS. HENKIN: Ms. Richardson? I asked if
21 there was an objection.
22 MS. RICHARDSON: No.
23 MS. HENKIN: There is no objection. A,
24 B and C are admitted into evidence.
25 (Exhibits marked A, B and C were

1 admitted into the record.)

2 MS. HUGHES: Thank you.

3 MS. HENKIN: Anything else?

4 MS. HUGHES: Not at this time.

5 MS. HENKIN: Ms. Richardson.

6 CROSS EXAMINATION

7 BY MS. RICHARDSON:

8 Q. I would like to bring attention to Exhibit 3

9 which is labeled confidential and proprietary. I'm not

10 intending to ask for confidential information. I just

11 wanted to clarify some of the testimony. I'm referring to

12 Exhibit 3. And does that exhibit -- is that an exhibit

13 that you are familiar with and reviewed?

14 A. Yes.

15 Q. And is that Exhibit 1 which you prepared in

16 connection with questions from L&E?

17 A. That's right.

18 Q. And is that Exhibit 1 where you were answering

19 a question about the insurance tax that we have been

20 discussing?

21 A. Yes.

22 Q. So the -- is it correct to say that the

23 calculations that you made relative to insurance tax in

24 the original filing were based on the information that's

25 contained in Exhibit 3?

1 A. Yes. That's how we did the calculation for
2 the federal insured fee.
3 Q. And I would like to now direct you to Exhibit
4 5.
5 A. I'm there.
6 Q. And is this also a set of responses to
7 interrogatories from L&E?
8 A. Yes, it is.
9 Q. And in that filing where you answered the
10 question about the estimate of the 2014 financial impact
11 of the federal changes and the attachment point used in
12 2014.
13 A. Yes.
14 Q. Can you read the second paragraph of your
15 answer?
16 A. The combination of these two changes? "That
17 is, the impact on reinsurance recoveries of the
18 transitional policy, plus any impact of actual versus
19 projected premiums, and the change in reinsurance
20 parameters, was intended to be cost neutral nationally,
21 but did have an upward impact on Blue Cross Blue Shield
22 Vermont's projected recoveries due to the attributes of
23 our projected population."
24 Q. And you prepared this answer?
25 A. Yes, I did.

1 Q. I have a question now about the attachment
2 point to follow up on Ms. Hughes' question about different
3 possibilities based on your assumptions in the filing
4 versus particular outcomes that may transpire when the
5 refund under the Federal Rule is.
6 You testified that there is a -- that there is
7 a possibility or there was an intention that was stated
8 but has not been followed through on to lower the
9 attachment point for transitional reinsurance program to
10 $45,000; correct?
11 A. Yes.
12 Q. And Blue Cross Blue Shield as we have been
13 reviewing assumed that there would be a 70 thousand dollar
14 attachment point instead of the 45 thousand dollar
15 attachment point?
16 A. That's right.
17 Q. If the filing is not modified to reduce the
18 attachment point to recalculate rates using the lower
19 attachment point, what effect would this have on Blue
20 Cross Blue Shield's contribution to reserve if the 45
21 thousand dollar attachment point is the one that is to
22 happen?
23 A. If it is adopted, which we consider unlikely,
24 we would -- the rates would be excessive by about the two
25 percent estimate of -- that L&E made of the change for

1 this assumption.
2 Q. So when you were describing what you would do
3 with the excess, this would be an excess rate of two
4 percent, would that -- how would that translate into the
5 contribution to reserves, if at all?
6 A. We would propose that it wouldn't because we
7 would again work with the Green Mountain Care Board to
8 make sure that that money found its way back to
9 policyholders in the most appropriate way we can do that.
10 Q. Would you intend to amend your filing to take
11 into account this additional money?
12 A. If an actual change is made, prior to the
13 rates going into effect, we could do that. We wouldn't
14 anticipate that if there is a proposal -- we wouldn't
15 anticipate that would happen until the November time frame
16 which is analogous to what happened this past year. And
17 it wouldn't be finalized most likely until March, that
18 payment parameters were finalized in March of this past
19 year. So we are kind of well into the benefit year
20 already.
21 So that there is some practical reasons why
22 that might not work out. But if they were to make that
23 proposal in the very near term, we could modify our
24 filing.
25 Q. What, if anything, could you do to affect

1 rates in 2015 based on the time frame that you're
2 describing or that you anticipate?
3 A. I don't know that we could do anything to
4 affect rates in 2015.
5 Q. Some of you said you would work with the Green
6 Mountain Care Board.
7 A. Some possibilities, and again certainly I
8 can't just make a unilateral decision, but a possibility
9 could be literally a rebate to members. It could be paid
10 out during 2015. DFR suggests in their opinion that if we
11 assume the 45 and it doesn't happen, if the 70 happens,
12 their opinion is that contribution to reserve would have
13 to be increased for the 2016 rates. Analogous to that, if
14 we assume that it's not going to happen and it does, we
15 could lower the contribution reserve proportionally for
16 2016 rates.
17 So there are a few possibilities, and it's not
18 something we have actually discussed with the Board, so I
19 can't really say how exactly we would do that.
20 Q. But one possibility that you would consider
21 viable would be rebates in 2015, actually lower the
22 rates --
23 A. Yes.
24 Q. -- that year?
25 MS. RICHARDSON: I don't have any

1 further questions.
2 MS. HENKIN: The Board? Let me start on
3 this end this time.
4 MS. RAMBUR: Thank you. I have a
5 question. I would like -- you stated that,
6 Mr. Schultz, that in your research with
7 others with a significant presence in the
8 exchange, you assume the higher attachment
9 point because you otherwise would be
10 imprudent. I think I'm paraphrasing but
11 it's close.
12 How many others -- could you tell me a
13 little bit more about that? In terms of,
14 you know, how many other states or places?
15 Was it a hundred percent, was it 50 percent?
16 Just others and significant.
17 THE WITNESS: We have spoken to Blue
18 Cross Blue Shield Association so it covers
19 most of the country. So most other states I
20 would say this comment applies to.
21 MS. RAMBUR: 50 of 50? I'm just trying
22 to understand what that means.
23 THE WITNESS: I don't know that I can
24 put a specific number on it, but I would say
25 the majority.

1 MS. RAMBUR: Thank you. No further
2 questions.
3 MR. GOBEILLE: So my question is limited
4 to my memory and my ability to research
5 quickly here. And perhaps I'm looking at
6 the wrong source. So forgive me if I'm
7 wrong.
8 But in Exhibit B under 2014 filing
9 assumptions the total expected recovery
10 pmpm, I had from your filing last year at
11 $25 and 78 cents. How does that relate to
12 that number?
13 THE WITNESS: The number you're
14 referring to was our original filing. We
15 amended the filing subsequent to that, and
16 one of the changes we made was for
17 transitional reinsurance. So if you look at
18 the final amended filing, you'll find the 31
19 dollars and 02 cents.
20 MR. GOBEILLE: We will look.
21 THE WITNESS: Very good.
22 MS. HENKIN: Let me go to Con.
23 MR. HOGAN: Yeah. I guess I don't have
24 any questions. Just your testimony was
25 really clear and I appreciate it. Thank

1 you.
2 THE WITNESS: Thank you.
3 MS. HENKIN: Dr. Hein.
4 MS. HEIN: And my question is not about
5 transitional reinsurance, but going back to
6 the way Ms. Greene ended her testimony was
7 that the future won't be like the past. So
8 in looking at the assumptions, that half
9 dozen of them, I wanted to focus actually on
10 the population and assumptions, particularly
11 around the risk adjustment portion of the
12 assumptions that went into that estimate.
13 So with the 9.8 percent requested rate
14 increase as you pointed out if you add up
15 all of the pluses that's a lot higher. It's
16 about 13 percent.
17 THE WITNESS: Right.
18 MS. HEIN: So a mitigating factor is
19 actually your assumption about risk
20 adjustment the population healthier.
21 THE WITNESS: That's correct.
22 MS. HEIN: So that's the one that I
23 really wanted to focus in on for a second.
24 THE WITNESS: Okay.
25 MS. HEIN: And I just wondered if that

1 assumption turns out not to be the case,
2 then we are going to have a very different
3 situation in which there may in fact not be
4 the mitigating contribution to lowering the
5 rate. And that it would in fact increase.
6 So my question has to do with the
7 contributions to that assumption that
8 overall -- there was an overall decrease of
9 6.9 percent to the 2015 rates. And that was
10 -- there were three components that went
11 into that decrease.
12 So I'm wondering if you could give us a
13 feel for the ranges of those three
14 contributions that ended up lowering the
15 rates to a significant degree and just to
16 refresh your memory --
17 THE WITNESS: Thank you.
18 MS. HEIN: There were changes in pool
19 morbidity of minus 5.7 percent. Secondly
20 was the impact of health stages on newly
21 insureds, the one you referred to of minus
22 .8 percent, and thirdly was the adjustment
23 for unutilized assumption of minus .4
24 percent. So you add all of those up you get
25 this pretty large mitigating decrease in the

1 requested rate increase.

2 THE WITNESS: Yes. Okay.

3 MS. HEIN: So are there changes of

4 those, or should we be worried about that

5 one?

6 THE WITNESS: Well I'm certainly worried

7 about it. But I think my assumptions are

8 reasonable and best estimate.

9 The bulk of that change, I believe

10 you're referring to the L&E opinion letter,

11 so they calculated these in somewhat

12 different order than we did. The biggest

13 one you refer to is the difference between

14 2013, our entire block of business,

15 individual and small group, versus just

16 those people who are on the exchange. So

17 that's the -- forgive me -- I believe 5.7.

18 MS. HEIN: Yeah, minus 5.7.

19 THE WITNESS: Minus 5.7 percent delta.

20 And that's something that was very solid.

21 We can identify these are the individuals

22 enrolled on the exchange. So some of the

23 less healthy individuals did not show up in

24 2014 for whatever reason. It may have to do

25 with more folks moving to Medicaid. It's

1 just conjecture. But we can really quantify
2 that fairly precisely. So that's pretty
3 solid.
4 Everything else kind of plays into the
5 new membership. And those are by their
6 nature more speculative. So one thing we
7 can observe, we can compare new members to
8 continuing members in terms of age and
9 gender. And based on industry factors, that
10 Milliman is a large actuarial consulting
11 firm, they provide these factors, we can
12 calculate that based on that age and gender
13 we could expect new members to be less
14 expensive than continuing members in any
15 given category. So if we look at just small
16 group, the new members in small group tend
17 to be younger than the continuing members in
18 small group. So it's reasonable to conclude
19 from that that they will be -- they will use
20 services less than the continuing members.
21 And that's what we have assumed.
22 That has some more variability. It may
23 turn out to your point that some of these
24 new members were in fact some of the members
25 that we lost from 2013 that we weren't able

1 to identify. And if that's the case, that
2 could have an impact. So there is more
3 variability to that piece of it. But we
4 felt comfortable with our assumption in
5 looking at the demographic data. Which was
6 really the best we could do at the time of
7 this filing because there was so little
8 experience on the exchange at that point.
9 Actually looking at claim costs doesn't
10 really tell us anything.
11 MS. HEIN: Thank you.
12 MS. HENKIN: Dr. Ramsay.
13 DR. RAMSAY: Just one question, not
14 about transition reinsurance, thank
15 goodness. But about again a contribution to
16 the premium. And you talk about increased
17 reimbursement to providers. And you use --
18 I think you used the term seven percent,
19 something like that. And we know that there
20 wasn't a large group. Certain amount --
21 certain number of Vermonters migrated from
22 VHAP into Medicaid.
23 Do you feel like that seven percent
24 somehow reflects in the overall cost
25 shifting that's constantly going on?

1 THE WITNESS: Yes.
2 DR. RAMSAY: It does. Okay.
3 THE WITNESS: Yeah. I think the cost
4 shift is definitely in there. So we did
5 look at what happened to commercial rates
6 last year, for example, as a result of
7 hospital budget approvals.
8 DR. RAMSAY: Right.
9 THE WITNESS: And you know, the way the
10 hospitals look at that, they have a certain
11 rate that they are allowed to increase by.
12 It's a fixed cost. It's a fixed number for
13 Medicare, and it's a fixed number for
14 Medicaid, and it tends to be less than that
15 overall budget approval. So all the shift
16 comes to commercial.
17 So we did factor that in. We assumed
18 that the cost shift essentially would be the
19 same moving forward as it was in from 2013
20 to 2014. So depending on what happens with
21 Medicaid and so on and so forth, that
22 assumption may -- or that has some
23 variability as well. But we did factor that
24 in.
25 DR. RAMSAY: Thank you.

1 MS. HENKIN: Anything else from the
2 Board? Anything else for this witness?
3 MS. HUGHES: I would like to reserve a
4 recall, if necessary.
5 MS. HENKIN: I will consider that as it
6 comes up. We will have to be very mindful
7 of time also.
8 MS. HUGHES: Thank you.
9 MS. HENKIN: Thank you, Mr. Schultz. Do
10 you have any other witnesses?
11 MS. HUGHES: No, I do not.
12 MS. HENKIN: The Department of Financial
13 Regulation did send a witness here. And
14 he's been sworn in. So Mr. Cassetty.
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1 DAVID CASSETTY
2 Having been previously duly sworn,
3 testified as follows:
4 THE WITNESS: Good morning.
5 MS. HENKIN: Good morning. We initially
6 assumed that the Commissioner was coming,
7 and I guess that assumption was incorrect.
8 So would you like to question yourself?
9 THE WITNESS: Yes.
10 MS. HENKIN: Okay.
11 THE WITNESS: Absolutely.
12 MS. HENKIN: Proceed.
13 THE WITNESS: My name's Dave Cassetty.
14 I'm the General Counsel at the Department of
15 Financial Regulation, and I am the designee
16 for Commissioner Donegan for today's
17 purposes.
18 We have given both the opinion letter
19 that actually went out, is required by
20 statute, and we have supplemented that based
21 on a reference in Lewis & Ellis's opinion
22 regarding impact on surplus and solvency.
23 I'm sure you've all read it, but the bottom
24 lines are we have recommended a contribution
25 to surplus of two percent, recognizing that

1 the carriers only asked for one percent in
2 their filing. That is the absolute minimum
3 that we would consider sufficient for
4 solvency purposes, although we do recommend
5 that it actually be two percent.
6 The major issue that came up in L&E's
7 report that we addressed with the
8 supplemental opinion was the --
9 MR. HOGAN: Could you speak up please?
10 THE WITNESS: Sure. The reason for the
11 supplemental opinion was the issue of the
12 transitional reinsurance attachment points,
13 and we wanted to comment on and agree with
14 their opinion that were you to accept the
15 recommendation they make of using the lower
16 attachment points, and that does not come to
17 pass, that that would adversely impact the
18 surplus. It would adversely reflect on the
19 company's solvency and would require
20 significant changes in the 2016 rates. So
21 we just wanted to -- since they had made
22 that recommendation and sort of noted that,
23 you know, if it doesn't happen it might be
24 some impact, we wanted to give you a heads
25 up that we agree with that, and that that

1 impact could be significant.
2 Otherwise, unless you, you know, there
3 are questions for me, I think you've got our
4 opinions. Those are -- they are the
5 opinions, in solvency, and they are based on
6 not just a review of the filings that have
7 gone here, but we do in a footnote note we
8 have ongoing financial examinations. We
9 look at the investment portfolio. We look
10 at a whole range of things, and it is an
11 ongoing, not a one-time thing, just for this
12 purpose. But it is part of our ongoing
13 obligations as their primary regulator. We
14 are continuously monitoring their health,
15 the status of the company, their membership.
16 It's something we do on an ongoing and
17 regular basis, and it involves a range of
18 factors that are, you know, not really
19 actuarial issues. They are not the same
20 things that you're hearing from the other
21 witnesses. But it is our statutory
22 obligation to ensure the solvency of them,
23 so we don't end up in a situation where we
24 were a number of years ago where actually
25 the Department had to step in and take, you

1 know, there is no guaranteed fund for health
2 insurance. Solvency analysis is designed to
3 avoid those problems.
4 And that's why we came with the
5 recommendation that given all of the factors
6 we examined, we recommend a two percent
7 contribution to surplus with an absolute
8 minimum of the one percent requested in
9 their filings.
10 MS. HENKIN: Do you have any questions?
11 MS. HUGHES: I have no questions of this
12 witness.
13 MS. HENKIN: Ms. Richardson?
14 CROSS EXAMINATION
15 BY MS. RICHARDSON:
16 Q. I have a few questions. But hopefully very
17 brief. I would like to -- you don't have a copy of the
18 exhibits. I'm going to refer you to Exhibit 11 which is
19 the annual statement of Blue Cross Blue Shield of Vermont.
20 MS. HENKIN: If you could provide him
21 with it.
22 THE WITNESS: Which one am I looking at?
23 11?
24 BY MS. RICHARDSON:
25 Q. 11.

1 A. Okay.
2 Q. And are you familiar with that document, the
3 annual statement of Blue Cross Blue Shield of Vermont?
4 A. I'm familiar with what this is. I've actually
5 never read this.
6 Q. And is the annual statement one of the factors
7 that the Department of Financial Regulation takes into
8 account when reviewing insolvency?
9 A. I would say directly, no. That it's actually
10 all the material that underlaid this. This is essentially
11 a report. That reflects a lot of the material that we do
12 rely on. That this statement itself, I think, you know
13 I'm sure that our analysts they review it, they review it
14 largely for accuracy, but it's the underlying data that we
15 are relying on.
16 Q. That would be contained in the report?
17 A. Some of it. Yes.
18 Q. In addition to others?
19 A. In addition to other things. Yes.
20 Q. I wanted to ask you a question about what
21 would happen if HHS does lower the attachment point for
22 the transitional reinsurance program to $45,000. Blue
23 Cross Blue Shield has assumed 70 thousand dollar
24 attachment point; correct?
25 A. Correct.

1 Q. If the filing is not modified to make any
2 change based on an anticipated lowering of the attachment
3 point, and HHS does lower the attachment point, what
4 effect would that have on the contribution to reserves for
5 Blue Cross Blue Shield?
6 A. I'm not sure that it would have any direct
7 impact on the contribution to reserves. And we really
8 don't refer to the contribution to reserves. That's in
9 the filing. The Department looks at it as surplus. We
10 are concerned about the amount of surplus and the
11 contribution to surplus.
12 MS. HENKIN: Can you speak up a little
13 bit?
14 THE WITNESS: Sure. Assuming that HHS
15 were only to adjust the attachment points
16 and make no other adjustments than the what
17 would be -- they would then be reimbursed
18 more money than the filing anticipates. Is
19 that what you're asking?
20 BY MS. RICHARDSON:
21 Q. Yes.
22 A. Yes. They would have more money coming in.
23 MS. RICHARDSON: I don't have further
24 questions.
25 MS. HENKIN: From the Board, Dr. Ramsay.

1 DR. RAMSAY: No questions.
2 MS. HEIN: No questions.
3 MS. HENKIN: Mr. Hogan?
4 MR. HOGAN: What does the phrase, a
5 quote; significant adverse effect on Blue
6 Cross Blue Shield Vermont solvency, what's
7 that mean?
8 THE WITNESS: Well as I think you heard
9 from Ms. Greene's testimony earlier, if you
10 sustain a negative impact on your surplus,
11 it can take years to rebuild that. And so
12 in order to -- given their current position
13 and the two percent or so swing that this
14 could affect, depending on what HHS actually
15 does, we would see something that would have
16 to be addressed with a -- you know, with a
17 larger contribution to surplus in the 2016
18 filings. And it may reflect also -- if the
19 rates are inadequate, it may reflect on the
20 other aspects of the rate as well.
21 But basically what that's saying is if
22 this assumption is accepted and proves not
23 to occur, that insurance is going to cost
24 more next year. It's going to have to be
25 made up. It's not coming out of the

1 surplus.

2 MR. HOGAN: So it doesn't necessarily
3 mean adverse effect on Blue Cross's
4 solvency.

5 THE WITNESS: Well it means that it's
6 going to have adversely -- you know, there
7 is -- it's a range. And it's going to push
8 them closer to the range where the
9 Department has to take some form of action.
10 And our job is to again because there is no
11 guarantee fund, our job is to ensure that
12 they stay in a healthy range. And if this
13 were to happen, it would be pushing them out
14 of that range, and we would be making
15 recommendations to get them back into it.

16 MR. HOGAN: Okay. Thank you.

17 MR. GOBEILLE: I'm all set. I just want
18 to thank you for coming.

19 THE WITNESS: Thanks.

20 MS. RAMBUR: One brief question. I want
21 to be sure I understand the responsibility
22 of your Department. The responsibility is
23 on solvency, but not considerations
24 particularly of reasonableness and
25 affordability; is that correct?

1 THE WITNESS: Well with regard to the
2 rates that is correct. That used to be our
3 function. That's been transferred over as
4 part of the health care reform to the Board.
5 We are still responsible for all the other
6 aspects of the insurance industry. And as
7 far as health insurance goes, we don't do
8 the affordability or reasonableness or
9 excessiveness or inadequacy of the rates
10 except to the extent that obviously
11 inadequate rates are going to at some point
12 impact the solvency of the company.
13 So we are really focused for purposes of
14 this hearing on that. It's a long-term or
15 longer-term analysis than just on individual
16 filings.
17 MS. RAMBUR: Thank you. No further
18 questions.
19 MS. HENKIN: Okay. Thank you, Mr.
20 Cassetty. I believe you're done for the
21 day. Because there are several new exhibits
22 we are going to take a 10-minute break
23 before L&E is going to start to testify.
24 And we are going to continue on until at
25 least 1 o'clock and not break for lunch at

1 noon.
2 Okay, we will take a little break right
3 now.
4 (Recess was taken.)
5 MS. HENKIN: All right, everybody.
6 Please everybody here. Are we missing
7 anyone at this point? We are back on the
8 record. And is everything back on?
9 UNIDENTIFIED SPEAKER: Yes.
10 MS. HENKIN: I know we have a nice
11 foundation. Everybody is done complimenting
12 each other. We will be able to keep moving
13 forward.
14 MR. GOBEILLE: Personal attacks are
15 always after noon, Judy.
16 MS. HENKIN: That's off the record. So
17 but -- so people will get to eat and get to
18 where we are going, let's move on. And I
19 believe the next testimony Mike Donofrio is
20 going to conduct the examination for the
21 actuaries; correct?
22 MR. DONOFRIO: Thank you, Judy. For the
23 record I'm Mike Donofrio. I'm the Board's
24 General Counsel. And I'll call David Dillon
25 on behalf of the Board. By way of very

1 brief background, Mr. Dillon as he'll
2 testify in a moment, is an actuary and a
3 principal of the firm Lewis & Ellis which is
4 the actuary that has been retained by the
5 Green Mountain Care Board to assist the
6 Board in its review of health insurance rate
7 filings in general. In order to allow Mr.
8 Dillon to warm to the chair and set a bit of
9 a foundation for his testimony and
10 questioning by the other attorneys, the
11 Board and the Hearing Officer requested that
12 I conduct a brief direct examination.
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1 DAVID DILLON
2 Having been previously duly sworn,
3 testified as follows:
4 DIRECT EXAMINATION
5 BY MR. DONOFRIO:
6 Q. So good afternoon, Mr. Dillon. Could you
7 state your name and spell your name for the record,
8 please?
9 A. David Dillon. D-I-L-L-O-N.
10 Q. And could you tell us what you do for a
11 living?
12 A. I have been with Lewis & Ellis as an actuary
13 for approximately 16 years.
14 Q. And could you describe a bit of your
15 background and credentials particularly as relevant to
16 this proceeding in terms of reviewing health insurance
17 rate filings?
18 A. When I came out of college with an actuarial
19 degree I started work with a Blue Cross Blue Shield plan
20 in the state of Arkansas. Worked there for three years.
21 And moved there to Lewis & Ellis directly. I've always
22 focused on health insurance.
23 I would say about five to 10 years ago, I was
24 focused on pricing of health insurance plans. And then
25 around 2008 to 2009, maybe a little bit before that, I

1 started assisting some states with health care reform, pre
2 ACA. And then that helped set the table to help with
3 health care reform work once the ACA was implemented, and
4 the majority of my work now is with ACA-related projects.
5 Q. Are there other states other than Vermont with
6 whom you work on these types of reviews?
7 A. Yes. So right now for this year Lewis & Ellis
8 the Dallas office works with eight states. Jackie Lee and
9 I directly work with six states regarding ACA-related
10 filings. And last year, the first year we assisted about
11 the same, maybe one more.
12 Q. And just for the record could you explain who
13 Ms. Lee is who you just referenced?
14 A. Yes. So Jacqueline Lee is one of our key
15 actuaries that helps in the reviews.
16 Q. Thank you. When did you begin work for the
17 Green Mountain Care Board?
18 A. January 1, 2014.
19 Q. And could you briefly and generally describe
20 the services that Lewis & Ellis provides on behalf of the
21 Board?
22 A. So the charge we were asked was somewhat
23 broad. You know, just help with actuarial services,
24 whatever that may be that comes up, but the bulk of the
25 work is with the rate review. To be the persons to review

1 the filings submitted by the companies, and recommend and
2 advise the Board on any modifications, if needed.
3 Q. And approximately how many filings have you
4 gone through that process for?
5 A. For all the states that we mentioned, like
6 this year, in 2015 we have reviewed approximately 100 ACA
7 filings. So we have pretty broad base of different
8 submissions by different carriers in different states.
9 Q. And about how many Vermont filings have you
10 looked at this year?
11 A. I would assume somewhere in the six to eight
12 range is a ball park.
13 Q. Could you describe the process that you use at
14 Lewis & Ellis when you receive one of these filings?
15 A. There is two main kinds of structures to our
16 program review. Set up is one, is we assign one key
17 primary reviewer to each company. Josh Hammerquist was
18 assigned the key reviewer for Blue Cross of Vermont, so he
19 is the primary reviewer on every submission by the
20 company. That way we have, you know, a quote unquote,
21 expert that knows all the details of the company, allows
22 for consistent circumstances for communication with the
23 company. We don't have to relearn the learning curve with
24 every submission.
25 The next layer of our review is Jackie Lee.

1 She helps as a peer reviewer on each of the company
2 submissions. She helps coordinate the issues that may
3 arise on any of the companies. So she is a peer reviewer
4 on both companies, that way she can see all the issues and
5 help assess the reasonableness of that.
6 And then the next layer is me. I am kind of
7 the big picture, I review all of the filings. I make sure
8 everything is consistent between the companies and the
9 market. And we also leverage my experience with the other
10 states and other carriers to make sure all the processes
11 are consistent with industry practice and things like
12 that.
13 Another key thing in our review is, you know,
14 a key thing in actuarial science is you can always focus
15 on one assumption in isolation, and so we do determine and
16 evaluate each assumption in isolation. However it is also
17 very key to look at the aggregate. You don't want any
18 unintended consequences or anything. So even though you
19 may have assumptions that appear reasonable in isolation,
20 but we do step back and look at everything in the
21 aggregate to make sure that makes sense in that way as
22 well.
23 Q. And is that approach and methodology that you
24 just outlined the same that you have applied to your
25 review of the rate filing at issue here today?

1 A. That is correct. Yes.
2 Q. Could you just look at the Table of Contents
3 of the binder in front of you for a moment, please. Do
4 you see it indicates that Exhibit 1 is the SERFF,
5 S-E-R-F-F, filing that was submitted by Blue Cross Blue
6 Shield of Vermont, do you see that?
7 A. Yes.
8 Q. Is that something you reviewed as part of your
9 review of this case?
10 A. Yes.
11 Q. And then the next -- I think exhibits 2
12 through 7 reflect letters containing questions and answers
13 back and forth between L&E and Blue Cross Blue Shield of
14 Vermont; is that right?
15 A. Correct.
16 Q. And are those materials that you reviewed as
17 well?
18 A. Yes.
19 Q. Exhibit 8 I believe is your report. Correct?
20 A. Correct.
21 Q. And I assume that is material you've also
22 reviewed.
23 A. Yes.
24 Q. What about Exhibit 9? Behind that tab are the
25 two letters from the Department of Financial Regulation,

1 did you have a chance to review those?
2 A. Yes. Those were shared by Ms. Judy Henkin,
3 and those were reviewed.
4 Q. How about the HCA's actuarial opinion?
5 A. Yes, that was provided to us as well.
6 Q. Great. Thank you. So I would like to turn
7 now to Exhibit 8, which is the Lewis & Ellis opinion in
8 this case. Very briefly I just want to clarify a couple
9 of terms that you use in the report. On page -- sorry --
10 page three, I apologize. Bottom of page two. You refer
11 to something called the Unified Rate Review Template or
12 URRT. Could you briefly explain what that is?
13 A. Yes. That is a federal requirement as part of
14 the ACA. HHS developed that template, and as part of
15 their reporting process they require all of the carriers
16 to fill out and provide certain pieces of information.
17 You know, a key thing with the URRT, it is not necessarily
18 representative of exactly how a carrier rates their
19 products. However, it is used as an informative tool on
20 key issues for the Feds and for the state reviewers to
21 assess the assumptions submitted.
22 Q. Great. I'm not going to go into a great
23 amount of detail. I suspect that will unfold in the rest
24 of the testimony you're about to give in terms of stepping
25 through this document. But I did just want to touch

1 briefly on a couple areas we have already heard some
2 testimony about.
3 You -- in this report Lewis & Ellis make a
4 recommendation with respect to transitional reinsurance;
5 correct?
6 A. Correct.
7 Q. And that recommendation was what?
8 A. To modify the lower attachment point to
9 $45,000.
10 Q. And as part of your -- as part of your process
11 of developing this recommendation, did you do any research
12 regarding how insurers are handling this issue in other
13 states?
14 A. Yes. So one of the advantages of working with
15 other states and looking at the other carriers, and as I
16 said we have looked at approximately a hundred carriers'
17 filings, is that there was a very diverse set of
18 interpretations of the transitional reinsurance.
19 Approximately I would say 40 percent of the carriers'
20 submission we received utilized the 45 thousand dollar
21 attachment point, and assumed that was going to be the
22 attachment point, based on the information provided by HHS
23 and then the remaining 60 percent assumed the 75,000
24 dollar attachment point.
25 Q. Thank you. Now you were here during the

1 testimony of Mr. Schultz; correct?

2 A. Correct.

3 Q. And so you heard Mr. Schultz gave some fairly

4 detailed and extensive testimony on this topic; correct?

5 A. Correct.

6 Q. Generally can you provide your reaction to his

7 testimony for the Board?

8 A. I think the -- my initial reaction is -- the

9 company's position is not surprising, you know, based on

10 again what we have seen with other filings. That the

11 company's position is -- their position is that the final

12 rule is the final statement, the one issued in March.

13 However, the other guidance was issued in May and was a

14 follow up, so that's why a lot of people consider that new

15 information that should be taken into consideration.

16 Q. And Mr. Schultz also gave some testimony

17 regarding the insurer fee. Do you remember that

18 testimony?

19 A. Yes.

20 Q. And actually let me back up a step. Lewis &

21 Ellis made a recommendation regarding the treatment of the

22 insurer fee in this document, right?

23 A. That is correct. Yes.

24 Q. And what was that recommendation?

25 A. Our recommendation was, as Mr. Schultz, as he

1 stated, they estimated they utilized information by Blue
2 Cross Blue Shield Association, to help them estimate what
3 that fee would be. They speculated that there would be
4 additional need to modify that. We asked for an, as Mr.
5 Schultz mentioned, you know, there is possibility of
6 groups going self insured, that would modify that number.
7 So their approach this year was consistent to last year.
8 And one of the things we asked was because of
9 your status as one of the largest carriers in the state
10 and the information, do you have, now with a year passed,
11 is there any more additional information to support that
12 extra layer of supporting the groups would go self insured
13 and that that would affect that. No additional
14 information was provided; quantifiable. And as a result
15 of no quantifiable information on that layer, we recommend
16 to go with the quantifiable calculation.
17 Q. Thank you. Just a few more general questions
18 about your role and your recommendation here for the
19 Board. In performing the analysis that you performed for
20 the Board you understand that there are certain statutory
21 criteria that the Board needs to evaluate in making these
22 rate review decisions, right?
23 A. Correct.
24 Q. So in -- and you mentioned earlier that you
25 look both at a component of a rate individually as well as

1 the components of the rate in the aggregate, is that fair?
2 A. Fair.
3 Q. So in your opinion and as reflected in the
4 recommendation is each of the modifications that you
5 recommended actuarially reasonable?
6 A. Yes. We believe that our final recommendation
7 with all the components together that all the rates would
8 be -- they would be adequate and not excessive once all of
9 those changes have been made.
10 Q. And further, do you believe that the rates
11 would be reasonably related to the benefits provided?
12 A. Yes.
13 MR. DONOFRIO: Thank you, I have no
14 further questions.
15 MS. HENKIN: I'm going to allow
16 questioning at this point from the carrier.
17 And then from the HCA, and then the Board
18 will have the opportunity to ask questions
19 after.
20 MS. HUGHES: We have no questions of
21 this witness.
22 MS. HENKIN: Ms. Richardson?
23 MS. RICHARDSON: Okay, I have a few
24 questions to follow up on Mr. Donofrio's
25 examination.

1 CROSS EXAMINATION
2 BY MS. RICHARDSON:
3 Q. Is it correct to say that you continue to make
4 the same recommendations that you offered in your report
5 in Exhibit 8 even after hearing the testimony from Blue
6 Cross Blue Shield today?
7 A. That is correct. I have not heard anything to
8 this point that would modify our recommendation.
9 Q. All right. I have a question about the
10 transitional reinsurance topic. You have recommended that
11 the rate should be modified to use the 45 thousand dollar
12 attachment point?
13 A. Correct.
14 Q. If HHS does actually lower the -- issue a
15 final rule lowering the attachment point to $45,000 and
16 the filing is not modified as you recommend to account for
17 the lower attachment point, what effect would that have on
18 Blue Cross Blue Shield's contribution to reserves or
19 surplus?
20 A. As I mentioned, one of the key parts of our
21 review is not only an assumption in isolation but in the
22 aggregate. In isolation I think it is easy to say what
23 the effect would be. However, you know there are a lot of
24 variables that will change between now and if they make
25 the change as well. So the ultimate impact would be hard

1 to measure.
2 Q. If you isolated that one factor would it
3 affect the two percent?
4 A. Yeah, I would think it would be relatively
5 consistent with our report number. Yes.
6 Q. With the report which quantified it as a two
7 percent impact on the rate?
8 A. Right.
9 Q. Did you also as part of your work for Vermont
10 this year review the 2015 rate filing for MVP?
11 A. Yes.
12 Q. And --
13 MS. HUGHES: I'm going to object. I
14 don't see the relevance of this.
15 MS. HENKIN: I'll let her continue to go
16 on this line right now.
17 BY MS. RICHARDSON:
18 Q. Are you familiar with the attachment point
19 that MVP used?
20 A. Yes.
21 Q. For transitional reinsurance, what was that
22 attachment point?
23 A. 45,000.
24 Q. You mentioned that you review carriers for
25 consistency in the market. Would this be an area where

1 you would recommend two carriers in Vermont be consistent?
2 A. I do think that the nature of your state with
3 such a small set of carriers, it is probably more
4 important than in other states where there is 20 carriers
5 to have the consistency of assumptions, yes.
6 Q. And I would like to refer to your report at
7 page six, page six. At the bottom of the page. There is
8 a paragraph there that refers to contribution to reserves,
9 actually two paragraphs. When you were assessing the
10 adequacy of the contribution to reserves for this filing,
11 were there any materials that you reviewed in addition to
12 this SERFF filing?
13 A. One key thing with our review is the bulk of
14 the solvency issue of this filing does fall with DFR. So
15 there was not much more reviewed other than the material
16 provided by Mr. Schultz and his staff. And that's why,
17 you know, our last paragraph focuses on, you know, there
18 are other things to consider rather than just our review.
19 Q. Did you review the 2013 annual statement?
20 A. Yes. The statement was reviewed.
21 Q. Okay. And does that -- I'm referring now to
22 Exhibit 11 of the filing. The annual statement have any
23 particular parts where solvency or adequacy of
24 contribution to reserves are particularly relevant?
25 A. When I look through a statement, there are two

1 main things that I look at in terms of solvency. One is
2 the RBC ratio that has been discussed by multiple parties
3 here. One of the other things I look at is the amount of
4 capital as a percentage of premiums written. Those are
5 kind of the two key things that I look at.
6 And based on our review of those measures, it
7 does appear that the RBC and the capital percentage of
8 premium have been relatively consistent with prior
9 history.
10 Q. I would like to direct your attention to page
11 29 of the annual statement, which is the five-year
12 historical data sheet which was referred to in earlier
13 testimony. Does that document have information in it
14 that's relevant to solvency and risk-based capital?
15 A. Yes. As I alluded to, the two metrics that I
16 look at are rows 14 and 15. The ratio of those two is a
17 metric that is evaluated when looking at solvency. And
18 then again I would look at row 14 divided by row 5 which
19 is the revenues. So those are the entries that I have
20 been discussing.
21 Q. Okay. And without going into the details of
22 the specific risk-based capital calculations that you did,
23 is it correct to say that you calculated RBC by using the
24 line 14 and line 15, dividing line 14 by line 15?
25 A. Yeah. The way I would characterize it is I

1 utilized Blue Cross's calculation. This is, you know, I
2 just took the numbers in their report and did that
3 relatively. But I did not do any independent calculation
4 of any numbers.
5 Q. But is it correct to say that risk-based
6 capital can be calculated using the 14 and 15?
7 A. Yes, that is correct.
8 MS. RICHARDSON: I don't have further
9 questions.
10 MS. HUGHES: I have one follow-up
11 question.
12 CROSS EXAMINATION
13 BY MS. HUGHES:
14 Q. So you did review the MVP exchange filing, and
15 can you tell us what percentage of the exchange
16 marketplace MVP has in 2014?
17 A. I believe my estimate is probably somewhere --
18 what's mentioned before around 10 percent of the market.
19 MS. HUGHES: Thank you.
20 MS. HENKIN: Board members. Dr. Ramsay.
21 DR. RAMSAY: Yes. On your
22 recommendations around reduced reinsurance
23 parameter for attachment point of 45,000,
24 you make an estimate of a reduction in
25 aggregated premium by two percent. That's

1 an estimate, right?

2 THE WITNESS: Correct.

3 DR. RAMSAY: It's not an absolute

4 figure, it's just an estimate. It could be

5 point five percent, it could be one percent,

6 it could be probably not more than two

7 percent, but that's what your estimate of

8 the reduction would be.

9 THE WITNESS: Yes.

10 MS. HEIN: Just a very brief question.

11 Do you have any thoughts about the timing of

12 the HHS announcement?

13 THE WITNESS: I think we have all

14 learned that we can't guess when HHS will

15 announce things. But I would probably

16 reiterate I think it was Mr. Schultz that

17 mentioned that November, between November to

18 March would be a good guess.

19 MS. HENKIN: Mr. Hogan.

20 MR. HOGAN: Mr. Schultz gave a solid

21 presentation on, in my language, the dangers

22 of separating these out into individual

23 elements on, you know, the 45,000 versus the

24 75, whatever the number was. He was arguing

25 for a wider look because of other changes in

1 fees. Your take on that?
2 THE WITNESS: Could you repeat the
3 question? I don't know if I completely
4 follow the fees part mentioned with the
5 attachment point.
6 MR. HOGAN: Yeah. He was saying you
7 can't really look at the attachment point
8 alone.
9 THE WITNESS: Oh, so I think you may be
10 referring to the coinsurance --
11 MR. HOGAN: That's correct.
12 THE WITNESS: -- adjustment, yes. So
13 Mr. Schultz's position is that it would be
14 likely that in tandem with attachment point
15 reduction there would be a coinsurance
16 adjustment.
17 MR. HOGAN: Right.
18 THE WITNESS: I don't share his
19 confidence that it will definitely happen in
20 tandem. I mean in 2014 the attachment point
21 was lowered without any corresponding
22 coinsurance. I think my concern might be
23 more for 2016. You know, as it has been
24 mentioned, you know, there are certain
25 amount of available funds, and I know there

1 is conjecture that the run-up might be in
2 '16, not in the interim.
3 MR. HOGAN: Okay. Thank you.
4 MR. GOBEILLE: How are you?
5 THE WITNESS: I'm good.
6 MR. GOBEILLE: So the first time you
7 came here you went through snow, ice --
8 THE WITNESS: Yeah, I think it's 90
9 degrees different maybe from when we were
10 here before.
11 MR. GOBEILLE: Were you wondering why
12 you took the job? And you are on the
13 record.
14 THE WITNESS: I will have to be honest,
15 yes.
16 MR. GOBEILLE: I can't blame you. So
17 earlier in the testimony today I was talking
18 about the financial statements in the back
19 of the book. And I made comments about
20 underwriting losses and revenue from
21 investments, and you heard what I was
22 saying. I don't know if you could speak to
23 that at all. But the question I believe
24 that we were really getting to is the --
25 from 2009 until now -- the health of this

1 company, its current situation and, you
2 know, how is it doing, and you know, the
3 question was -- I think Con made the point
4 here's a great number, here's a great
5 number, great trend, great trend, but what
6 do you not like?
7 I pointed that out as what I see as
8 peril. Do you disagree or where do you see
9 all that? And I know it's not really fair
10 to ask such a --
11 THE WITNESS: Well the way I would
12 phrase it is you must be cautious in relying
13 on investment income to always help bail you
14 out on the operation side. So you know,
15 based on this it does look like the
16 investment income has been very helpful to
17 help offset some of the losses. So you
18 know, you can't ignore it. But I'm just
19 being cautious to say that you can't always
20 rely on the investment income to help the
21 overall profitability of the company.
22 MR. GOBEILLE: Okay. Thank you. All
23 set, Judy.
24 MS. RAMBUR: I just have one question.
25 You testified that in a state with a few

1 number of carriers there is some logic to
2 having a uniform attachment point using the
3 assumptions. Would you just comment on
4 that? When you layer in additional factors
5 like difference in the number of lives
6 insured?
7 THE WITNESS: Yeah. One of the issues
8 that has hit several states one thing we
9 really haven't hit today is like risk
10 adjustment. You know, that is one of the
11 three R's. It's a very important issue to
12 the establishment of the rates. And one of
13 the issues that's happened in a lot of the
14 states is like risk adjustment is supposed
15 to be risk neutral. You know, a zero sum
16 game. All the ins and the outs are supposed
17 to measure out.
18 And you know, we have realized that the
19 carriers all have different information, and
20 you sum things, and they don't always
21 balance. So that's one of those things you
22 do have to be cognizant of. Especially here
23 because of the transparency in the state and
24 the small number of carriers. We just
25 believe that the consistency is good because

1 of those factors.

2 MS. RAMBUR: Thank you.

3 MS. HENKIN: Anything else from the

4 Board? Mike, do you have anything else?

5 MR. DONOFRIO: All set. Thank you.

6 MS. HENKIN: Thank you.

7 THE WITNESS: Thank you.

8 MS. HENKIN: Just a reminder, all the

9 witnesses are under oath from this morning.

10 I think there is only at this point the

11 HCA's witness, so we will continue.

12 MS. RICHARDSON: Call Donna Novak.

13 MS. HENKIN: I am going to ask you again

14 to speak up, Lila, please, and speak into

15 the mic.

16 MS. RICHARDSON: I moved the mic, so I

17 hope that will help.

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1 DONNA NOVAK
2 Having been previously duly sworn,
3 testified as follows:
4 DIRECT EXAMINATION
5 BY MS. RICHARDSON:
6 Q. Could you please state your name and address?
7 A. Donna Novak. 156 West Calle Guija, in
8 Sahuarita, Arizona. She has my card for the spelling.
9 Q. And where are you employed now?
10 A. NovaRest, Inc.
11 Q. And could you describe what that company is?
12 A. It's an actuarial consulting firm that I
13 founded in 2002.
14 Q. And you stated you are employed there. Have
15 you been there since 2002?
16 A. Yes, February 2002.
17 Q. Can you turn to Exhibit 10 in the binder,
18 please, which is the actuarial opinion report that you
19 filed?
20 A. That's correct.
21 Q. And does that document include the description
22 of your education and professional experience?
23 A. Yes. It does.
24 Q. Is that included in the curriculum vitae which
25 is at pages 13 to 16 of the report?

1 A. That's correct.
2 Q. I have got some questions -- just want a
3 little bit more about your professional experience as it
4 relates to providing an opinion in this matter. How long
5 have you worked as an actuary?
6 A. I became an ASA in 1990, but I already had
7 been doing actuarial work for 20 years at that point, been
8 doing actuarial work.
9 Q. Could you describe what it means to be an ASA
10 which is one of the set of --
11 A. Designation I had.
12 Q. -- designations after your name on the report?
13 A. Right. It's Society of Actuaries designation
14 based upon passing a number of exams, and then continuing
15 education.
16 Q. And you also have a designation of MAAA after
17 your name on the report. Could you briefly describe what
18 that is?
19 A. Member of the Academy of Actuaries, and beyond
20 just being an ASA, the Academy of Actuaries has a series
21 of actuarial standards of practice that you have to follow
22 in order to keep that designation.
23 Q. Okay. And you mentioned continuing education
24 that you have participated in.
25 A. Yes. All three of the organizations that I

1 have designations with, the Conference of Consulting
2 Actuaries, the Academy of Actuaries, and the Society of
3 Actuaries have continuing education requirements.
4 Q. Have you -- are you part of those?
5 A. I usually make them around May or June with
6 all my activities.
7 Q. Could you describe your experience with
8 actuarial review of health insurance rate filings?
9 A. Rate filings specifically? Yeah. My earliest
10 review experience was reviewing Medicare supplement
11 filings, and what was called ACRs, which was the precursor
12 to the Medicare bids for CMS. And then since 2005 I've
13 reviewed Medicare bids and audited Medicare bids, and then
14 after passing of ACA, I, along with another firm, advised
15 CMS on what should be put into some of the rules around
16 the implementation of ACA, some of which were rate filings
17 and rate review.
18 I started reviewing rates first for
19 unreasonable rate increases right after ACA when that was
20 the first level of review. I helped two states to
21 develop, improve rate review processes, because of being
22 and wanting to continue to be qualified to review rates,
23 I've helped two other states look at best practices. I've
24 created or helped create in one state and in Puerto Rico a
25 rate review process, a rate filing process along with

1 templates and everything.

2 I led a group at the Actuarial Standards Board

3 that rewrote the actual standard of practice on rate

4 filing and rate review. I've participated in the new

5 practice note yet to be released for the Academy of

6 Actuaries. I review ACA rates in six states for the

7 Department of Insurance. In one state for the AG. And in

8 three states for consumer advocates.

9 Q. Okay. And specific to reviewing rates on --

10 that are for plans that are offered under the health care

11 exchange, could you describe what you've done in that

12 area?

13 A. The process or the number?

14 Q. The number.

15 A. The number, this year for ACA exchange filings

16 we are reviewing right around 50. Last year I'm sorry,

17 some of those were off exchange. They are all ACA, and I

18 don't -- a handful are off exchange only which we try to

19 coordinate with the on exchange to get the view of the

20 whole marketplace. Last year it was a little bit more

21 than that.

22 Q. So how many states have you reviewed filings

23 for the 2015 exchange year?

24 A. For 2015 I think it's five states. And one

25 state, that's Puerto Rico.

1 Q. Okay. What are the other states?
2 A. Illinois, Iowa, Georgia, New Jersey, Rhode
3 Island and Vermont.
4 Q. And Puerto Rico is --
5 A. And then Puerto Rico, okay, so Puerto Rico and
6 those are the ones for departments of insurance or AG.
7 And then California, Arizona, and Vermont for consumer
8 advocate.
9 Q. Have you ever worked for a regulatory agency?
10 A. No. The closest I've come is Blue Cross Blue
11 Shield Association which my role was regulatory in looking
12 at the solvency of the health plans and coming up with
13 plans to improve solvency and following through on those
14 plans. But it wasn't a regulatory agency.
15 Q. Do you have any professional experience in
16 your work with health care rate reviews with reviewing
17 solvency of health insurance carriers?
18 A. Not as much with the rate reviews as -- well I
19 played kind of a key role in the development of risk-based
20 capital formula, and have been following up with the NAIC
21 and as part of the Academy of Actuaries have written a
22 number of comment letters on changes to risk-based
23 capital, including proposed changes to risk-based capital
24 for the additional risk of ACA.
25 I've done a number of financial exams for

1 insurance departments of carriers that include solvency.
2 And I've been an expert for a number of Form A filings
3 with business associations, mergers, and with companies
4 going for profit and solvency was, of course, a big part
5 of that issue too.
6 Q. And when you refer to N-A-I-C --
7 A. National Association of Insurance
8 Commissioners.
9 Q. Have you done any work related to solvency as
10 part of the work that you described with the Blue Cross
11 Blue Shield Association?
12 A. As I said, one of my major roles when I was
13 with Blue Cross Blue Shield Association was monitoring
14 Blue Cross Blue Shield plans whose solvency was a concern.
15 Working with them to come up with plans to improve their
16 solvency level and following through on those plans.
17 Q. And when did you do that work?
18 A. '93 to '97-ish. It's on my CV when I was
19 doing that.
20 Q. I'm not planning to ask further questions
21 about Ms. Novak's qualifications. I didn't know if the
22 process would include a voir dire at this point from Blue
23 Cross?
24 MR. HOGAN: Include what?
25 MS. HENKIN: A voir dire. We already

1 had stipulated to her CV. I think we can
2 continue on to the substantive questions,
3 and we have the qualifications, and she has
4 confirmed those. And we have no objection
5 over here.
6 MS. RICHARDSON: Okay. Thank you.
7 BY MS. RICHARDSON:
8 Q. Again, I'm going to refer you primarily in
9 your testimony to Exhibit 10 which is the actuarial
10 opinion that you have provided. Could you describe what
11 procedures you use in performing your actuarial review and
12 analysis of the rate filing at issue today?
13 A. It's the same process we used in reviewing
14 rate filings in other states. First we do a summary of
15 the rate filing and kind of the format that we are used to
16 and are consistent with so we can compare.
17 We have a series of questions that are part of
18 the effective rate review process plus a few that I have
19 added. And we go through those questions to see if we can
20 answer them. Are the trends appropriate, are they
21 appropriate in the marketplace. Those types of questions.
22 Ones we can't answer we develop a list of questions to ask
23 called objections in the SERFF terminology.
24 Whoever has been assigned the rate filing has
25 that peer reviewed by one of the other senior actuaries to

1 make sure that we didn't miss something and then get
2 answers to those objections and come up with our
3 conclusions, and then we have those conclusions peer
4 reviewed.
5 Q. Okay. And when you're referring to we and
6 our, who are the other people who are involved?
7 A. Okay. In this particular case, it was myself,
8 is primary, and I might have an actuarial student that
9 does a lot of summarization and research and calculations.
10 In most states we look at the whole market, and he'll put
11 things side-by-side for me. And then my peer reviewer in
12 Vermont was a subcontractor of mine, Barbara Niehus, N-I-E
13 -H-U-S.
14 Q. And could you explain what sources of
15 information and data you used in your analysis of the rate
16 filing today?
17 A. The rate filing itself, all of the questions
18 from Lewis & Ellis, the answers to the questions from
19 Lewis & Ellis and the financial statement.
20 Q. Subsequent to filing your report dated August
21 4, did you file a supplemental report?
22 A. I filed supplemental information after I had a
23 little bit more time to review some.
24 Q. And do you have Exhibit 10A?
25 A. Yes, I do.

1 Q. Could you explain what that is?
2 A. There were some materials that I received
3 after my report, and this is an acknowledgment that I had
4 received those materials, and that my opinion didn't
5 change based upon those materials, but they did give me
6 some additional information.
7 Q. Okay. And but that information was the fourth
8 set of interrogatories from Lewis & Ellis and two response
9 letters to that?
10 A. Correct.
11 Q. Are the data and information that you relied
12 on in preparing your testimony and your report the type
13 that are reasonably relied on when actuaries would review
14 health insurance rates?
15 A. Yes. Very consistent with information that we
16 normally get.
17 Q. So I'd like to direct you to sections of your
18 report where you describe your conclusions, which is
19 starting at page nine. And could you explain what your
20 conclusion in your report is about whether the rate
21 requested by Blue Cross Blue Shield should be modified?
22 A. The one modification that I had identified was
23 that the transitional reinsurance program they used the 70
24 thousand dollar attachment point. And I recommended the
25 use of a 45 thousand dollar attachment point.

1 Q. And could you review your reasons for doing
2 that, for making that recommendation?
3 A. Yeah. There were really three. And the first
4 one that I mention is probably the most important to me.
5 And that is that CMS publicly came out and said that they
6 intended to make that proposal. I have been very --
7 working very closely with CMS first as a client, but then
8 as reviewing rates for the work we did with the Academy of
9 Actuaries, we interact with CCIOO directly to try to get
10 guidance. I find they are very reluctant to put anything
11 in writing. Very, very reluctant. If they put something
12 in writing it shows to me a strong intention to follow
13 through on it. And further indication to me is that they
14 did do it this year. That they did make that adjustment
15 this year when circumstances were right for it and when
16 they decided that circumstances were such that they would
17 make adjustments.
18 And I don't think I used the word windfall,
19 but I also did from some of the exhibits interpret that
20 there was an advantage last year to Blue Cross Blue Shield
21 of Vermont from the lowering of the attachment point, and
22 that would in some way counteract any potential for next
23 year.
24 Q. And you heard testimony from Paul Schultz
25 relevant to the effect for Blue Cross Blue Shield on the

1 lowering of the attachment point in 2014. Did anything in
2 his testimony or exhibit he presented change your opinion?
3 A. No.
4 Q. Could you just again emphasize the point in
5 your report to the language that you believe shows an
6 intention to change the attachment point. I think I
7 quoted in here, so we don't have to go to the exact
8 exhibit, but it was the exhibit that we looked at earlier.
9 And what CMS or HHS said is that we intend to propose
10 changes to the reinsurance parameters for 2015. Generally
11 consistent with these recommendations, specifically in the
12 proposed 2016 payment notice, we intend to propose a lower
13 2015 attachment point from $70,000 to $45,000. We may
14 also propose to modify the target 2015 coinsurance rate
15 based on estimates of rollover of funding from 2014 and
16 estimates of collections and payments for 2015. These
17 proposals will be subject to notice and comment
18 rulemaking.
19 So in quoting this language did you intend to
20 say this was a final rule?
21 A. No.
22 Q. A proposed --
23 A. It's proposed.
24 Q. -- statement of intention?
25 A. Maybe the issue is that the document is called

1 the Final Rule for Benefit and Payment Parameters. That's
2 the document that this was quoted in.
3 Q. But would you agree with the other witnesses
4 that this is -- this May document indicates an intention
5 but it hasn't actually changed the parameters?
6 A. Yes, I would agree with that.
7 Q. Would you agree that the final rule would be
8 likely to be issued in the time frame that has been
9 suggested between November and March?
10 A. Yes. And I would suspect it would be later in
11 that time period rather than earlier.
12 Q. Have you had experience looking in the other
13 rate filings for this year, for the 2015 rates from other
14 states, with reviewing the attachment point for
15 transitional reinsurance?
16 A. Yes, I have.
17 Q. And what are you aware of that has happened in
18 other states?
19 A. In most states, especially ones that have
20 multiple carriers, we see both the $70,000 and the $45,000
21 used. I have not determined what percent use which one,
22 but we see both.
23 Q. Okay. And are you aware of any rate review
24 decisions that have required using the 45 thousand dollar
25 --

1 A. I review rates in Rhode Island which is a very
2 similar state to Vermont in that they have one major
3 carrier in the individual market. I review the rates of
4 the individual market there along with the actuary
5 actually that did the peer review in Vermont, Barbara
6 Niehus. The original filing was for 70 thousand dollar
7 attachment point. And I think the final was that Blue
8 Cross Blue Shield voluntarily reduced it to 45,000 after
9 some questions.
10 Q. Are you aware of decisions in any other
11 states?
12 A. I've seen public information about
13 Connecticut. And there it was reduced from 70,000 to
14 45,000.
15 Q. Okay. Now I wanted to briefly review your
16 assessment of the recommendations in the Lewis & Ellis
17 report. So turning to Exhibit 8. And I would like to
18 just ask you briefly to review the paragraph at the top of
19 page nine. The exhibit --
20 A. Okay.
21 Q. -- which summarizes recommendations that Lewis
22 & Ellis is making for modifications. And could you review
23 the first bullet point at the top of the page and just
24 briefly summarize your understanding of that?
25 A. The recommendation is to use the standard HHS

1 induced utilization factors for the benefit of richness
2 factors. And --
3 Q. And do you agree with that recommendation?
4 A. I agree that the HHS-induced utilization
5 factors are probably the best induced utilization that we
6 have that separates out the increased demand because of
7 lower cost versus selection.
8 Q. Okay. I would ask you now to look at the
9 recommendation, the second recommendation about the
10 adjusting the -- adjusting the AV by changes in family
11 tiering.
12 A. Yes, we are all trying --
13 Q. The changes in family tiering adjustment
14 factor.
15 A. We are all trying to get the geography right,
16 and I agree with that recommendation.
17 Q. I would then ask you to look at the last
18 bullet and summarize what the -- those analysis
19 recommendation is in that bullet point?
20 A. Similar to my recommendation to use the
21 reduced reinsurance parameter of 45,000 dollars, estimate
22 the reinsurance recovery and they have calculated an
23 impact on the rate of a negative two percent.
24 Q. So do you agree with that recommendation,
25 consistent with yours?

1 A. Yes. That is consistent with my
2 recommendation.
3 Q. Relevant to the issue of the transitional
4 reinsurance attachment both you and Lewis & Ellis are
5 recommending the lower attachment point of $45,000. So if
6 HHS does lower the attachment point to $45,000, and this
7 filing is not modified and continues to use a rate which
8 is based on the higher 70 thousand dollar attachment
9 point, what effect would that have on Blue Cross Blue
10 Shield's contribution to reserves or surplus?
11 A. If all else was held equal and that was the
12 only change, it would increase it.
13 Q. In your testimony just now in your report
14 you've indicated that you reviewed the 2013 annual
15 statement of Blue Cross Blue Shield as part of your review
16 of the filing.
17 A. Yes.
18 Q. And could you explain why you reviewed that
19 document?
20 A. Part of my process, I think all of us have a
21 slightly different process, part of my process which
22 actually is indicated by having effective rate review
23 process is to look at solvency issues, and having been one
24 of the creators of risk-based capital, I always look at
25 risk-based capital levels and trends.

1 MS. HUGHES: I would object. This goes
2 beyond the scope of the expert's report that
3 we were provided.
4 MS. RICHARDSON: There has been a
5 discussion about solvency. I'm trying to
6 establish what was used.
7 MS. HENKIN: I'm going to allow this.
8 It's relevant to what we have discussed here
9 as the advocate's response. I'm going to
10 allow this.
11 MS. HUGHES: I would like the record to
12 reflect a continuing objection.
13 MS. HENKIN: The record reflects a
14 continuing objection.
15 BY MS. RICHARDSON:
16 Q. Referring you to Exhibit 11 which is the 2013
17 annual statement, is this the document that you were
18 referring to that you reviewed?
19 A. Yes.
20 Q. And you mentioned that you reviewed it in
21 connection with solvency. Was there any particular
22 document that you used?
23 A. I used the five-year historic exhibit which is
24 on page 29. And specifically, when I look at risk-based
25 capital, rows 14 and 15.

1 Q. Okay. And without -- can you explain very
2 briefly what risk-based capital is?
3 A. Risk-based capital is the -- it's actually a
4 set of intervention levels developed by the National
5 Association of Insurance Commissioners. And the
6 percentage used in order to determine those intervention
7 levels is the ratio of total adjusted capital to
8 authorized control level risk-based capital.
9 Q. Okay. Is it correct to say this chart doesn't
10 directly provide the risk-based capital numbers for the
11 carrier?
12 A. No. You have to divide two numbers to get the
13 percentage.
14 Q. And without again giving specifics about the
15 risk-based capital, can you describe what the calculation
16 you used using this document is?
17 A. Yeah, I divide row 14 total adjusted capital
18 by row 15 authorized control level risk-based capital.
19 Q. And after reviewing this material and the
20 annual statement, do you have an opinion about whether the
21 risk-based capital level as of the end of 2013 with this
22 report is adequate?
23 A. I would say it's adequate.
24 Q. I don't have further questions.
25 CROSS EXAMINATION

1 BY MS. HUGHES:
2 Q. So Ms. Novak, did the whole number of
3 individuals that Blue Cross estimated in its 2014 exchange
4 filing actually materialize in 2014?
5 A. I don't know that I've done that calculation.
6 But I would be -- I can't answer that from my own
7 knowledge or calculation.
8 Q. So in your testimony you quoted page 7, you
9 quoted from a rule, and you attributed that to the benefit
10 and payment parameter rule, final rule for 2015.
11 A. The one that was published in May. Yes.
12 Q. In May. So was that --
13 A. May 27.
14 Q. Was that the benefit and payment parameter
15 rule that was published in May?
16 A. Yes.
17 Q. Do you have the binder in front of you?
18 A. I do.
19 Q. And can you look at the third from the end
20 page in Exhibit 12. And can you read the title of the
21 rule?
22 MS. HENKIN: Could you please answer yes
23 also for the record.
24 THE WITNESS: I'm sorry.
25 BY MS. HUGHES:

1 Q. Can you read the title of the rule from May
2 27.
3 A. I'm sorry. I always have a hard time finding
4 the title. The action is final rule. And the title page
5 says Patient Protection and Affordable Care Act Exchange
6 in Insurance Market Standards for 2015 and Beyond Final
7 Rule.
8 Q. So does that contain the words payment and
9 benefit parameters anywhere?
10 A. No, it does not.
11 Q. If you flip back to the very first page
12 Exhibit 12, can you read the title of that rule?
13 A. Patient Protection of Affordable Care HHS
14 Notice of Benefit and Payment Parameters for 2015 Final
15 Rule.
16 Q. Okay. So your opinion quotes from this
17 earlier rule.
18 A. No, it quotes from the later one.
19 Q. So your --
20 A. Title of it was incorrect.
21 Q. Your cross reference is incorrect?
22 A. The title I gave it is incorrect. The
23 reference that I gave and in the footnote I believe I gave
24 refers to the May 27. I have to look at the footnote and
25 the quotes from the May 27.

1 Q. But you labeled that the Final Rule for the
2 Benefit and Payment Parameters for 2015. Is that the
3 Final Rule for the Benefit and Payment Parameters for 2015
4 that you were quoting from?
5 A. No. It's the Final Rule for the Patient
6 Protection and Affordable Care Act Exchange and Insurance
7 Market Standards for 2015 and beyond.
8 Q. Okay. So the May 27 rule actually did not
9 change the 2015 parameters per se?
10 A. No. It just indicated a proposal to change
11 them.
12 Q. If the Board adopts your recommendation to
13 decrease the attachment point to $45,000 and you're wrong,
14 will the exchange rates be inadequate?
15 A. Yes. If the assumption is wrong, the exchange
16 rates will be inadequate.
17 Q. Thank you. No further questions.
18 MS. HENKIN: Do you have anything else?
19 MS. RICHARDSON: No.
20 MS. HENKIN: Okay. Dr. Rambur.
21 MS. RAMBUR: Okay. Thank you. Just a
22 couple of questions. You testified that you
23 agree with L&E's recommendation about the
24 attachment point.
25 Do you also agree with Mr. Dillon's

1 earlier testimony that it's not optimal to
2 have different assumptions when there is so
3 few carriers in the state, or do you
4 disagree with that?
5 THE WITNESS: Yes. When there is so few
6 carriers, there is a lot of assumptions we
7 all know go into a rate filing. And some of
8 them it's totally appropriate to have
9 different assumptions, but one that is a
10 matter of predicting a particular future
11 event in this case what HHS will do.
12 I agree that those it just makes sense
13 for them to be the same.
14 MS. RAMBUR: And my second question
15 relates to DFR's earlier testimony which
16 really focused on solvency being a key
17 responsibility in the sense to the public.
18 And also holding that in my attention and
19 also the statement in the document, I'll
20 just read this, in determining appropriate
21 rates, decision makers should give any
22 benefit of the doubt to consumers and to
23 taxpayers who together are the cost of
24 Vermont's health insurance coverage. So we
25 as a Green Mountain Care Board hold a

1 responsibility in a sense to the public in
2 that way but also through solvency.
3 Could you talk that through with me a
4 little bit given that we don't have the
5 privilege of having one piece to look at?
6 THE WITNESS: Yes. I can. Giving
7 advantage to the consumer, for instance,
8 saying rather than give a rate increase now
9 I would rather leave that money in their
10 pocket, and if need be, have a larger
11 increase later, there is a tradeoff there.
12 You know, because of the larger increase
13 later might be a problem. But usually the
14 advantage is to leave the money in the
15 consumer's pocket from the consumer
16 perspective.
17 But on the other hand, I've done a lot
18 of work with solvency, and you have to
19 protect the solvency of the insurance
20 company. So the question becomes at what
21 point is that solvency threatened. You
22 know, how close can you get. How -- at what
23 point is it threatened, and do you have to
24 take that more into consideration than the
25 consumer?

1 MS. RAMBUR: Okay. Thank you.
2 MR. GOBEILLE: All set. Thank you.
3 DR. RAMSAY: I'm all set.
4 MS. HENKIN: Anything else with this
5 witness?
6 MS. RICHARDSON: No.
7 MS. HENKIN: Okay. And you have no
8 further witnesses.
9 MS. RICHARDSON: That was our one
10 witness.
11 MS. HENKIN: All right. Thank you very
12 much, Ms. Novak.
13 With that, we are going to conclude this
14 portion of the hearing. I don't know if
15 anyone has signed up from the public. I did
16 not check that list. I don't know. We do
17 have a period for public comment. If in
18 fact there is public comment, not questions,
19 so if witnesses very specific to this
20 filing, and no one has signed up, so if
21 anyone wants to make written comment that's
22 here because they don't want to speak at
23 this point, that information is available on
24 the rate review Web site that you can link
25 on to through the Board's Web site, or you

1 can call the 828-2177 number is our number,
2 or you can write snail mail, and comment is
3 open until the 18th for the parties. Memos
4 are due on the 20th of this month. And a
5 decision is going to be issued in this no
6 later than the second of September. After
7 our nice, long, holiday weekend there should
8 be a decision. And it will also be -- that
9 will be the written decision which will be
10 issued, and it will also be announced
11 decision at the next following Board
12 meeting.
13 Tomorrow, for anyone who is really
14 interested in being back, we have the MVP
15 hearing starting in this room again at 9:00
16 A.M. And if there is nothing else, I'm
17 going to conclude the hearing.
18 MR. GOBEILLE: Thank you, Judy. I will
19 take the meeting back over only to formally
20 ask for a motion to adjourn.
21 MS. RAMBUR: So moved.
22 MR. GOBEILLE: Is there a second?
23 MS. HEIN: Second.
24 MS. HENKIN: Any discussion? All those
25 in favor?

1 ALL BOARD MEMBERS: Aye.
2 MR. GOBEILLE: Any opposed?
3 (No response.)
4 MR. GOBEILLE: Thank you everyone.
5 (Whereupon, the proceeding was
6 adjourned at 1:10 p.m.)
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1 C E R T I F I C A T E

2

3 I, Kim U. Sears, do hereby certify that I
4 recorded by stenographic means the hearing re: Docket
5 Number 018-14, at Room 11 of the Vermont State House,
6 State Street, Montpelier, Vermont, on August 12, 2014,
7 beginning at 9 a.m.
8 I further certify that the foregoing
9 testimony was taken by me stenographically and thereafter
10 reduced to typewriting and the foregoing 170 pages are a
11 transcript of the stenograph notes taken by me of the
12 evidence and the proceedings to the best of my ability.
13 I further certify that I am not related to
14 any of the parties thereto or their counsel, and I am in
15 no way interested in the outcome of said cause.
16 Dated at Williston, Vermont, this 13th day
17 of August, 2014.
18 ______________________
19 Kim U. Sears, RPR
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