

**STATE OF VERMONT  
GREEN MOUNTAIN CARE BOARD**

In re:  
BlueCross and BlueShield of Vermont  
2021 Individual and Small Group Rate  
Filing

GMCB-005-20rr

SERFF No. BCVT-131936226

**BlueCross and BlueShield Vermont's Post-Hearing Memorandum**

Dated: July 28, 2020

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For the reasons set forth below and based upon the evidence and arguments in the record and presented at hearing, BCBSVT respectfully asks that the Board approve its proposed rates as modified by the adjustments recommended by Lewis & Ellis (L&E).<sup>1</sup>

## **INTRODUCTION**

When a proposed rate is actuarially sound, there are only two choices: approve it, or force the insurer to operate at a loss. There is no dispute that BCBSVT's proposed rates are actuarially sound. L&E, the Board's actuary, closely reviewed the rates and suggested only minor adjustments. BCBSVT agreed with most of them and chose not to dispute L&E's utilization trend. The HCA did not even attempt to question the rate development.

Instead, the HCA, with its counsel badgering witnesses and needlessly prolonging the hearing, pushed a new and obviously untenable theory of rate construction: Forget sound actuarial practice (even though Vermont law requires it), brush aside any thought of sustainability, and use these rates to react in the moment to current events. The HCA went so far as to accuse BCBSVT of profiting from the pandemic and offered that charge as its primary reason for denying the proposed rates.

The undisputed evidence refutes the HCA's accusation. The short-term slowdown in claims this spring is only one part of the complex and still-unfolding pandemic. BCBSVT's COVID modeling and RBC outlook show that the overall impact

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<sup>1</sup> References to "the proposed rates" should be understood to mean the rates proposed in the filing as modified if L&E's recommendations are accepted, unless otherwise noted.

of the pandemic on reserves is likely to be neutral—and the potential of a negative impact remains a real risk. Yet, unlike its competitor, BCBSVT has not included any additional pandemic-related costs in its 2021 rates, instead choosing to pay those costs from reserves. It will cover testing, treatment, the deferral to 2021 of care originally scheduled to take place during 2020, and any vaccine costs from its reserves. In addition, it has funded targeted measures that assist providers with cash advances to ease cash flow problems and provided flexibility with premium payments to allow Vermonters to continue their coverage despite nonpayment, among other measures that eased provider burden or reduced member cost sharing. That is the proper function of reserves: to protect ratepayers from unexpected costs or the potential loss of access to care. Ex. 12 at 10; Ex 13 at 11-13; Tr. 28, 216-17.

At the conclusion of the hearing, the HCA himself used public comments from Vermonters to powerfully underscore harsh realities that bear repeating: Health care costs continue to outpace most measures of economic growth; many Vermonters cannot afford those costs; and the pandemic has understandably ratcheted up those concerns and the fear they bring.

BCBSVT is well aware of these painful truths. But the HCA left out this key fact: As long as health care keeps getting more expensive, insurance premiums have to rise too. The math does not work any other way—without the premiums, health care providers cannot be paid at levels that allow them to remain viable. Funding the ordinary, expected costs of health care out of BCBSVT's reserves is unsustainable

and dangerous. Its reserves, which amount to about three months of BCBSVT's typical claims costs, cannot prop up Vermont's health care system.

As explained below, the proposed rates satisfy the Board's rate review criteria, for three main reasons: First, the undisputed evidence shows that the proposed rates are actuarially sound and will enable BCBSVT to serve its members' current health care needs while not placing their future health care access in jeopardy. Second, it is undisputed that BCBSVT is properly using reserves to make the rates as affordable as possible by covering pandemic-related costs and thereby saving ratepayers at least \$10 million, or -3.2 percent, of projected 2021 claims costs. Third, the proposed rates do not ask 2021 policyholders to contribute one penny towards resolution of the pension loss; try as he might, the HCA's counsel was unable to dent this critical and undisputed fact. In sum, the rates as modified by L&E satisfy the statutory criteria and should be approved.<sup>2</sup>

### **LEGAL FRAMEWORK**

The rate review process requires the Board to balance a set of interdependent criteria to assess "whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State." 8 V.S.A. § 4062(a)(3). Given the

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<sup>2</sup> BCBSVT notes that the following statutory criteria were not discussed, let alone disputed, at the hearing, and are amply satisfied by the evidence in the record: that the proposed rates: are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; are not unfairly discriminatory; promote quality care; and promote access to care. The memorandum primarily focuses on the criteria that the parties and the Board discussed at the hearing: whether the rates: are affordable; protect BCBSVT's solvency; and are adequate and not excessive.

complexities of the health care system, the Board must grapple with the inevitable push and pull among cost, access, quality, and solvency. *See In re BCBSVT Large Group Filing et al.*, GMCB-002/003-19rr, at 6 (May 23, 2019) (observing that the statutory standards “are ‘general and open-ended,’ the result of ‘the fluidity inherent in concepts of quality care, access, and affordability’” (quoting *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16)). Indeed, the Board has recognized that failing to properly balance these factors “imperils Vermonters’ access to care.” *Id.* Further, recognizing that at its core a proposed rate is an actuarial projection of future health care costs, the Board’s rate review rule added that the Board must also find that the proposed rates are not excessive, inadequate, or unfairly discriminatory. Rule 2.000, § 2.301(b).

## ARGUMENT

### **I. It is undisputed that the proposed rates are actuarially justified.**

This foundational piece of the Board’s review is straightforward this year. As L&E’s David Dillon explains in his prefiled testimony, rates are adequate “if they provide for payment of claims, administrative expenses, taxes, and regulatory fees and have reasonable contingency or profit margins,” and they are excessive “if they exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins.” Ex. 16 at 4-5; *see also* Ex. 11 at 24. The evidence in the record is unequivocal, and unchallenged, that the proposed rates are adequate and not excessive.

To begin with, the information presented by BCBSVT in the initial filing, its responses to the Board’s, the HCA’s, and L&E’s questions, and the prefiled testimony

of Chief Actuary Paul A. Schultz amply document that the rates are adequate without being excessive. *See* Exs. 1-9, 11. Mr. Schultz confirmed this at hearing, explaining that, like last year, specialty pharmaceuticals are driving up claim costs and causing most of the proposed rate increase—about 3.7 percentage points of the proposed increase. Tr. 80-81. Dr. McIntosh provided clinical context for increased costs that are driven by lifesaving new treatments that come with a steep price tag. Tr. 29-30. There is no evidence in the record suggesting otherwise.

The evidence also shows that BCBSVT's projected cost of insurance<sup>3</sup> is low. Administrative costs plus CTR totals 9.6 percent of the requested rates. Ms. Greene described BCBSVT's focus on "operating efficiency" and its ongoing efforts to run the organization as efficiently as possible and keep administrative costs at or below 7% of premium enterprise-wide. Tr. 220-21. Answering questions from Board Member Usifer, Mr. Schultz explained that projected 2021 administrative costs remain very low compared to the industry, especially when viewed as a percentage of premium, which provides a more accurate view than a PMPM basis. Tr. 168-69 (percentage of premium is "more apt comparison" because administrative costs are variable and depend on the number of claims and amount of care consumed). In response to similar questions, Mr. Dillon made the same point, explaining that "Blue Cross plans do tend to be sicker, tend to have more claims," and that "single-state, smaller Blues don't have as big a . . . membership base to spread their admin as compared to the large insurers." Tr. 405.

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<sup>3</sup> Mr. Schultz defined "cost of insurance" as administrative costs plus CTR plus profit. Ex. 11 at 10; Tr. 111. BCBSVT's rates do not include any profit. Ex. 12 at 3.

L&E confirmed that the proposed rates are actuarially sound. Their analysis of the filing concluded that, subject to six recommended changes,<sup>4</sup> the rates are adequate and not excessive. Ex. 9 at 23; Tr. 396. L&E highlighted that once again BCBSVT's administrative cost trend and proposed CTR are very low relative to the industry, by any measure. Ex. 9 at 19-23; Tr. 399, 405.

As both Mr. Schultz and L&E explained, the Board must address the hospital budget process in determining the unit cost trend in the final rates. BCBSVT assumed in the Filing that the Board would approve hospital budgets similar to last year. Ex. 15 at 4. If, however, the hospital budget process results in higher unit cost trends, the proposed rates will no longer be adequate. As Mr. Dillon testified, the result of the hospital budget review "needs to be implemented" whether "it's an up, down, or sideways." Tr. 395. BCBSVT agrees with L&E that, to the extent updated information about unit cost trends is available via the July 31, 2020 hospital budget submissions, that information must be used to update the assumed unit cost trends in the Filing. Ex. 9 at 13, 23. In short, the Board must ensure that there is balance between its treatment of these rates and the hospital's commercial rate increases.

Indeed, the Board has the regulatory tools to do so: In addition to controlling the size of hospitals' individual and collective commercial rate increases, the Board "shall set reasonable rates for health care professionals . . . in order to have a *consistent* reimbursement amount accepted by these persons." 18 V.S.A. § 9376(b)(1)

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<sup>4</sup> As explained in Mr. Schultz's supplemental prefiled testimony, BCBSVT agreed with five of the six, and chose not to dispute L&E's recommended change to BCBSVT's utilization trend assumption. See Ex. 15 at 2-4.



(emphasis added). The Board’s rate-setting authority enables it to, for example, eliminate or reduce the cost-shift (by approving hospital commercial rate increases closer to Medicaid/Medicare increases) and to enhance parity among providers by reducing academic medical center revenue.

The importance of the Board’s regulatory authority over hospital budgets and rates was apparent from the candid discussion of negotiations in executive session. That confidential session directly contradicts the Board’s repeated claim—including earlier this month—that its “continued downward pressure on premium rate increases will foster vigorous contractual negotiations between the insurer and providers.” *In re BCBSVT Large Group Filing et al.*, GMCB-002/003-20rr, at (July 17, 2020); *In re BCBSVT Large Group Filing et al.*, GMCB-002/003-19rr, at 7 (May 23, 2019); *see also In re BCBSVT 2020 VISG Filing*, GMCB-006-19rr, at 17 (Aug. 8, 2019) (“We expect BCBSVT to . . . us[e] its substantial bargaining power to reduce unnecessary utilization and negotiate lower prices with providers.”). The complexities of the system and interplay between hospital reimbursement rates and insurance rates is also reflected in current concerns about lost hospital revenues. The Board has pushed BCBSVT to reduce costs by reducing payments to providers. Meanwhile, the sharp decline in hospital revenue this spring prompted immediate concern that the revenue shortfall be made up to protect hospitals’ viability. There is no little irony to the fact that the Board may approve higher hospital rates to replace their lost revenues at the same that it directs BCBSVT to find ways to reduce its payments to

hospitals. This system needs fixing—but the record shows that it cannot be fixed by reducing premiums below actuarially supported levels.

The HCA did not attempt to question or probe the actuarial underpinnings of the proposed rates, nor present or develop evidence contrary to the above discussion of the interplay between hospital budgets and insurance rates. On this record, there is only one conclusion: the proposed rates are adequate (subject to the outcome of the hospital budget review process) and not excessive.

## **II. The proposed rates are affordable and promote access to quality care while appropriately protecting solvency.**

Year after year, this part of the Board’s analysis collides with painful truths: Health care costs are unaffordable for many Vermonters. Health care costs are growing faster than most other economic measures. The subsidy “cliff” is an obstacle for many working families seeking insurance. The HCA’s memorandum, as in past years, will document this problem with government data and other credible sources.

These hard truths do not, as the HCA contends, authorize the Board to slash the rates. Affordability must be evaluated along with the statutory instructions that the rates be adequate but not excessive (as explained above), promote access and quality, and protect solvency. Both Mr. Schultz and Mr. Dillon explained that some of BCBSVT’s costs are attributed to its overall less-healthy population as compared to MVP. Tr. 165, 400-01, 405. That point bears emphasis: Vermonters who need health care because of their health conditions are more likely to choose BCBSVT, even though the premium is higher. That choice reflects their confidence in BCBSVT—that it will help them navigate what can be a confusing health care

landscape and it will pay for their health care needs. By advocating that BCBSVT's premiums be reduced well below the cost of providing care, the HCA is ignoring the fact that health care providers need to be paid for the care they deliver to policyholders.

Inadequate rates undermine the health care system. The money that BCBSVT takes in as premiums *is* the money it pays out to providers. Because inadequate rates do not reduce the actual cost of health care, any supposed gain in affordability is a chimera. Future policyholders will have to pay for the underfunded costs of current policyholders through higher rates. Threatening insurer solvency harms consumers too. It increases the risk that an insurer will be driven out of the Vermont market, thus reducing competition. And in the worst-case scenario, insolvency would place the entire burden of the cost of care on consumers, who cannot afford it. The full funding of adequate rates is thereby critical to both insurer solvency and affordability.

The HCA's focus on what individuals can afford to pay in premium misses another critical aspect of affordability. Because of Vermont's longstanding community-rating laws, rates must be developed and assessed for the population or community that purchases the plans, not on the circumstances of specific individuals. Tr. 110. For a Vermonter who needs a specialty drug that costs over \$24,000 a month, BCBSVT's \$675 monthly premium is unquestionably affordable—it is far, far less expensive than the cost of their health care. But it requires 39 Vermonters who use no health care whatsoever to support their one neighbor with an expensive health

care need. Those healthier Vermonters may view their premiums as unaffordable. But what they contribute is what it takes to pay for the cost of health care for the community of 40, and to pay for the assurance that they, too, will be covered if an accident or illness changes their circumstances. Vermont's community rating laws require this type of calculus, just on a much larger scale: 88% of premiums are used to fund the health care needs of the community.<sup>5</sup>

Against that backdrop, BCBSVT has taken proactive steps to keep the proposed rates as low as possible, and thereby enable the Board to conclude that the proposed rates satisfy the affordability criterion, while not undermining the others.

First, BCBSVT shielded ratepayers from pandemic-related costs by funding them out of reserves rather than including them in premium. *See* Ex. 1 at 43 (filing includes "COVID-19 impact of zero within the 2021 premium rates."); Ex. 12 at 10, 32; Tr. 98, 216-217. Although at the time of filing BCBSVT did not have sufficient information to estimate the 2021 costs of the pandemic, the modeling it completed in early July enables such a projection. *See* Exs. 6, 7. As Mr. Schultz explained, the model indicates that the COVID-19 pandemic is likely to have an impact on 2021 claim costs that is "fairly significantly" higher than the claim costs projected in the Filing. Tr. 90. Ex. 15 at 6. Over the course of 2020 and 2021, the modeling showed "really no scenarios" that result in significantly lower claims costs over that two-year period. Tr. 90-91.

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<sup>5</sup> The remaining 12% represents taxes and fees as set by federal and state government, and BCBSVT's industry-low cost of insurance.

The model can be used to estimate that 2021 claim costs are likely to exceed those in the filing by at least \$9.6 million. Tr. 98. If BCBSVT were to refile these rates today, but without its commitment to keep COVID costs out of premium, it would file a 9.7% increase (before applying L&E's recommendations). *Id.* Put differently, BCBSVT is absorbing 3.2% of premium rather than passing 2021 pandemic related costs along to ratepayers. *Id.* This is no different from a 3.2% annual premium discount or a \$10 million rebate. *Id.* BCBSVT has already returned the entirety of the expected net reduction in 2020 claims costs by funding a portion of 2021 premiums out of surplus.

L&E reviewed BCBSVT's COVID modeling, and concluded that BCBSVT's "modeling approach to assess [a] wide range of scenarios was reasonable and appropriate." Tr. 398. Notably, L&E's David Dillon co-authored the American Academy of Actuaries "recently released Issue Brief on the Drivers of Health Insurance Premium Changes which includes the effects of COVID-19." Ex. 16 at 3. Across the 50+ filings Mr. Dillon and his colleagues at L&E have reviewed this year, they are observing COVID impacts of 0 to 3-4 percent. Tr. 397.

Oliver Wyman suggested that BCBSVT's COVID modeling was "conservative," and that the most likely range of outcomes ranges up to 105 basis points of RBC. But that math simply does not work. As Mr. Schultz testified, approximately \$20 million in care was deferred in March-May, while BCBSVT has paid \$4.4 million in COVID-related claims through July 14. Tr. 210. That means, at most, BCBSVT could see a \$15.6 million positive RBC impact, which translates to 73 basis points, if no further

COVID-related expenses occur over the next two years, and no additional deferred care returns. Because both of these assumptions are highly implausible, RBC will almost certainly be far less favorable than this figure. As Dr. McIntosh testified, BCBSVT is likely to see increased claims costs for COVID-19 treatment, especially as fall and winter bring people inside and schools and colleges reopen. Ex. 13 at 6-9; Tr. 24-25. And deferred care will return, because the need for that care has not changed and hospitals are improving their ability to continue providing routine care while also treating COVID-19 patients. Ex. 13 at 11; Tr. 36-38 (“we’re much more likely to see an ongoing combination of regular, ongoing care and then outbursts of Covid that are getting treated also separately in the same institution”).

Second, BCBSVT has proactively implemented cost-cutting strategies to mitigate premium increases. BCBSVT has continued to work closely with its pharmacy benefit manager to improve network pricing and maximize rebates. It has also developed strategies in partnership with its contracted lab benefit manager that have dramatically reduced expenditures on laboratory services. Altogether, these rate mitigation measures result in a reduction of 1.7 percent, or a projected \$5.2 million savings. Ex. 1, § 1.5 at 15; § 3.4.7.1 at 35-38; § 3.4.7.2 at 40. These savings stand in stark contrast to the modest 0.4 percent premium increase due to increases in BCBSVT’s administrative costs. Ex. 1, § 1.8 at 19.

Third, as discussed above, BCBSVT has maintained its track record of keeping its administrative costs and CTR lean. By definition, that means that BCBSVT has also maintained its traditionally high medical loss ratio. This year, its projected ACA

MLR is 90.3 percent, again well above the 80% threshold below which the Affordable Care Act requires insurers to rebate premiums in order to promote affordability.<sup>6</sup>

Taken together, these actions demonstrate BCBSVT's commitment to, and success in, keeping the proposed rates as low as possible without being inadequate. That is precisely the balance point among the interdependent criteria of affordability, access, and quality, as they are all supported by solvency. Reducing the proposed rates any further will upset that balance and jeopardize the goal of a sustainable health care system.

**III. The proposed rates do not reflect the pension-asset loss and it should not be part of the Board's decision.**

BCBSVT fully understands the seriousness of the loss in value of its pension assets. But this is a rate-review proceeding. It is not, and cannot be, a factfinding inquiry into the losses recently suffered by the National Retirement Trust and other pension trusts and institutional investors. That is not an area within the Board's jurisdiction—indeed, an inquiry of that kind is both irrelevant and almost certainly preempted by ERISA. *See, e.g., Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 945 (2016) (holding that state-law reporting requirements intruded upon central aspect

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<sup>6</sup> Issuers in the individual, small group and large group markets owed a record-high amount of rebates in 2019. They are projected to pay out nearly twice as much in 2020, and will likely pay out even more than that in 2021. Some issuers have generated favorable press by accelerating these rebates into 2020. Paying those rebates, however, does not signal admirable behavior. It means that they have charged excessive rates in the past. BCBSVT, in contrast, targets an MLR in the low 90s and an industry-leading cost of insurance in the single digits. BCBSVT has never paid an ACA MLR rebate, and will not approach the payout threshold in 2020 or 2021. Instead, BCBSVT offers an industry-leading cost of insurance that makes rates *as affordable as possible* up front.

of plan administration and were preempted by ERISA); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (ERISA preemption clause indicates Congress's intent to establish the regulation of employee welfare benefit plans as exclusively a federal concern).<sup>7</sup>

There are two key points that BCBSVT wants to emphasize in response to questions and concerns raised by the Board at the hearing.

First, as BCBSVT witnesses repeatedly affirmed at the hearing, not a penny of this rate request is tied to the pension loss. The rate filing would have been the same had the loss not happened. The rate has three main components: (1) the cost of providing health care in 2021 to BCBSVT's members; (2) the cost of providing insurance (administrative costs and CTR); and (3) state and federal taxes and fees. None of those components is affected by the pension loss. Notably, the filed CTR of 1.5% matches that filed in each of the last two years.

As some Board members noted, the pension loss may be relevant to BCBSVT's RBC levels. But as Commissioner Pieciak observed, the impact of the pension loss

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<sup>7</sup> The HCA's effort to exploit the pension loss at the hearing was unfortunate and short-sighted. The hearing officer drew an appropriate line in barring questions about how funds were invested and who made investment decisions—a line that the HCA's counsel repeatedly tried to cross. Tr. 238-239, 244, 247-248, 253. The HCA's counsel also offered colorful speculation about the pension assets lacking any factual support. Tr. 19-20, 241, 244. And even though the plan documents provided by BCBSVT clearly explained the functioning of the National Retirement Trust, the HCA's counsel frequently interchanged BCBSVT's own investment portfolio with the pension assets, thus trying to create a false perception that the BCBSVT Board of Trustees selected pension investments. Tr. 240-242, 244-245, 248, 250-251. Attempting to harass BCBSVT's witnesses may make good theater but has nothing to do with the Board's statutory obligation to assess the proposed rates based on the prescribed criteria. In any event, the HCA's refusal to recognize the overriding concern regarding potential litigation to recoup the losses is baffling. Undermining those efforts hurts the interests of the ratepayers the HCA is supposed to represent.



will not be known for some time, and will depend on market performance, overall pension funding levels, and the likelihood and timing of any recovery. Tr. 303-04, 319-20.

Second, BCBSVT has an unflagging duty to its retirees, employees, and ratepayers to protect their interests in trying to recover these losses. As BCBSVT explained to the Board prior to hearing, the cause of the losses is being investigated and legal counsel is advising on potential litigation. Ex. 22. BCBSVT has a strong track record of transparency and candor in its dealings with the Board and, consistent with that longstanding approach, disclosed the loss and provided additional information in advance of the hearing. But it simply cannot risk undermining the goal of recovering the pension losses. Its responses and disclosures to this Board in a public proceeding are unavoidably constrained by that overriding concern.

### **CONCLUSION**

The proposed rates should be approved. As L&E observed, based on historical outcomes, “BCBSVT has successfully projected future results.” Ex. 9 at 21. A comparison of BCBSVT’s MLR to national averages confirms that BCBSVT has been consistently on target and keeps its cost of insurance low. Ex. 23; Tr. 116-17. The proposed rates are already effectively “discounted” because they do not include the cost of returning deferred care or COVID-related costs. The rates are set at the level required to fund access to the quality care that Vermonters demand and Vermont hospitals and doctors provide. There is no basis on this record to reduce them.

Dated: July 28, 2020

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**CERTIFICATE OF SERVICE**

I certify that I have served the above Post-Hearing Memorandum on Michael Barber, Amerin Aborjaily, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Kaili Kuiper, Eric Schultheis, and Jay Angoff, counsel for the HCA, by electronic mail, Delivery Receipt requested via Microsoft Outlook, on July 28, 2020.

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