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July 7, 2020

VIA EMAIL

Michael Barber
Amerin Aborjaily
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Re: BCBSVT 2021 Vermont Individual and Small Group Rate Filing
GMCB-005-20rr
Prefiled Testimony

Dear Michael and Amerin,

Consistent with the scheduling order in this matter, we are serving prefiled testimony for four of BCBSVT's witnesses: Dr. Kate McIntosh, Ruth Greene, Paul Schultz, and Andrew Garland. Their prefiled testimony and attachments are included with this letter. In addition to the documents cited in and attached to the prefiled testimony, the witnesses may have relied upon any of the prior filings and submissions in this docket.

As we discussed at the May 22 status conference, BCBSVT expects to offer further testimony at the hearing to respond to or otherwise address ongoing developments, including the L&E actuarial memorandum and prefiled testimony, DFR's solvency opinion, and any expert report or testimony filed by the HCA. Because the COVID-19 pandemic remains a rapidly changing situation, BCBSVT may also offer additional testimony at the hearing to address any relevant changes or updates related to the pandemic. Further, as noted in Mr. Garland's prefiled testimony, to the extent BCBSVT offers testimony in its case-in-chief or in response to cross-examination or Board questions regarding BCBSVT's negotiations with health care providers, BCBSVT will request that the testimony be taken in a closed session at the hearing. Thus, although we have endeavored to simplify the remote hearing through the submission of written prefiled testimony, these filings do not represent a complete statement of the direct testimony of these witnesses.

As set forth in Section 8 of the Second Amended Scheduling Order, BCBSVT may submit additional prefiled testimony on July 13, 2020. As discussed at the May 22 status conference, the short turnaround period from the L&E memorandum means that supplemental prefiled testimony can only serve a limited purpose. BCBSVT's full response to the L&E memorandum, L&E prefiled testimony, DFR solvency opinion, and HCA expert report and/or prefiled testimony will almost certainly also include live testimony at the hearing.

A final point on the documents: we are serving with this letter versions of the prefiled testimony that are high-quality PDFs, with only the single page containing the fully executed Remote Notorial Certification as a scanned PDF to show the original signatures. Our understanding is that, for purposes of the remote notarization procedure, the "original" document is the complete scanned document generated by the notary public. We will separately serve those "originals" by email on the Board and the HCA today. Our recommendation, however, is that the Board and the parties treat the versions served with this letter as the filed documents for purposes of the hearing. They are more readable, text searchable, and have a much smaller file size. The originals can be kept separately as proof that the documents were properly notarized. BCBSVT will maintain the paper versions.

Please be in touch if you have any questions about these filings.

Best regards,

STRIS & MAHER LLP

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Enclosed: Prefiled testimony of Mr. Andrew Garland
Prefiled testimony of Ms. Ruth Greene with attachments
Prefiled testimony of Dr. Kate McIntosh with attachment
Prefiled testimony of Mr. Paul Schultz with attachment

cc: Jay Angoff
Kaili Kuiper
Eric Schultheis
Thomas Crompton
Christina McLaughlin

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: BlueCross and BlueShield Vermont 2021 Individual and Small Group Rate Filing SERFF No. BCVT-132371410	GMCB-005-20rr

PREFILED TESTIMONY OF ANDREW GARLAND

Dated: July 7, 2020

Mr. Andrew Garland, being duly sworn, does hereby depose and say as follows:

Mr. Garland, what is your current employment?

I am the Vice-President for Client Relations and External Affairs at Blue Cross & Blue Shield of Vermont (BCBSVT).

How long have you held that position?

For approximately five years.

What are your responsibilities as Vice-President for Client Relations and External Affairs?

I oversee BCBSVT client-facing functions including sales, account management, marketing, communications and brand management. I also lead a small team focused on healthcare reform, including our work with OneCare VT.

Please briefly describe your professional background before assuming your current position at BCBSVT.

I started with BCBSVT in 2002 and worked in the organization until 2012. During that time, I served in a number of roles, including the Director of Provider Contracting and the corporate Director of Network and Provider Affairs. In 2012, I took a position with MVP as Vice President of Payment Reform and Enterprise Network Strategy and the Vice President for Vermont. I left MVP in 2015 to return to BCBSVT.

As part of your work, are you familiar with BCBSVT's participation in Vermont's accountable care organization, or ACO?

Yes. Working with the ACO, known as OneCare Vermont, is part of my job responsibilities. I am the executive sponsor for engagement with OneCare and BCBSVT's director of health care reform works directly with me.

How many commercial payers participate in OneCare Vermont?

Until 2020, BCBSVT was the only commercial payer participating in OneCare. I believe that MVP began working with OneCare in 2020, but only on a shared-savings basis. The other payers that participate are public payers—Medicare and Medicaid.

Are health care providers required to participate in OneCare?

No, participation for providers is voluntary, and providers can choose to participate only for some payers. More providers participate with public payers than with the commercial payer. At this point, 10 hospitals, 5 federally qualified health centers, and more than 95 physician practices participate in OneCare's commercial payer arrangement.

Please describe briefly how OneCare's financial arrangement works for the commercial payer.

To facilitate the goal of lowering the cost of care while improving quality and maintaining or improving access, BCBSVT participates, through OneCare, in a shared savings program with providers. This approach recognizes that as providers work at making the health care system more efficient, their fee-for-service revenues will decrease, but they will be made whole by sharing in the savings created for the system as a whole. To share savings with providers, we need to assess whether savings were achieved. So a critical component of the shared savings program is a projection of a baseline—that is, projecting a level of health care spending that would be expected if OneCare doesn't make any improvements. That is the baseline for measuring OneCare's performance. We measure the actual cost against that baseline when the period is over. If the actual cost of care is lower than the baseline, we share half of the savings with OneCare and through them, with providers. If the actual cost of care is higher than the baseline, then they return half of that over-spend to us. The risk runs both ways.

Does the Green Mountain Care Board's premium rate-setting affect the ACO financial arrangement for the commercial payer?

Yes, there is a direct, one-to-one relationship between the premiums set by the Board and the baseline expenditure projection. Any changes the Board makes to the premiums or any of the underlying assumptions flow through directly to that projected expenditure. If rates are cut or assumptions are lowered, that will reduce the projected baseline for the OneCare commercial payer arrangement. That, in turn, makes it harder for providers to achieve savings as measured against the baseline. If the rates approved by the Board are underfunded—that is, if the rates are reduced below the actuarial projections—it's much more difficult for providers to succeed. Providers understand this dynamic, and they are less willing to participate in the commercial payer arrangement as a result. It's a financial risk for them and they also perceive a risk to their

credibility if they are not able to demonstrate success. This dynamic has almost certainly slowed the growth of our OneCare program.

Has the pandemic impacted the financial model that BCBSVT and OneCare have accomplished?

Yes, the pandemic's effects on the health care system caused problems for providers and OneCare.

Please explain.

OneCare's contracts with provider networks require providers to meet many quality requirements to earn revenues under those contracts. BCBSVT and OneCare have worked together to strengthen those requirements and create increasingly more effective incentives for quality care. OneCare reached out to BCBSVT as the pandemic began because providers were struggling with cash flow and also facing obstacles to meeting the quality goals as their practice patterns were significantly disrupted. To assist providers and help maintain the viability of the All Payer Model, the ACO, and its commercial network, BCBSVT and OneCare agreed to two important changes for the 2020 contracts.

First, we agreed to set the quality requirements largely aside this year. There will be no financial consequences for providers for not doing the work that otherwise would have been required for BCBSVT members. This will be a reporting-only year, so performance on quality measures will not impact the flow of funds to practices.

Second, we agreed to dramatically limit the risk corridors to protect the integrity of the program. Before the pandemic, our contract provided for a 50/50 split of savings and risk up to 6% above and 6% below the baseline expenditure. In this unprecedented situation, however, it was clear that actual claims experience over the next few months—whether they come in above or below the expected baseline—will be result of forces beyond the control of OneCare and BCBSVT. If we find that claims ultimately come in anywhere near our original baseline, it will

almost certainly be a random occurrence, and unfortunately not a result of our hard work to help build a better health care system.

With that in mind and because both BCBSVT and OneCare are committed to the long-term success of the All Payer Model, we negotiated a new risk arrangement that will demonstrate to the federal government that we are working hard to achieve the scale targets outlined in the APM agreement. To that end, we worked very hard with the ACO to find a creative solution that would support the ongoing viability of payment reform. The outcome was to dramatically limit the scope of the risk corridors and to agree that whatever the final performance against the benchmark, all surpluses, whether on the plan side or on the OneCare side, will be reinvested in quality programming next year. This outcome qualifies for federal scale program inclusion, and we think demonstrates to CMMI that BCBSVT and OneCare worked very well together to keep the momentum of payment reform moving in the right direction.

Because of our strong working relationship with and support of the ACO, BCBSVT was able to negotiate this resolution that supports ongoing payment reform efforts.

Did BCBSVT take other steps to support the ACO during this time?

Yes, BCBSVT also rolled out its prospective payment system for hospitals on April 1, 2020. We built that payment system specifically to support the All Payer Model and OneCare. With the prospective payment system, hospitals receive predictable, fixed payments each month. The underlying shared savings and shared risk program remains in place, so after the end of the year, the prospective payment will be settled based on the performance to benchmark. Prospective payments assist with immediate cash flow problems. Only one hospital, Southwestern Vermont Medical Center, was signed up to go live on April 1. We believe that many other hospitals intend to participate in the program; however, a number of our hospital partners were dealing with large technology projects early in the year and elected to defer participation. With the pandemic unfolding, BCBSVT and OneCare reached out to hospitals, and reiterated that hospitals could still elect to participate in the prospective payment system on April

1, or any time thereafter. At this time, no other hospitals accepted the offer; however, we fully expect that many more will begin participating once they have adjusted to the near term pressures that the pandemic has put on their organizations.

Mr. Garland, are you familiar with BCBSVT's negotiations with health care providers, including hospitals?

Yes.

In your view, is it appropriate to provide further testimony regarding these negotiations in this public, pre-filed testimony?

No. First, for our negotiations with providers to be successful, it is critically important that we maintain a relationship of trust. We discuss many difficult issues in negotiations and try to have candid exchanges of views. If I were to speak about these discussions publicly, it would erode that trust and substantially harm BCBSVT's commercial interest in having productive, successful negotiations with providers.

Second, our negotiations and their outcomes represent commercially and competitively sensitive information. It is information that BCBSVT keeps confidential, and disclosure of it would undermine our commercial interests and provide a business advantage to competitors and providers.

Accordingly, if BCBSVT elects to offer further testimony in its case-in-chief or in response to cross-examination or Board questions regarding BCBSVT's negotiations with health care providers, it will request that the testimony be taken in a closed session at the hearing.

REMOTE NOTORIAL ACT CERTIFICATE

State of Vermont, County of Washington.

Sign or sworn remotely before me through a secure communication link on July 7, 2020 by Andrew Garland.

Executed by Andrew Garland on July 7, 2020
Andrew Garland *Date*

Signature of notary public: Alan Cunningham 7/7/20

Printed name of notary public Alan Cunningham

Commission number: 157.0004452

Commission expiration date: 01/31/2021

Title of office is Notary Public.

CERTIFICATE OF SERVICE

I certify that I have served the above Prefiled Testimony of Andrew Garland on Michael Barber, Amerin Aborjaily, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Kaili Kuiper and Eric Schultheis, counsel for the HCA, by electronic mail, Delivery Receipt requested via Microsoft Outlook, on July 7, 2020.

/s/ Michael Donofrio
Michael Donofrio

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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: BlueCross and BlueShield Vermont 2021 Individual and Small Group Rate Filing SERFF No. BCVT-132371410	GMCB-005-20rr

PREFILED TESTIMONY OF RUTH GREENE

Dated: July 7, 2020

Attachments:

Attachment	Title
A	Ruth Greene CV
B	*In the Matter of Blue Cross and Blue Shield of Vermont Risk-Based Capital Range Study*, No. 19-007-1 (Vt. Dep't of Fin. Reg. Feb. 7, 2019)
C	Memorandum from Ruth Greene to Paul Schultz, May 8, 2020
D	BCBSVT Response to L&E 7/1/2020 Questions and attached RBC Outlook
E	Letter from Don George to Green Mountain Care Board, June 29, 2020
F	A.M. Best Press Release, July 1, 2020

Ms. Ruth Greene, being duly sworn, does hereby depose and say as follows:

Ms. Greene, what is your position at Blue Cross?

I am treasurer and chief financial officer at Blue Cross Blue Shield of Vermont (BCBSVT) and have served in that position for 7.5 years, since 2012.

What are your responsibilities as treasurer and chief financial officer?

I am responsible for Corporate Accounting, Treasury, Actuarial, Underwriting, and Enrollment Services. I provide on-going strategic and operational financial support and leadership, to enable BCBSVT to manage its growth, development, and expenses. I oversee management and external financial audit processes to assure that effective financial systems are in place from which to manage BCBSVT's day-to-day operations as well as its strategic future. I have testified before the Green Mountain Care Board at hearings from 2014 through 2019 regarding BCBSVT's Vermont individual and small group rate filings.

Please provide a brief description of your professional and educational background before joining BCBSVT as treasurer and chief financial officer in 2012.

I have worked in leadership roles in corporate finance and accounting in the insurance industry for over 30 years. I grew up in Vermont and graduated from the University of Vermont in 1983. I began my career at Arthur Young as an auditor in their Portland, Maine office where I spent three years, rising to a Senior Auditor role. In 1986, I took a job at Unum. Over the 26 years at Unum, I held multiple financial positions both in the U.S. and abroad rising to leadership level within a number of business units and eventually serving as Vice President/Chief Financial Officer, Global Business Technology. I was also licensed as a Certified Public Accountant in Maine for 12 years.

Is your current CV attached as Attachment A?

Yes.

What is BCBSVT's mission?

BCBSVT is "committed to the health of Vermonters, outstanding member experiences and responsible cost management for all of the people whose lives we touch." Our vision is a "transformed health care system in which every Vermonter has health care coverage and receives timely, effective, affordable care."

In your view, is BCBSVT's business guided by its mission and vision?

Yes.

Is BCBSVT a for-profit company?

No, BCBSVT is a not-for-profit organization.

When BCBSVT submits a filed rate for approval, does that rate include any profit?

No.

As part of your responsibilities as treasurer and chief financial officer, are you familiar with BCBSVT's financial operations?

Yes, I am responsible for managing all aspects of BCBSVT's financial operations.

Are you familiar with BCBSVT's financial results and reserves?

Yes.

Ms. Greene, did you direct BCBSVT's chief actuary to file a contribution to policyholder reserves (CTR) of 1.5% for the 2021 Vermont Individual and Small Group Rate Filing?

Yes. I explained the basis for filing a 1.5% CTR in my memorandum to Paul Schultz dated May 8, 2020, which is Attachment C to this prefiled testimony and was provided to the Board as part of BCBSVT's 2021 Individual and Small Group Rate Filing.

Please briefly explain what policyholder reserves are and why they are important.

BCBSVT is obligated to pay members' claims, even in the face of unexpected circumstances, higher claims and costs, or financial losses. Like all insurers, we experience years when claims are higher than expected and premiums are underfunded. Every insurance company has to be able to weather losses. When we suffer a loss, the money comes from the reserves. Other contingencies require a financial buffer. We may experience regulatory changes that increase our costs or funding changes—for example, in recent years the federal government failed to make payments that were required and expected under the Affordable Care Act. The policyholder reserves—which we also call member reserves, and can be referred to as surplus—are the funds that BCBSVT holds to make sure that it can pay claims in any circumstances. The reserves are also needed to support membership growth, expansion into new market segments, or investment into innovative solutions that will improve quality and lower the cost of care.

Please briefly explain the term risk-based capital and its connection to member reserves.

Risk-based capital is a point in time measure of whether an insurer has enough reserves. It compares the amount of risk taken on by the company to its available reserves. Risk-based capital, or RBC, is expressed as a ratio between the amount of our reserves and a figure that represents our risk. It is developed based on a methodology from the National Association of Insurance Commissioners that is mandated by the Vermont Department of Financial Regulation (DFR).

Based on this methodology, the risk taken on by the company as of December 31, 2019 requires a minimum of $139 million in reserves.

What is BCBSVT's philosophy in managing its contributions to member reserves, or CTR?

I explained BCBSVT's CTR philosophy in detail at pages 1-2 of my memorandum to Paul Schultz, dated May 8, 2020, which is attached to this prefiled testimony as Attachment C. I incorporate that discussion here. In brief, BCBSVT believes that CTR should be managed to an adequate long-term level rather than fluctuating significantly from year to year. In our view, a long-term CTR of 1.5% represents an adequate, yet not excessive, contribution to member reserves. CTR at that level allows us to manage short-term fluctuations and maintain reserves within our established, modest target range. The Board's consulting actuary, Lewis & Ellis, agreed in 2019 that a 1.5% CTR was reasonable. Specifically, Lewis & Ellis opined that "BCBSVT's proposed CTR is reasonable in light of its underlying risks and L&E believes that is allows the Company to offset the impact of trend and other potential adverse events with appropriate consideration given to maintaining the CTR at an adequate long-term level." Letter from Lewis & Ellis to Green Mountain Care Board, July 9, 2019, at 23.

Does BCBSVT have any regulatory requirements that govern its risk-based capital?

Yes. The Vermont Department of Financial Regulation (DFR) has ordered BCBSVT to maintain sufficient reserves such that BCBSVT's risk-based capital ratio falls within a range of 590 to 745 percent. *In the Matter of Blue Cross and Blue Shield of Vermont Risk-Based Capital Range Study*, No. 19-007-1 (Vt. Dep't of Fin. Reg. Feb. 7, 2019) (attached as Attachment B). DFR's order provides that "[i]f BCBSVT's RBC ratio falls below or increases above the approved range, BCBSVT shall promptly develop a plan to move within the range within a reasonable time and shall submit such plan to the Commissioner." *Id.*

What is BCBSVT's current RBC ratio?

As of December 31, 2019, BCBSVT's RBC ratio is 567.

How does that compare to the required range?

It is below the minimum of the required range.

When did BCBSVT last update its RBC plan to DFR?

On January 3, 2020—before the COVID-19 pandemic—BCBSVT filed an updated RBC plan with DFR. That plan is summarized in Attachment C. If our 2020 results were to match expectations at that time, we would have moved into the required range by the end of 2020.

You note that the RBC plan was updated before the pandemic. Does the pandemic affect BCBSVT's plan for moving into the required RBC range?

Yes. The pandemic has changed many aspects of our financial outlook and created a substantial degree of uncertainty. The pervasive unknowns regarding the severity, timing and government response to the COVID infection and hospitalization rates and the timing and volume of the pent up demand for health care services created during the COVID19 stay at home order make it impossible to predict with any certainty what claims utilization will be over the next 12-24 months. We have analyzed a number of scenarios, but no one knows which scenario will unfold. As explained in Attachment D, we have provided the results of this recently completed scenario modeling analysis to DFR, the Green Mountain Care Board, and the HCA. This is but one of the significant uncertainties that impact BCBSVT's plan for moving into the required RBC range.

BCBSVT also used the results of this modeling analysis to complete a projection of BCBSVT's RBC at the end of 2020 and at the end of 2021. This projection was provided to DFR, the Green Mountain Care Board, and the HCA. The RBC Outlook included in Attachment

D illustrates many variables that will impact reserves over the coming months and provides a range of RBC projections based on the different scenarios addressed in the model. This analysis shows an RBC range of 516% to 581% for year-end 2020. For year-end 2021, it shows an RBC range of 419% to 545%. These projections assume that the 2021 rate increase is approved as filed.

What are the most significant factors related to the pandemic that affect or potentially affect BCBSVT's reserves?

The pandemic has affected every aspect of our operations, including our financial operations. The pandemic is continuing to unfold in Vermont, nationally, and internationally, and there is no way to definitively predict how it will impact Vermont, Vermont's health care system, and our members for the next 12 to 24 months. Critical factors that contribute to uncertainty regarding our financial outlook and reserves include the following:

- As noted above, we have modeled many scenarios regarding how the pandemic could affect our claims experience. Through stochastic modeling, we understand that the more likely scenarios over the three-year period from 2020-2022 show the near-term claims slowdown being offset by returning care, the cost of COVID testing, diagnosis and treatment, and the cost of vaccines for our members. That said, there are scenarios where reserves could increase and there are scenarios where reserves could decrease.
- Financial markets remain volatile and market losses affect our reserves. BCBSVT's year-to-date losses through May 31, 2020 are approximately $3 million in realized and unrealized equity losses. That directly affects the amount of our reserves.
- Our pension assets recently suffered a loss of value—as of May 31, 2020, approximately $40.6 million, representing a 58.5% loss in value. That amount represents approximately 180 percentage points of risk-based capital (RBC).

Attachment E, which is a letter from Don George to the Green Mountain Care Board, provides more information about this loss.

- Because of the pandemic, we have provided additional flexibility for members and groups with respect to premium payments. We will incur some level of additional costs for uncollectable premiums as a result.
- We have incurred additional costs to support health care providers during this challenging time, including provider advances to ease cash flow problems. Reserves will be depleted by the amount of any provider advances that are not repaid.
- On page 5 of Attachment C, I list other programs and initiatives we have adopted as part of our response to the pandemic. I incorporate that list here. As noted in Attachment C, we do not yet know the costs and ultimate risks of these programs. We understand the legislature could require extension of many of these programs into 2021.
- Claims costs could increase due to "COVID allowances" given to hospitals in the form of commercial rate increases as temporary adjustments to compensate for fiscal year 2020 utilization that was not realized due to the pandemic.
- We have experienced additional costs related to operations during pandemic, including expenses related to moving our workforce to remote work and changing workflows to respond to new circumstances. To date, the incremental costs have been more than $275,000, and that figure is likely to increase. Through May 31, BCBSVT has realized savings of approximately $250,000 from lower claims processing transaction costs, and roughly $100,000 from reduced travel expenditures.
- The CARES Act positively affected our reserves by accelerating AMT refunds.
- We have two lawsuits against the federal government seeking to recoup payments on behalf of our members that were not made as required by the Affordable Care

Act. The pandemic has affected court operations and is likely causing some delay in the final resolution of these matters.

In sum, our reserves and RBC will be very volatile for the next few years. We are experiencing short-term benefits from the slowdown in claims costs but, long-term, BCBSVT will have to bear costs as that care returns as well as any unpredictable costs associated with pandemic.

In the face of all this uncertainty, you directed your chief actuary to file the same CTR that BCBSVT has filed in recent years. Please explain why you made that decision.

There are three primary reasons that I believe a CTR of 1.5% is appropriate for this filing.

First, as we have consistently testified in these hearings, BCBSVT believes that CTR should be managed to an adequate long-term level rather than fluctuating significantly from year to year with changes in membership and health care trend. We file a CTR consistent with our long-term target. Again, I outlined BCBSVT's CTR philosophy in detail at pages 1-2 of Attachment C and incorporate that discussion here. In my view, the reasons that support our approach to CTR continue to apply even in these uncertain times. Maintaining an adequate surplus level is critical for any insurer. If BCBSVT's reserves are too low, we:

- have less flexibility to respond to customer needs;
- require higher CTR in rates in order to avoid further deterioration;
- are hindered in our ability to attract or retain business or to handle membership growth. For example, we required use of $3.6 million from reserves to develop and offer Vermont Blue Advantage. We were able to respond to consumer demand for a Medicare Advantage program in Vermont and serve the needs of more Vermonters.

BCBSVT must remain financially strong in order to continue to provide Vermonters with access to high quality care, outstanding member experiences, and responsible cost management. Realizing a sustainable CTR over time is key to achieving that goal.

Second, given the substantial degree of uncertainty caused by the pandemic, it would be imprudent to reduce our CTR from our long-term rate. Indeed, the pandemic illustrates the need for adequate reserves that provide a financial buffer during times of uncertainty and financial stress. Stability is particularly important in times of change. In recent years, we have experienced significant change in the health care market, including the continuing evolution at both the federal and Vermont levels of the individual and small group market and changes in the health care reform environment. This year we have experienced an unprecedented global pandemic. This crisis may continue for the next 12 to 24 months and its ongoing and future impacts on Vermont are uncertain. We need to maintain our reserves to ensure that we are in a position to respond to this ongoing crisis—by paying for claims, helping Vermonters stay insured and maintain access to care, and helping to support our health care providers.

Third, although BCBSVT may face additional costs in 2021 due to the pandemic, it is appropriate and consistent with our CTR philosophy to fund those costs out of our reserves. Our policyholder reserves are intended to protect our members in times of uncertainty. BCBSVT has long maintained that a pandemic is one reason to maintain surplus. We may experience higher than expected claims in 2021, both because of the return of care deferred during 2020 and because of claims for treatment related to COVID-19 and a potential vaccine. We have not factored those potential higher claims into our rates and have adhered to our long-term 1.5% CTR in this filing. Any increased costs in 2021 due to the pandemic will be funded from policyholder reserves. Put another way, I have concluded that the requested 1.5% CTR is sufficient to meet our financial targets even if the pandemic increases our costs beyond what is expected in 2021.

In your view, is a 1.5% CTR adequate and not excessive?

Yes.

BCBSVT has experienced a reduction in claims so far this year because of the pandemic. Why didn't BCBSVT reduce or eliminate its rate increase for 2021 to reflect these lower costs in 2020?

It is simply too early to take that step. We are in the first few months of an ongoing health care and economic crisis that may continue for the next 12 to 24 months. As I have explained above, BCBSVT needs to maintain its reserves to weather uncertainties and unpredicted costs as the pandemic continues to unfold. It is possible, if Vermont remains fortunate and does not experience significant outbreaks or other costs related to the pandemic, that savings in claims may result in reduced rate increases or refunds in the future. But to take that step now, when so little is known about how this pandemic will affect Vermont and the United States would be imprudent. We have to protect policyholders by safeguarding our solvency and financial position to ensure that we can pay claims and provide access to quality care going forward.

Please describe BCBSVT's financial experience in the individual and small group market.

Since 2014, BCBSVT has sustained losses of $29 million in the individual and small group market. As explained in Attachment C, if we obtain a recovery in both of our lawsuits against the federal government, that will reduce our losses in this line of business. But even with those recoveries we will still have lost over $12.5 million, with losses in four out of six policy years. Resolving structurally deficient rates with one-time revenues increases the level of risk in the marketplace. I incorporate the discussion and chart on page 3 of Attachment C here. This trajectory of consistent losses is not sustainable over time.

You mentioned that BCBSVT has two lawsuits pending against the federal government. Please briefly describe the status of these lawsuits.

In one of the cases, we are suing the federal government for unpaid risk corridor payments under the Affordable Care Act. Based on a recent U.S. Supreme Court decision in a

related case, a recovery in this case is now likely, but we do not yet know when our case will be resolved.

In the other case, we are suing the federal government for unpaid cost-sharing reduction payments. The federal government continues to maintain that it has no liability for these payments. We do not know when this case will be resolved.

You also noted that AMT tax refunds affect BCBSVT's reserves. Please explain.

The Tax Cut and Jobs Act enacted in late 2017 repealed the corporate alternative minimum tax (AMT). Consistent with that provision, BCBSVT expected to receive refunds of AMT over a four-year period from 2019 to 2022. The CARES Act accelerated the payment of the 2021 and 2022 refunds into 2020. Those two years combined amount to approximately $9.1 million which would, in turn, increase RBC by 42 percentage points. Assuming that the credits are refunded to BCBSVT in accordance with the provisions set out in the Tax Cut and Jobs Act and the CARES Act, these funds will be added to member reserves to mitigate future rate increases.

Are you familiar with the factors that the Board is required to consider in reviewing BCBSVT's rates?

Yes. When reviewing a proposed rate the Green Mountain Care Board considers 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. In making its decision, the Board must consider the analysis and opinion provided by the Department of Financial Regulation regarding the impact of the proposed rate on the insurer's solvency and reserves.

In your view, do the proposed rates meet those criteria?

Yes. The proposed rates satisfy and strike an appropriate balance among the factors that the Board must consider. Those factors cannot be considered in isolation. A rate that is not adequate and undermines insurer solvency by definition cannot promote access to care or quality of care. Likewise, reducing a rate without actuarial justification to make it more affordable threatens solvency and risks undermining access to care and quality of care. The uncertainty caused by the pandemic makes it all the more necessary to ensure that rates are adequate and protect insurer solvency.

BCBSVT takes numerous steps to promote access to quality care for its members, including our quality management program, focus on preventive care and wellness, utilization management and care management. We have been a committed partner in healthcare reform efforts and payment reform in Vermont. We provide our members with a comprehensive global network. And our administrative costs are very low in comparison to other insurers.

There is an inherent tension between affordability and quality of and access to care. Vermont's standards for quality and access to care are high. Our proposed rates reflect the cost of providing health care to Vermonters.

BCBSVT shares the Board's concern—and the concern of so many Vermonters—that health care costs are too high. It is critical to recognize, however, that reducing insurance rates below what is actuarially justified—that is, below the cost of providing care—does not reduce the cost of health care. Reducing rates does not "bend the curve." Rather, it forces the insurer to operate at a loss, which is unsustainable and risks the stability of the entire system.

You mentioned that BCBSVT's administrative costs are low. What percentage of the as-filed VISG premium reflects administrative costs?

7.9 percent.

How does that compare with other insurers?

Our administrative expenses are lower than those of over 80% of other Blue plans. We work hard to keep our administrative costs low while doing the work necessary to administer the plans and ensure access to quality care for our members. We need sufficient resources, including qualified staff and technology, to meet the needs of our members and participate meaningfully in health care reform initiatives. By way of example, our staff was able to respond quickly and appropriately during the pandemic. Our staff adapted processes and provided COVID-related information to both our customers and our providers, and also worked to configure our claims system for COVID-related benefit changes, such as waiving member cost sharing for COVID-19 testing and treatment claims.

Does the figure for administrative costs in the proposed rate assume a 3% average salary increase for BCBSVT employees?

Yes.

Why is that increase justified?

It is critical for BCBSVT to retain and attract high-quality employees to serve our customers, run the company efficiently, support the state's goals in health reform, and respond in times of crisis. Our work in many areas, including payment reform, actuarial, ACO, and care management requires a high level of expertise and benefits from stability and low turnover. Providing modest annual increases helps us to retain employees, which is important to achieving our mission while avoiding costs and lost productivity associated with high turnover. Even at the customer service level, it takes eight weeks to train a new representative.

A 3% average increase is modest and represents a market-driven approach to retain and attract qualified employees. Eliminating this increase would change the average filed rate by about three twentieths of one percent. Nonetheless, we recognize the difficult times our Vermont

members, employers and providers are going through as a result of the pandemic. We have not yet made a financial decision regarding salary increases for 2021.

Are you familiar with AM Best's assessments of BCBSVT?

Yes. AM Best is a rating company that produces independent financial strength ratings for companies. They specialize in insurance companies. As a member of the Blue Cross and Blue Shield Association, we are required to have a financial strength rating. It is one of the mechanisms that the Association uses to make sure that the Blue Card network has strong financial underpinnings.

Please describe AM Best's most recent announcement regarding BCBSVT.

AM Best announced a change to BCBSVT's outlook on July 1, 2020. Their press release is attached as Attachment F. Last year, as I explained at this hearing, AM Best changed our credit outlook to negative, the first time they had taken such a step. AM Best has now revised the outlook from negative to stable for the Long-Term Issuer Credit Rating (Long-Term ICR) and affirmed the Financial Strength Rating (FSR) of B++ (Good). As the press release explains, this change was driven predominantly by the increase in BCBSVT's RBC during 2019 due to the receipt of AMT credit refunds and the expectation that the remaining AMT credit refunds will be accelerated in 2020. AM Best's announcement references our trend of underwriting losses and indicates that the AMT refunds provide an offset in the near-to-medium term.

REMOTE NOTORIAL ACT CERTIFICATE

State of Vermont, County of Washington.

Sign or sworn remotely before me through a secure communication link on July 7, 2020 by Ruth Greene.

Executed by Ruth Greene (*Ruth Greene*) on 7/7/2020. (*Date*)

Signature of notary public: Alan Cunningham 7/7/20

Printed name of notary public: Alan Cunningham

Commission number: 157.0004452

Commission expiration date: 01/31/2021

Title of office is Notary Public.

CERTIFICATE OF SERVICE

I certify that I have served the above Prefiled Testimony of Ruth Greene on Michael Barber, Amerin Aborjaily, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Kaili Kuiper and Eric Schultheis, counsel for the HCA, by electronic mail, Delivery Receipt requested via Microsoft Outlook, on July 7, 2020.

/s/ Michael Donofrio
Michael Donofrio

Stris & Maher LLP
28 Elm St
Montpelier, VT 05602
Telephone: (802) 858-4465
michael.donofrio@strismaher.com

Attachment A

Prefiled Testimony of Ruth Greene

Ruth K. Greene

CONTACT INFORMATION

Address: 445 Industrial Lane, Berlin, Vermont
Telephone: (802) 371-3210

PROFESSIONAL AFFILIATIONS / CERTIFICATIONS

Other Education

- Certified Public Accountant, licensed CPA in State of Maine for 12 years. CPA Exam first time pass
- Knowledge Management Masterclass, Middlesex University/ CIBIT, London, England, United Kingdom
- Training in Lean Six Sigma continuous improvement methods

CAREER DETAILS

October 2012 to present
Blue Cross and Blue Shield of Vermont
Vice President, Treasurer and Chief Financial Officer
Berlin, Vermont

As a member of the BCBSVT executive team, I am responsible for Corporate Accounting, Treasury, Actuarial, Underwriting, and Enrollment Services. I provide on-going strategic and operational financial support and leadership, as well as provide accurate and timely management reports enabling the organization to more aptly manage its growth, development and expenses. I also provide effective oversight of management and external financial audit processes and assure that the most effective financial systems are in place from which to management the day-to-day operations and the company's strategic future.

UNUM Corporation (1986-2012)
2010 to September 2012
Vice President, Chief Financial Officer, Global Business Technology
Portland, Maine

As a member of Global Business Technology executive team, I was responsible for establishing and executing financial management strategy for global technology shared services organization. I was also responsible for short-term and long-term financial plans that align with operating businesses. I lead the design and implementation of financial reporting that provides transparent view of technology investments and benefit of spend. I was responsible for enterprise-level technology vendor management strategy; leading design and implementation of global procurement center of excellence. I lead a team of 28 to 30 finance and procurement professionals; total GBT organization is 1500 people and approximately $300 million annual spend.

2008 to 2010
Vice President, Corporate Strategic, Capital and Investment Planning, Portland, Maine

I supported the executive decision making through researching market and economic trends and overseeing strategic analysis including competitive intelligence. In addition I prepared agenda and materials for annual strategic review session with board of directors. I also synthesized cash-flow generating aspects of business plans into forward looking view and recommended ways to maximize capital efficiency. In addition, I managed the process of diagnosis and analysis of financial statement impact of future investing activity.

2005 to 2008
Vice President, Planning and Forecasting, United States Brokerage, Portland, Maine
United States Brokerage operations encompassed $6 billion in earned premium, more than 8,000 people and operating expense budget of $1 billion. Reporting to the Chief Financial Officer of United States Brokerage I led the group of executives responsible for business functions in determining and executing business plans to achieve financial objectives. I was also responsible for overall business and financial planning for the largest Unum operating entity.

2002 to 2005
Assistant Vice President, Head of Underwriting Metrics and Planning
Portland, Maine
Metrics and planning support for underwriting function covering all group and individual products; 800 people and operating budget of $70 million. I started up the metrics function to consolidate tracking, measurement and reporting of underwriting results including demonstrating value of underwriting to the business. I led the business initiative and budget planning processes for underwriting function. I was the project sponsor for initiative to create reliable information system to provide regional portfolio managers with relevant context to support decision-making.

1998 to 2002
Vice President, Director and Chief Financial Officer – Finance, Strategy and Corporate Development, Unum Limited (United Kingdom), Surrey, England, United Kingdom
A wholly-owned subsidiary of Unum Corporation, Unum Limited is the market leader in the United Kingdom in group income protection insurance; annual premiums of $240 million, ROC consistently in excess of 15 percent, assets of over $1 billion and 500 employees.
I was in a key cross-functional role responsible for finance, strategy, identification of growth opportunities and implementation of development initiatives to achieve Company's vision of market leadership and profitable growth. My accomplishments included the strategic review of the business, re-design of sales force compensation plans and consultative review of best practices in the areas of risk management and underwriting. I was also recognized for creating a high degree of collaboration and teamwork among the senior management team. My duties also included management of product pricing, capital management, value-based management, management and regulatory reporting, and investment strategy including asset/liability matching. In addition, I was responsible for business and financial planning including project appraisal. I was also a member of the risk and controls review group to oversee operational controls.

1996 to 1998
Vice President, Director - Finance, Unum Limited (United Kingdom)
Surrey, England, United Kingdom
Reporting to the Managing Director (Chief Executive Officer), I was responsible for accounting, reporting (parent co., management and regulatory), budgeting, planning, cash flow management and tax oversight. This was a leadership role and I was actively involved in all aspects of business and financial plan development and execution.

1992 to 1996
Assistant Vice President and Controller, Investment Division
Portland, Maine
Reporting to the Chief Investment Officer, I was responsible for accounting and reporting for Unum's invested assets (Statutory and GAAP bases). My key responsibilities included accurate income projections by product line, allocation of cash flows and effective reporting and analysis. The Portfolio consisted of $10 billion bonds, stocks, mortgages and real estate; managed staff of 40.

1986 to 1992
Manager / Director, Corporate Accounting
Portland, Maine
I was responsible for the operation and control of the general ledger including management of closing deadlines and installation of new general ledger and chart of accounts in support of both Statutory and GAAP accounting. I was also responsible for SEC and internal reporting, GAAP and Statutory accounting, and accounting policies. I managed a professional staff of 14 members and coordinated external audit and resolution of issues.

1983 to 1986
Arthur Young & Company
Portland, Maine
Arthur Young & Company was one of the world's largest accountancy firms. It was acquired by Ernst & Young LLP in 1989 which is a professional services company and provides assurance, auditing, technology and security risk, enterprise risk management, transaction support, merger and acquisition, actuarial, and real estate advisory services

- **Audit Senior**
  I planned and executed audits for companies in various industries including publishing, healthcare, banking and non-profit.

CAREER SUMMARY

I grew up in Vermont and graduated from the University of Vermont in 1983. I began my career at Arthur Young as an auditor in their Portland, ME office where I spent three years, rising to a Senior Auditor role. In 1986, I took a job at Unum. Over the 26 years at UNUM, I held multiple financial positions both in the US and abroad rising to leadership level within a number of business units. In 2012, I returned to my home State of Vermont to become the Treasurer and CFO of Blue Cross and Blue Shield of Vermont.

EXPERT TESTIMONY

Provided expert testimony before Green Mountain Care Board at hearings from 2014 through 2019 regarding BCBSVT Vermont individual and small group rate filings.

Attachment B

Prefiled Testimony of Ruth Greene

STATE OF VERMONT
DEPARTMENT OF FINANCIAL REGULATION

IN THE MATTER OF:	)	
	)	
Blue Cross and Blue Shield of Vermont	)	No. 19-007-I
Risk-Based Capital Range Study	)	

ORDER

WHEREAS, the Commissioner of the Department (the "Commissioner") is responsible for administering and enforcing the insurance laws of the State of Vermont, including 8 V.S.A. §§ 10, 11, 12, 15, 3304, and 8302; and

WHEREAS, the Department has consulted with its actuaries and, with them, reviewed materials submitted by Blue Cross and Blue Shield of Vermont relating to its risk-based capital range; and

WHEREAS, the Company cooperated with the Department in its inquiry and review by responding to inquiries and providing documentary evidence and other materials;

NOW THEREFORE, the Commissioner makes findings and conclusions as follows:

FINDINGS OF FACT

1. Blue Cross and Blue Shield of Vermont (BCBSVT) is a nonprofit licensee of Blue Cross Blue Shield Association, conducting health-insurance business in the State of Vermont.

2. Risk Based Capital (RBC) is a method of measuring the amount of capital appropriate for an insurance entity to support its overall business operations in consideration of its size and risk profile.

3. RBC, properly applied, requires companies with differing risk profiles to hold different amounts of capital, and for companies and regulators to modify RBC for a given company over time, as the company's risk profile and size change.

4. Since 2011, BCBSVT has targeted an RBC ratio range of 500% to 700%.

5. Since 2013, BCBSVT's RBC ratio has been between 558% and 666%, and has been more stable than the ratios for most other similar entities.

6. As a not-for-profit health insurer, BCBSVT, like other such entities, is generally limited to raising capital from its own operations, while a for-profit entity may have other capital sources.

7. BCBSVT is a member of the national Blue Cross Blue Shield Association (BCBSA), and therefore is subject to the terms of a BCBSA license.

8. BCBSVT would face monitoring by BCBSA if its RBC ratio were to fall beneath 375%; BCBSVT has stated that its risk tolerance is for no greater than a 10% chance of a drop to that level over a five-year time horizon, and no greater than a 1% chance of a drop to 200% over that time horizon.

9. BCBSVT's stated risk tolerance is reasonable and appropriate in light of the above facts.

10. BCBSVT's actuarial consultant recommends, and BCBSVT requests, that the Department approve an RBC ratio target of 590% to 745%.

11. BCBSVT's request is based on a recommendation from an actuarial firm that is qualified to complete the actuarial analysis and give such a recommendation, and the firm used reasonable assumptions, considered appropriate risks, and produced a reasonable and appropriate recommendation for the surplus range.

12. The Commissioner's retained actuaries are qualified to evaluate the BCBSVT actuarial analysis and have done so employing accepted actuarial methods.

13. BCBSVT's requested range is reasonable and appropriate in light of the risk-based capital factors in 8 V.S.A. § 8302(c).

ORDER

NOW, THEREFORE, based on the Commissioner's Findings of Fact, the Commissioner orders as follows:

1. The Commissioner approves BCBSVT's proposed RBC ratio of 590% to 745%.
2. BCBSVT shall not, in any regulatory proceeding, state or imply that its RBC ratio target is other than 590% to 745%.
3. If BCBSVT's RBC ratio falls below or increases above the approved range, BCBSVT shall promptly develop a plan to move within the range within a reasonable time and shall submit such plan to the Commissioner.
4. BCBSVT shall review its RBC range at least once every five years, and more frequently if there is a material change affecting the appropriate range.
5. This Order shall be governed by and construed under the laws of the State of Vermont.

Entered at Montpelier, Vermont this 7th day of February, 2019.

Michael S. Pieciak, Commissioner
Department of Financial Regulation

Attachment C

Prefiled Testimony of Ruth Greene

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

MEMORANDUM

To: Paul Schultz, Chief Actuary

From: Ruth Greene, VP and CFO

Date: May 8, 2020

Subject: Contribution to Policyholder Reserves for 2021 Vermont Individual and Small Group filing

Upon consideration of the points documented in this memorandum, I am directing you to file a contribution to policyholder reserves (CTR) of 1.5 percent for the 2021 Vermont Individual and Small Group rate filing.

BCBSVT CTR Philosophy

BCBSVT holds that a long-term CTR of 1.5 percent represents an adequate, yet not excessive, contribution to policyholder reserves. CTR at this level within a typical trend and growth environment allows us to manage short-term fluctuations in order to maintain surplus levels that are within our established, modest target range.

Should BCBSVT's surplus level fall outside our target range, we would adjust our filed CTR accordingly. That is, in the event that surplus exceeds our targeted range, we would reduce our filed CTR from the long-term rate, all else being equal. Similarly, in the absence of mitigating factors, we would need to file a CTR that exceeds the long-term rate should surplus fall below our target range.

BCBSVT believes that CTR should be managed to an adequate long-term level rather than fluctuating significantly from year to year with changes in membership and health care cost trend. For this reason, we file a CTR equal to our long-term target. It is our expectation that our future filings will also include contribution to policyholder reserves equal to this target. While the long-term CTR target may exceed or fall below that required to maintain our surplus position in any given year, maintaining an adequate long-term assumption will allow the market to avoid rate shocks in years of high growth in projected claims costs.

BCBSVT also chooses to file consistent CTR across product lines. Many insurers file higher CTR for products with more inherent risk. For instance, the dynamic regulatory environment means that the individual and small group market is considered to be riskier

than many other market segments. However, BCBSVT considers it to be more equitable to all Vermonters to use the same CTR target across filings.

An adequate long-term contribution to policyholder reserves should exceed the minimum required to keep pace with increases in total claims costs. While best estimate assumptions are by definition expected to lead to equal likelihood of gains and losses, unexpected events or periods of sustained losses may lead to financial deterioration of sufficient magnitude to threaten a company's solvency.

Apart from modest investment income, CTR is the only source of sustained funding to sustain policyholder reserves for BCBSVT. While any rate filing is by definition an estimate of future costs and is therefore subject to gains or losses, BCBSVT files no additional margin beyond the required CTR. Any rate shortfall will first be paid out of CTR, while any shortfall beyond the approved CTR for a particular filing will be funded from existing policyholder reserves (i.e. surplus).

Maintaining an adequate surplus level is critical for any insurer. Consequences of low surplus include reduced flexibility in responding to customer needs, a need for higher margins in rates in order to avoid further deterioration, and a reduced ability to attract or retain business or to handle membership growth. Stability is particularly important in times of change, including the continuing evolution at both the federal and Vermont levels of the individual and small group market, the health care reform environment in Vermont, and the ongoing COVID-19 crisis.

BCBSVT must remain financially strong in order to continue to provide Vermonters with access to high quality care, outstanding member experiences, and responsible cost management. Realizing a sustainable CTR over time is key to achieving that goal.

Tax Cuts and Jobs Act

The Tax Cuts and Jobs Act enacted in late 2017 is anticipated to have two specific impacts on BCBSVT's financials. First, as of the 2018 tax year the BCBSVT legal entity is no longer subject to federal income taxes (note that BCBSVT subsidiaries continue to be taxable). The savings resulting from the elimination of BCBSVT's annual federal tax obligation have been passed on directly to our customers in premium rates through the reduction of our long-term CTR to 1.5 percent from its historical level of 2.0 percent.

The second expected impact results from the repeal of the corporate alternative minimum tax (AMT) in the new law. As a low to moderately capitalized Blue Plan, BCBSVT has been subject to federal income taxes at an AMT rate since 1987. AMT credits accumulated by BCBSVT since 1987 have become refundable under the law, and the total AMT credit balance is scheduled to be paid to BCBSVT over a four year period from 2019 through 2022, based on filed federal tax returns for years 2018 through 2021. The recently enacted CARES Act includes provisions for accelerating the timing of the 2021 payments. Assuming that the credits are refunded to BCBSVT in accordance with the provisions set out in the

Tax Cuts and Jobs Act and the CARES Act, these funds will also be used for the direct benefit of our customers as they are received from the IRS.

Outstanding Litigation

BCBSVT has retained counsel to sue the federal government to recover unpaid risk corridor program payments, and, in a separate suit, the unpaid 2017 and 2018 CSR funding. In a case involving other insurers, the United States Supreme Court recently held that the government is required to pay the risk corridor payments. Both of our lawsuits remain pending, but this recent decision strengthens our positions. Even in the event of favorable outcomes, speed to recovery will depend on how the federal government proceeds in resolving the cases and may linger into 2022 or beyond.

While we do not expect an imminent resolution to either case, it is instructive to review restated historical financials including the potential recoveries in both matters:

Year	Member Months	Filed Contribution to Reserve	Approved Contribution to Reserve*	Actual Contribution to Reserve	Actual operating gains/(losses)
2014	638,492	1.0%	-0.1%	1.0%	$2,570,373
2015	768,293	1.0%	1.0%	-1.1%	($3,689,584)
2016	835,541	2.0%	0.8%	-2.2%	($8,607,884)
2017	820,156	2.0%	1.0%	1.0%	$4,251,320
2018	630,163	2.0%	-1.0%	-1.6%	($5,713,876)
2019	520,854	1.5%	0.0%	-0.4%	($1,396,912)
Cumulative	4,213,499	1.6%	0.3%	-0.6%	($12,586,563)

Actual losses sustained to date have totaled $29 million. The recovery of damages in their entirety improves BCBSVT's cumulative performance in the QHP market by nearly $16.5 million, or 0.8 percent of premium. Nonetheless, BCBSVT will have lost over $12.5 million on this line of business since inception, equal to a reduction of 55 percentage points of risk-based capital. This trajectory is not sustainable in the long term.

Department of Financial Regulation Risk Based Capital Order

On February 7, 2019, the Commissioner of the Vermont Department of Financial Regulation (DFR) issued an order approving a target Risk Based Capital (RBC) range of 590 percent to 745 percent. The order states, in part:

> "If BCBSVT's RBC ratio falls below or increases above the approved range, BCBSVT shall promptly develop a plan to move within the range within a reasonable time and shall submit such plan to the Commissioner."

BCBSVT's year-end RBC ratio of 567 percent remains well below the minimum of the range ordered by the Commissioner.

Risk Based Capital Plan

On January 3, 2020, BCBSVT filed an updated RBC plan with DFR. Updated to the final 2019 RBC of 567 percent, the 2020 portion of the plan was as follows:

RBC position as of December 31, 2019	**567%**
Impact of changes in insured volume	+75%
$8.7 million AMT Refund expected during 2020	+42%
Projected impact 2020 operating results	-17%
Projected impact of 2020 investment results	+16%
$3.6 million contribution toward Vermont Blue Advantage start-up costs	-20%
$1.1 million funding of Civica Rx	-6%
Expected RBC position as of December 31, 2020	**657%**

BCBSVT is pleased to be able to make investments into new enterprises that will generate cost savings while improving access to care for Vermonters. Through a joint venture of BCBSVT and Covantage Health Partners, a subsidiary of BCBS of Michigan, Vermont Blue Advantage will offer high-quality Medicare Advantage products to Vermont seniors starting in 2021, enabling Vermonters who have valued Blue Cross Blue Shield coverage for their entire working lives to remain Blue into retirement. Civica Rx is a joint venture of many Blue plan partners that will manufacture and supply – at zero profit – certain generic drugs where a lack of competition has fostered excessively high prices and profits. Starting in 2022, CivicaRx will introduce certain generic drugs to the market at a price point that is a fraction of the current cost. Because BCBSVT is able to replenish RBC with the AMT tax credits, we are able to not only mitigate rate increases but also invest in these exciting new ventures to the benefit of Vermonters.

If 2020 results match expectations, unlikely given the COVID-19 pandemic, BCBSVT would have expected to be within the target RBC range by the end of 2020. We note that, all else being equal, it is better to be near the middle of the target RBC range rather than at an end point, as this minimizes the probability of falling out of the range and triggering a required corrective market action[1]. We do not intend to waver from our CTR philosophy while within the target range, which will generally have the effect of very modestly increasing RBC when near the low end of the target range and very modestly decreasing RBC when approaching the high end of the target range.

Of course, many aspects of our financial outlook changed with the onset of the COVID-19 pandemic. While the January RBC plan provides a solid foundation to understand BCBSVT's capital position entering 2020, the pervasive unknowns make it impossible to generate with any degree of certainty an RBC outlook for the balance of 2020 into 2021.

[1] The Axene Health Partners RBC study indicates that the point within the target RBC range from which it is least likely to fall outside the range within a one-year period is 690 percent.

COVID-19

BCBSVT's primary responsibility to Vermonters is to maintain continuity of coverage and claims payments for the duration of the COVID-19 crisis. This understanding necessitates that we continue to rate appropriately so that we can provide extra flexibility to customers and providers who are struggling financially. In only eight weeks, BCBSVT has demonstrated this commitment to the Vermont health care ecosystem in a wide variety of programs. Working closely with state regulators, we:

- Waived member cost sharing for COVID-19 tests and associated telehealth, office, urgent and emergency care visits;
- Expanded access to telemedicine services for members and their providers;
- Paid for Store and Forward means of transmission of medical information;
- Waived cost sharing on inpatient treatment of COVID-19 and are currently working to implement a waiver of cost sharing for medically necessary follow-up care;
- Implemented and extended a special enrollment period to allow the uninsured to enroll in QHP coverage; and
- Continue to work closely with DFR on measures that will remove barriers to access to high-quality prescription drugs.

We have and will continue to comply with these and other regulatory mandates, including covering an eventual COVID-19 vaccine and serological testing at zero cost share. Furthermore, we have unflinchingly ventured well beyond regulatory requirements to offer a number of additional programs to members and providers. Over the past several weeks, we:

- Waived cost share for urgent telemedicine visits through Amwell, our telemedicine partner;
- Paid for telephone triage to allow providers to manage patient needs and direct patients to receive the appropriate care;
- Have allowed additional flexibility for refills and home delivery of essential maintenance medications;
- Temporarily suspended administrative denials such as prior authorization requirements in certain circumstances;
- Extended premium relief to large groups facing financial challenges;
- Extended grace periods for members in all lines of business;
- Provided over $6 million in advance payments to Vermont hospitals;
- Made an additional $2 million available to independent Vermont providers;
- Continue to allow flexibility to group customers so that workers who have been laid off can continue to have access to quality health insurance; and
- Are working quickly to develop and implement a program that will provide targeted relief to Vermonters burdened by health care costs.

These initiatives come with a wide variety of costs and risks. We can start to measure the financial impact of some of these programs, but the costs of many will remain unmeasurable for several months or even years.

Furthermore, the worldwide economic crisis spawned by the pandemic and necessary societal response of social distancing will be felt by Vermonters and Vermont companies as well, including BCBSVT. We continue to closely monitor premium revenue as grace period have been extended for groups and members who may be struggling financially. Our investment portfolio is another source of significant risk.

These costs and risks have are counterbalanced by the deferral of non-emergent care that has taken place during the declared state of emergency. The resulting reduction in claims costs relating to our insured lines of business bolsters policyholder reserves. We understand that a deferral of necessary but non-emergent care is different from an elimination of services – much of this care will take place once restrictions are loosened. An inestimable portion of the boost to surplus must therefore be temporary.

Only eight weeks into an environment with so much uncertainty, it is impossible to confidently conclude that we are tracking to a capital position that is above, below, or safely within our mandated RBC range. However, we also appreciate that accelerations in volatility and uncertainty are themselves a reason that greater RBC may be required. Furthermore, while MLR rebates will refund excessive premiums to policyholders in the event of a continued claims downturn, there is no similar mechanism to protect policyholder reserves or solvency in the event of a surge in claims. For these reasons, we consider it imprudent to reduce CTR from our long-term rate at this time in reaction to the pandemic.

I understand that you have opined that the continued pandemic could very reasonably be projected to increase 2021 claims costs beyond their expected level in the absence of the crisis. In this circumstance, the proposed rates would be inadequate to cover the cost of claims projected in the filing. BCBSVT has long maintained that a pandemic is one reason to hold surplus. Given that the designed function of policyholder reserves is to weather the types of uncertainties created by a pandemic without resorting to extreme rate fluctuations, any increased cost in 2021 due to the COVID-19 pandemic will be funded through policyholder reserves. Said differently, I am comfortable that the filed CTR of 1.5 percent will yield our targeted financial outcome in the event that the COVID-19 pandemic is responsible for 2021 claims increases beyond those projected in the filing.

Market Considerations

In proposing a CTR for any given filing, BCBSVT must consider competitive and marketplace conditions while maintaining the framework of our overarching CTR philosophy and complying with the DFR RBC order.

BCBSVT experienced a loss of individual and small group membership from 2019 to 2020. Our competitor in this market enjoys a pricing advantage that is expected to persist into

2021. While we will continue to strive to maintain or grow our market share of the single risk pool, we cannot do so by intentionally underfunding premiums or by filing a CTR that does not adequately protect us from short-term fluctuations or unforeseen events, particularly when facing a time of unprecedented uncertainty with an RBC below the target range.

Conclusion

In consideration of all the above, I direct you to file a 1.5 percent CTR for the 2020 Vermont Individual and Small Group rate filing.

Attachment D

Prefiled Testimony of Ruth Greene

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

July 4, 2020

Mr. Kevin Ruggeberg, A.S.A., M.A.A.A.
Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 07/01/2020 Questions re:
Blue Cross and Blue Shield of Vermont
2021 Vermont Individual and Small Group Rate Filing
(SERFF Tracking #: BCVT-131936226)

Dear Mr. Ruggeberg:

In response to your requests dated July 1, 2020, here are *your questions* and our answers:

1. *Please provide revised URRT and filing exhibits representing the following updates:*
   a. *Updated 2019 risk adjustment figures communicated by L&E.*
   b. *Correction to weighted average medical trend calculation as noted in a prior objection response.*
   c. *Correcting URRT taxes and fees as noted in a prior objection response. Please also confirm the Profit & Risk Load and the Administrative Expense line items of URRT worksheet 2.*
   d. *Reduced credit card fees as noted in your prior response.*

   Please see attached *2021 BCBSVT Revised Exhibits 3J to 9B.xlsx* and *Revised 2021 BCBSVT URRT.xlsx*.

   The updated average rate increase is 6.5 percent.

   We updated the medical cost and utilization to reflect the new weights by category, as described in our response to question 5 of your June 11, 2020 request. These changes are shown on the revised exhibit 3J.

   We updated the credit card fees to reflect the updated calculation described in our response to question 4 of your June 26, 2020 request. This change is reflected on the revised exhibit 7A.

   We updated the 2019 risk adjustment transfer total by using the final RATEE information for BCBSVT and adjusting MVP's PLRS to arrive at the transfer amounts L&E provided via email on June 13, 2020. We also adjusted the 2021 premium increase to reflect the other changes described above. The result of this change is shown on the revised exhibit 4.

The table below demonstrates the incremental impacts to the average rate increase.

Step	Average Rate Increase	Incremental Impact (multiplicative)
Filed	6.340%	
Updated Medical Trends	6.470%	0.122%
Updated Credit Card Fees	6.298%	-0.162%
Updated Risk Adjustment	6.536%	0.224%

We updated the URRT for the changes listed above. We also corrected the plan names, as described in our response to question 1 of your May 19, 2020 request, as well as correcting the plan adjustment factors (worksheet 2, section III) to reflect 2021 information, as noted in our response to question 5 of your June 26, 2020 request. Profit & Risk Load, Administration Expenses, and Taxes and Fees in that section of the URRT now represent the 2021 factors, matching exhibits 7A through 7C.

2. *Please provide the currently expected 2020 claims, premiums, membership, Total Adjusted Capital (TAC), and Authorized Control Level (ACL), as of 6/30/2020 and 12/31/2020 in light of the impact of COVID19.*

In the interest of time and completeness, we are providing two documents that are more fully responsive to this question than a literal interpretation could be, understanding that certain specific elements of your request are not directly enumerated in our response. If we have misinterpreted the intent of your inquiry, we will promptly follow up with any specific data elements you require that are not already incorporated within the attachments.

We have completed an actuarial evaluation of the effect of plausible scenarios related to the COVID-19 pandemic in 2020 and 2021 on BCBSVT's risk-based capital position. Please see attached *BCBSVT Actuarial Report_COVID-19 Modeling.pdf*.

We have also completed a projection of RBC to December 31, 2021, based on our best knowledge at this time of significant impacts to BCBSVT's financial position over the next 18 months. The actuarial modeling of the COVID-19 impact feeds into the RBC projection. Please see attached *RBC Outlook.pdf*.

Please let us know if you have any further questions, or if we can provide additional clarity on any of the items above.

Sincerely,

Paul Schultz, F.S.A., M.A.A.A.
Chief Actuary

BCBSVT RBC Outlook 2020-2021

Prepared for DFR/GMCB
July 4, 2020

Future COVID Wave Severity[1]

	Vermont	New York Capital Region	No Second Wave	Boston	Suburban SE New York	Firmness of Amount	Expected Timing	Notes
RBC as of December 31, 2019			**567%**			actual		
Impact of changes in insured volume			75%			baseline		
$8.7M AMT credit expected in 2020			42%			firm		
Projected impact of 2020 operating results			-17%			baseline		
Projected impact of 2020 investment results			16%			baseline		
$3.6M investment in Vermont Blue Advantage start-up costs			-20%			firm		
$1.1M founding investment in CivicaRx			-6%			firm		
Subtotal: "Baseline" 2020 View			**657%**					
Equity market losses ($3M through May 2020)			-14%			actual	5/31/2020	
Acceleration of remaining AMT credit refund (CARES Act)			42%			firm	Sep-20	
2019 Final & 2020 Projected Risk Adjustment true-up			2%			firm	6/30/2020	Actual 2019: $20,273,879 (vs. booked $17,876,616) Projected 2020: $20,300,000 (vs. forecast estimate of $22,219,351)
Litigation recovery – risk corridor judgement (90% of $11M)			46%			firm	2020?	Timing of recovery not 100% certain
Surplus impact of 1/1/21 pension valuation (year-end 2020)			-180%			estimate	12/31/2020	BCBSVT's pension assets recently experienced a substantial loss of value—as of May 31, 2020, approximately $40.6M
Subtotal: 2020 View before COVID impacts on operations			**553%**					
Estimated RBC impact of COVID related claims and deferred care in 2020	98%	91%	60%	74%	33%	mean of stochastic modeling	2020	See *BCBSVT Actuarial Report_COVID-19 Modeling*
Uncollectible premiums due to COVID Emergency Order			-21%			estimate	2020	
Cancelled recoupment of Blueprint overpayments			-6%			actual	2020	
Uncollectible provider advances (50% RBC at risk)			TBD				12/31/2020	
COVID response cost - for deductibles waived on wellness generics and insulins through 12/31/2020			-7%			estimate	2020	
COVID response cost - increased retail pharmacy utilization (driven in part by the loosening of early refill edits and other measures to enhance access and affordability for members)			-18%			projection	2020	We do not consider retail pharmacy in our COVID modeling. Based on 2020 actual experience through June, we estimate that pharmacy claims will be about $4M higher than expected in the 2020 forecast.
COVID response cost -waived cost sharing for emergent telehealth visits through our telehealth partner			0%			estimate	2020	Very low impact to date
COVID response cost - BCBSVT Pharmacy Assistance Program			0%			estimate	2020	Very low impact to date
COVID response cost - suspension of claims audit activity (FWA)			-19%			estimate	2020	The 2020 forecast assumed that FWA recoveries would continue at the same rate as 2018, about 1.42% of medical claims. The suspension of the program will increase claims by about $4M above projections.
Estimated RBC as of December 31, 2020	**581%**	**574%**	**543%**	**557%**	**516%**			
Estimated RBC impact of COVID related claims in 2021	-56%	-63%	-41%	-78%	-117%	mean of stochastic modeling	2021	See *BCBSVT Actuarial Report_COVID-19 Modeling* Note an additional RBC impact of -22% to -31% in 2022
Litigation recovery – CSR (90% of $7M)			29%			firm	2021?	Timing of recoveries not 100% certain
Additional capital needed for Group Medicare Advantage growth			-9%			estimate	2021	Market demand is emerging
Cost of COVID response support 2021			-TBD					Depends on duration of support programs
GMCB approves hospital COVID allowances			-TBD					This amount could be large
2021 operating and investment results (net of COVID impacts and ACL increase due to health care cost trend)			0%			estimate	2021	Our long-term CTR assumption of 1.5% is selected to allow RBC to remain flatif rates are approved as filed and membership remains at current levels
Estimated RBC as of December 31, 2021	**545%**	**531%**	**522%**	**499%**	**419%**			
Notes:								
Estimated RBC impact of tail of returning care and vaccinations extending into 2022	-25%	-26%	-22%	-28%	-31%	mean of stochastic modeling	TBD	See *BCBSVT Actuarial Report_COVID-19 Modeling* Could be reflected in 12/31/2021 financials as a premium deficiency reserve if estimable at that time
Total impact of COVID claim scenarios	17%	2%	-3%	-32%	-115%			Sum of rows 21, 31 and 40
RBC as of May 31, 2020	695%							

Key Assumptions:

- 2021 VISG rate increase is approved as filed
- No significant loss of membership due to economic downturn

[1] See *BCBSVT Actuarial Report_COVID-19 Modeling* for a definition and detailed description of these scenarios.

Attachment E

Prefiled Testimony of Ruth Greene

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

June 29, 2020

Kevin Mullin, Chair
Jessica Holmes, Ph.D.
Robin Lunge, J.D., MHCDS
Tom Pelham
Maureen Usifer

Green Mountain Care Board
144 State Street
Montpelier, VT 05620

Re: Docket Nos. GMCB-002-20rr, GMCB-003-20rr, GMCB-004-20rr, GMCB-005-20rr

Dear Members of the Green Mountain Care Board,

In connection with the above-referenced filings, I write to inform the Board and the parties about a matter bearing on BCBSVT's solvency and reserves. Like many employers, BCBSVT has an ongoing financial and legal obligation to fund its pension commitments to its employees. BCBSVT's pension assets recently experienced a substantial loss of value—as of May 31, 2020, approximately $40.6 million, representing a 58.5% loss in value. That amount represents 180 percentage points of risk-based capital (RBC). We have disclosed this loss to the Department of Financial Regulation. We recognize and anticipate that the Board may have questions about this matter.

By way of brief background, BCBSVT provides pension benefits to its employees by offering an ERISA-governed defined benefit plan in conjunction with several other Blues around the country. We have access to this plan through our association with the national Blue Cross and Blue Shield Association. During the market disruption due to the global pandemic, plan assets sustained substantial losses that appear to be distinct from and in excess of the general market losses resulting from COVID-19. Because the losses occurred at the national program level, where the pension-asset investment decisions are made, all of the participating Blues, including BCBSVT, are affected.

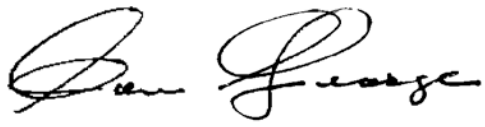
Although, as mentioned above, the current amount of the loss is $40.6 million, the long-term impact of the pension plan loss on BCBSVT's surplus and RBC is unclear. The process of investigating and assessing potential remedies for this loss, including potential legal action, is in its earliest stages. At this time, we are unable to provide specifics about the cause or causes of the loss, the potential for legal action, the timing of potential actions and their outcomes, or how the process may unfold more generally.

Moreover, figuring out the extent and cause(s) of the loss and determining next steps will likely (and unfortunately) be a lengthy process measured in months and years, not days and weeks. Because that process is still in its beginning phase, it is unlikely that BCBSVT will have additional significant information to share by the time the Board issues a decision on BCBSVT's 2021 Vermont Individual and Small Group rate filing.

In light of the above, we respectfully request that, if the Board or the HCA has questions about this matter, the Board pose them to BCBSVT in writing (as the Board typically does with non-actuarial questions) in advance of the VISG hearing. Because of the potential for legal action related to the pension loss, BCBSVT must consult with counsel in responding to any question about this matter, and thus doing so at hearing would be difficult, if not impossible.

Please do not hesitate to contact me or my team with questions.

Sincerely,



Don George
President and CEO

cc: Michael Fisher, Office of the Health Care Advocate
Michael Pieciak, Commissioner, Vermont Department of Financial Regulation

Attachment F

Prefiled Testimony of Ruth Greene

businesswire
A BERKSHIRE HATHAWAY COMPANY

AM Best Revises Issuer Credit Rating Outlook to Stable for Blue Cross and Blue Shield of Vermont and Its Subsidiary

July 01, 2020 09:55 AM Eastern Daylight Time

OLDWICK, N.J.--(BUSINESS WIRE)--**AM Best** has revised the outlook to stable from negative for the Long-Term Issuer Credit Rating (Long-Term ICR) and affirmed the Financial Strength Rating (FSR) of B++ (Good) and the Long-Term ICR of "bbb+" of Blue Cross and Blue Shield of Vermont and its wholly owned subsidiary, The Vermont Health Plan, LLC. The outlook of the FSR is stable. These companies are collectively known as BCBSVT Group. Both companies are domiciled in Berlin, VT.

The Credit Ratings (ratings) reflect BCBSVT Group's balance sheet strength, which AM Best categorizes as strong, as well as its marginal operating performance, neutral business profile and appropriate enterprise risk management.

The revision of the Long-Term ICR outlook to stable reflects a material improvement in BCBSVT Group's risk-adjusted capital for 2019, as measured by Best Capital Adequacy Ratio (BCAR). The increase in BCBSVT Group's BCAR was driven predominately by the receipt of an alternative minimum tax (AMT) credit by BCBSVT Group, as the companies continue to report underwriting and net losses. An additional AMT credit is expected to be received in 2020, which is anticipated to be larger than previously expected. Under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the payment of the AMT credit is being accelerated, and all remaining credits are to be paid in 2020.

BCBSVT Group has reported a trend of underwriting losses for a four-year period through 2019. This has been due mainly to BCBSVT Group being unable to achieve adequate rate increases through Vermont's rate review process for its exchange business. Current year results have shown significant fluctuations due to COVID-19, and the final impact to 2020 is still unknown as there remains a high degree of uncertainty around medical expenditures and investment portfolio impact. However, the strengthening of BCBSVT Group's risk-adjusted capital from the AMT receipts should provide an offset for any potential unfavorable operating results or non-operating adjustments to capital over the near to medium term.

BCBSVT Group maintains a high market share and good brand awareness in its primary market. The company remains flexible and has introduced new and innovative products and services to address the needs of its employer groups and members. The company is working currently on the introduction of Medicare Advantage products, which will diversify its enrollment base further.

This press release relates to Credit Ratings that have been published on AM Best's website. For all rating information relating to the release and pertinent disclosures, including details of the office responsible for issuing each of the individual ratings referenced in this release, please see AM Best's Recent Rating Activity web page. For additional information regarding the use and limitations of Credit Rating opinions, please view Guide to Best's Credit Ratings. For information on the proper media use of Best's Credit Ratings and AM Best press releases, please view Guide for Media - Proper Use of Best's Credit Ratings and AM Best Rating Action Press Releases.

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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: BlueCross and BlueShield Vermont 2021 Individual and Small Group Rate Filing SERF No. BCVT- 132371410	GMCB-005-20rr

PREFILED TESTIMONY OF DR. KATE MCINTOSH

Dated: July 7, 2020

Attachments:

Attachment	Title
A	Dr. Kate McIntosh CV

Dr. Kate McIntosh, being duly sworn, does hereby depose and say as follows:

What is your current employment?

I am the Senior Medical Director and Director of Quality at Blue Cross and Blue Shield of Vermont (BCBSVT).

Please describe your primary job responsibilities.

I have a range of responsibilities in my roles as Senior Medical Director and Director of Quality. My primary responsibilities include management and oversight of the following: medical policy; utilization management; quality of care issues; BCBSVT member safety; National Committee for Quality Assurance (NCQA) accreditation; HEDIS measures; access and satisfaction surveys; credentialing of providers and BCBSVT network quality; physician

advisory groups; BCBSVT's quality relationship with OneCare, and BCBSVT's COVID-19 pandemic response.

Please describe your clinical experience.

I received my MD from the University of Colorado Health Sciences Center in 1994 and completed a pediatric residency at the University of Michigan Health Sciences Center. I am board-certified in pediatrics and a Fellow of the American Academy of Pediatrics.

I have 22 years of clinical experience. From 2004 until 2019, I was President and Managing Partner of an independent pediatric practice, Rainbow Pediatrics in Middlebury, Vermont. From 2011 to 2019, I was Chair of Pediatrics at Porter Hospital.

Is your current CV attached to this prefiled testimony as Attachment 1?

Yes.

As part of your employment responsibilities at BCBSVT, do you stay informed regarding public health, medical, and scientific information about the COVID-19 pandemic?

Yes.

Do you regularly review news and information about new infections, hospitalizations, and deaths from COVID-19?

Yes, I regularly review current news and public health information about new infections, hospitalizations, and deaths related to COVID-19 in Vermont, nationally, and internationally.

Do you regularly review medical and scientific information regarding COVID-19, including information related to prevention, treatment, symptoms, and vaccine research?

Yes.

Do you regularly review information related to pandemic trends and modeling?

Yes.

Please list some of the sources you regularly review for public health, medical, and scientific information regarding the COVID-19 pandemic.

I regularly review news and information from the following sources, among others:

- Johns Hopkins Coronavirus Dashboard
- IHME University of Washington predictive modeling
- Vermont Department of Health daily updates
- Other state and local health departments as needed
- CDC
- European Centers for Disease Control (ECDC)
- World Health Organization (WHO)
- UpToDate (an evidence-based clinical resource, written by over 7,100 physician authors, editors, and peer reviewers)
- General news sources: New York Times, Washington Post, The Economist
- MedLine, New England Journal of Medicine, Annals of Internal Medicine, Journal of the American Medical Association, and other medical journals
- Preprint websites that publish non-peer reviewed early publications

How many Vermonters have tested positive for COVID-19?

As of June 30, 2020, 1,210 Vermonters have tested positive for COVID-19.

How many Vermonters are currently hospitalized for treatment related to COVID-19?

As of June 30, 2020, one Vermonter is currently hospitalized for COVID-19.

How many Vermonters have died from COVID-19?

As of June 30, 2020, 56 Vermonters have died of COVID-19.

What is Vermont experiencing now in terms of new infections?

In June, Vermont's average of number of new infections per day was between 7 and 8. That rate is higher than May, when the average number of new infections per day was between 3 and 4.

What is the United States experiencing now in terms of new infections?

On July 1, 2020, the United States reported a single-day total of approximately 50,000 new cases. This is nearly twice the number of new infections two weeks ago and is a higher number of daily infections than at any time previously during this pandemic. As of July 1, the 14-day percent change in new infections was 87% and is expected to rise.

Based on your knowledge and expertise, do you believe it is currently possible to predict the future curve of COVID-19 infections and hospitalizations in Vermont?

No.

Why not?

It is possible to do some very short-term modeling since, for example, we know that deaths lag cases by about four weeks, and also that significant changes in the occurrence of new cases lag governmental behaviors like shutting down bars or schools or citizen behaviors like crowding beaches or protests by about 4 to 6 weeks. However, these models are inherently inaccurate because of our incomplete understanding of this virus and are also subject to sudden changes due to unforeseen circumstances such as super-spreader events; policy changes; events in neighboring states; virus mutations; and other unknown variables.

We cannot accurately predict what is going to happen more than 4 to 6 weeks in the future. Multiple states are reporting their highest single-day totals of the pandemic. We are seeing record numbers of new cases and hospitalizations in hot spots in the United States such as Texas, Florida, and Arizona, and other countries such as Brazil and Russia. The pandemic is persistent and unpredictable. Although international research is proceeding at an unprecedented pace, at this point, our treatment and prevention options are minimal to non-existent.

Please explain further the basis for your characterization of the pandemic as persistent and unpredictable.

From a medical perspective, despite an enormous amount of research and effort, little has changed with regard to effective medications or vaccination since the beginning of the pandemic. The virus is continuing to spread, to infect tens of thousands of people every day, and to cause serious illness and death. The medical and scientific community is only beginning to learn critical information about this virus. The virus spreads relatively easily through respiratory droplets and aerosols. The available evidence indicates that approximately 35% of those infected are asymptomatic, which makes it difficult to control the spread of infection and will prolong the outbreak. Developing research indicates that testing antibody levels is not likely to be helpful in the near future to gauge individual or community actions. Treatment remains primarily supportive. The various antivirals that are available have variable utility and none have been shown to be highly effective. Although there are many vaccines in development, the actual effectiveness of these vaccines remains to be seen, and the development and implementation timeline remains very uncertain.

We still have many unanswered questions about COVID-19. For example, although states including Vermont are planning to reopen schools this fall, we do not yet know how contagious children are when infected with COVID-19 and thus do not know how much the virus will spread in schools. Vermont has many colleges, and there is a great deal of uncertainty

about the risks to their local communities of opening these institutions. Also, as businesses re-open and we attempt to keep our economy functioning, we are likely to face increased resurgence and repeated hot spots, even within the state of Vermont.

Evidence is also building that most people may not develop lasting immunity even after being infected with SARS-CoV-2. Antibodies to the virus usually are induced in those who have become infected, although in one recent study from The Rockefeller University published in the journal Nature found that 33% of patients who had tested positive for COVID-19 failed to develop enough antibody to be considered to have any immunity at all. Only 1.8% showed antibody levels high enough to be considered to be immune and the majority had enough antibody to probably be considered partially immune. Compounding this is preliminary evidence from a study in China that antibody levels begin to fall within 1 to 3 months of the resolution of the infection, possibly leading to a further loss of immunity.

These findings are not surprising, as other coronaviruses have been seen to confer only partial immunity. In other coronaviruses, immunity develops soon after infection but gradually wanes over time and re-infection is common.

For all of these reasons, there is a concern that immunity may not be lasting and re-infection may occur with COVID-19. If this is the case, the timelines for this virus are even more uncertain.

Based on your knowledge and expertise, do you expect that the COVID-19 infection rate in Vermont will remain at its current levels for the next 12 to 24 months?

No. In my opinion, the next 12 to 24 months will be a highly unpredictable time for the pandemic. The pandemic in Vermont and nationally is likely to be cyclic, with recurring waves of infections for at least the next 12 to 24 months. Because the virus spreads more easily from person to person indoors, it will be much more difficult to limit the spread of infection during the

winter months. The scientific community is concerned that there will be a dramatic surge in infections in the fall and winter.

Vermont is only a short drive from several major urban centers that have experienced significant outbreaks, and travel from those areas is a potential source of new outbreaks. It is likely that over the next 12 to 24 months, Vermont will experience multiple centers of outbreak affecting a broad swath of individuals and communities.

Will public health measures aimed at prevention affect how the pandemic unfolds in Vermont?

Yes, public health measures including social distancing, testing and contact tracing, requirements for masks, and limits on public gatherings all help reduce the spread of the virus. We are seeing that states like Texas and Florida that reopened quickly are experiencing high rates of new infection. Vermont's experience over the next 12 to 24 months will depend in part on whether the state takes a conservative, cautious approach to loosening restrictions and allocates sufficient resources to testing, contact tracing, and other measures that can effectively contain outbreaks. We do not yet know whether that will be the case.

Are there other factors that may affect how the pandemic unfolds in Vermont?

Yes. As many people now realize, the lack of effective federal coordination has been a serious problem in the United States. It substantially undermines the accuracy and usefulness of critical information, including rates of new infection. That is a continuing problem as we try to predict the future curve of the pandemic in Vermont and elsewhere.

There are numerous other factors that may play a role in the way the pandemic unfolds in our state. Vermont is not an island. Examples of external factors that will affect Vermont include: incoming travel by visitors from around the country and the world; decisions that colleges and universities make around re-opening; actions at residential and long-term care

facilities. Luck will also play a role; some outbreaks will be worse than others because of chance—such as an asymptomatic but highly contagious person present in a setting that is particularly crowded or poorly ventilated.

Are you familiar with current news and information regarding potential vaccines for COVID-19?

Yes.

Based on your clinical experience and education, are you generally familiar with the process for developing of new vaccines?

Yes.

What is the potential timeline for a vaccine for COVID-19?

The international effort to develop potential vaccines is extraordinary. According to the WHO, there are 18 vaccines in clinical evaluation and 129 vaccines in preclinical evaluation. The prevailing hope from the National Institute of Allergies and Infectious Disease is that a successful vaccine will be developed and implemented by the end of 2021.

Further, based on current research and evidence, it is likely that any coronavirus vaccine will not be 100% effective in preventing infection. I expect that if a vaccine is approved, it may require annual administration.

As you stated above, the average number of new infections per day in June in Vermont was between 7 and 8. In your professional judgment, would it be responsible for BCBSVT to plan ahead for the next 12 to 24 months on the assumption that infection rates in Vermont will stay at the current level?

No. In my view, taking that approach would be irresponsible and contrary to current evidence about this ongoing pandemic. We have to remember that because of our early success, our population remains vulnerable to infection. There is a tension between economic health and population health and we are trying to thread this needle carefully in Vermont. Vermont has been exceptionally fortunate in our coronavirus outbreak, in no small measure due to exceptionally prudent government action as well as low population density. However, we would be wise to remember that South Korea was in a similar position as Vermont is now—and a single super-spreader event occurred, where a single individual resulted in a cluster of more than 5000 cases within 4 weeks.

Based on your knowledge and expertise as a clinician and medical professional, do you expect that BCBSVT will see increased claims costs related to COVID-19 treatment over the next 12 to 24 months?

Yes, unfortunately that is what I expect. The pandemic is continuing, case counts are rising dramatically in some parts of the United States, and public health restrictions are loosening. More people will be treated and hospitalized for this illness.

Do you see any particular risk factors for BCBSVT's members?

Yes. Overall, Vermont has an older population, and age is a risk factor for COVID-19. Chronic conditions are also a risk factor for COVID-19. For our QHP members, 62% of adults (age 20 and over) have a chronic condition and 31% of children and youth (2-19) have a chronic condition.

Are you familiar with work that BCBSVT's chief actuary, Paul Schultz, has been conducting to attempt to model deferred and delayed care related to the pandemic and stay-at-home orders?

Yes.

Did you assist Mr. Schultz with certain aspects of this work?

Yes.

What assistance did you provide?

I worked closely with Mr. Schultz and the actuarial team to develop and provide certain inputs for the model. Specifically, I reviewed 33 categories of care, assessed whether specific types of care were likely to return, and developed assumptions for the return of care for each service category. Overall, we estimated that 56.1% of the services that were deferred during the slowdown period will be made up. I also assisted in developing assumptions about changes in demand that certain claim categories will experience in the future due to the more lasting changes to the care delivery system that are likely to result from the pandemic.

Was the information you provided to Mr. Schultz consistent with your best professional judgment?

Yes.

You have opined that you expect more outbreaks in Vermont in the next 12 to 24 months and more people treated and hospitalized for COVID-19. In your view, does that mean that claims for non-COVID-related treatments are likely to be significantly reduced in that time frame?

Not necessarily. Hospitals are innovating around ways to keep non-COVID patients safe. I expect that they will try to maintain as many elective procedures and routing therapies for individuals without COVID as possible at the same time that they fulfill their mission for their COVID patients. Therefore, I anticipate both an increase in the number of patients with COVID along with a simultaneous return toward baseline for elective procedures.

Are you familiar with actions that BCBSVT has taken in response to the COVID-19 pandemic?

Yes. I have taken a lead role in coordinating and managing BCBSVT's response to the COVID-19 pandemic. Throughout this period, BCBSVT has taken steps to keep members covered, expand access to coverage, extend payment flexibility, facilitate telemedicine, ease prior authorization requirements, and support providers.

Please describe the steps that BCBSVT has taken to help keep its members covered during this period of financial challenges.

We have taken a number of steps to help maintain coverage for our members and provide flexibility in making premium payments:

- provided an extra 30-day grace period for payment deadlines;
- suspended terminations for non-payment from March through June 2020; as of this date, no QHP member or group has been terminated for nonpayment since before March 13, 2020;

- allowed insured groups to continue paying for insurance for furloughed workers, and have not re-rated groups with membership changes greater than 10%;
- "paused" groups that have laid off workers so they can be re-instated as they return to normal business.

What steps has BCBSVT taken to facilitate access to health care during the pandemic?

Throughout this time, we have worked with regulators and providers to make it easier for our members to access health care, both for COVID-19 related testing and treatment and for other needed care. Steps BCBSVT has taken include:

- BCBSVT waived member cost-sharing related to COVID-19 treatment and non-emergency medically necessary ambulance transport, through December 31, 2020.
- We permitted telephone visits to be billed as telemedicine and authorized telephone triage at zero cost share.
- To facilitate preventive care, we authorized payment for health checks for established patients (adults and well child checks for children over the age of one).
- We waived the deductibles for generic wellness medications and insulins to help our members treat their chronic conditions and thus, hopefully, lower their risks of complications from COVID-19.
- We created a Pharmacy Assistance Program to help our members who are having trouble affording their co-pays. We work with their provider and our medical pharmacist to do a comprehensive evaluation of their medications and to assist their move onto a lower cost medication if appropriate. We also help them take advantage of coupon and discount programs offered by the pharmaceutical companies, and offer subsidies to reduce their co-payments.
- We authorized payment for depression and other behavioral health screening tests via telemedicine or telephone.

- We authorized payment for Intensive Outpatient Therapy Services and crisis/group psychotherapy by telemedicine or telephone.
- We authorized payment for additional ABA services, speech therapy, occupational therapy, physical therapy, intensive outpatient therapy offered via telemedicine/telephone.
- For our preferred telemedicine provider, we waived cost share for urgent and acute visits.
- To make it easier for members to get prescriptions and limit pharmacy visits, we allowed early refills; gave pharmacists prescription override codes to decrease the number of times frail people went to the pharmacy; offered 90-day parity on mail order and in-person refills; offered a one-time waiver for 180-supply for chronic medications; and allowed up to 60-day supply for specialty medications when appropriate.
- We entered into a letter of agreement with the home health agencies permitting billing for telemedicine for any services they feel they can appropriately provide remotely.
- We extended imaging authorizations to 180 days.
- We loosened prenotification requirements for acute inpatient medical, mental health, and substance abuse admissions.
- We loosened prenotification requirements for home health skilled nursing.
- We suspended prior authorization for inpatient skilled nursing admissions and inpatient acute rehabilitation admissions.
- We suspended prior authorization for home infusion for the State of Vermont.
- We loosened the requirement for non-emergent transport for patients with COVID-19 to allow them to be transported safely for medical evaluation and to their homes from the hospital as long as isolation precautions are required.

In sum, we quickly revised policies and adopted emergency policies to make it easier for our members to access care, and for providers to get paid for providing that care—while serving the overall public health objectives of limiting contact visits and helping people stay home as

much as possible. BCBSVT has voluntarily extended all its emergency policies to December 31, 2020.

REMOTE NOTORIAL ACT CERTIFICATE

State of Vermont, County of Washington.

Sign or sworn remotely before me through a secure communication link on July 6, 2020 by Kate McIntosh.

Executed by [signature] on 7/6/20.
Kate McIntosh *Date*

Signature of notary public: Alan Cunningham 7/6/20

Printed name of notary public Alan Cunningham

Commission number: 137.000 4432

Commission expiration date: 01/31/2021

Title of office is Notary Public.

ALAN THOMAS CUNNINGHAM NOTARY PUBLIC COMMISSION NO. 167.000162 MY COMM. EXP. 1/31/21 STATE OF VERMONT

CERTIFICATE OF SERVICE

I certify that I have served the above Prefiled Testimony of Dr. Kate McIntosh on Michael Barber, Amerin Aborjaily, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Kaili Kuiper and Eric Schultheis, counsel for the HCA, by electronic mail, Delivery Receipt requested via Microsoft Outlook, on July 7, 2020.

/s/ Michael Donofrio
Michael Donofrio

Stris & Maher LLP
28 Elm St
Montpelier, VT 05602
Telephone: (802) 858-4465
michael.donofrio@strismaher.com

Attachment A

Prefiled Testimony of Dr. Kate McIntosh

Kate Helen Carey McIntosh, MD, MBA, FAAP

Clinical and Management Experience

2019 to Present

Blue Cross and Blue Shield of Vermont
Berlin, VT
Senior Medical Director and Director of Quality

2018 to 2019

Blue Cross Blue Shield of Vermont
Berlin, VT
Associate Medical Director

2004 to 2019

Rainbow Pediatrics
Middlebury, VT
President and Managing Partner

2011 to 2019

University of Vermont Health Network Porter Hospital
Middlebury, VT
Chair, Department of Pediatrics

2013 to 2018

Vermont Information Technology Leaders
Burlington, VT
Medical Director

2013 to 2018

McIntosh Medical Consulting
Shoreham, VT
Principal

2004-2013

Northlands Job Corps
Vergennes, VT
Pediatric Consultant

1998-2004

Crystal Lake Clinic
Benzonia, MI
Practicing Pediatrician

1997-1998

Norwood Hospital
Norwood, MA
Pediatric Hospitalist

Governance Experience

- Board of Directors Vermont Program for Quality in Health Care, Montpelier VT 2019-present
- Board of Directors University of Vermont Health Network Porter Hospital, Middlebury VT 2012-2018
- Vice Chair of Quality Committee University of Vermont Health Network Porter Hospital, Middlebury, VT 2017-2018
- University of Vermont Health Network Population Health and Quality Committee, Burlington, VT 2017-2018
- Medical Executive Committee University of Vermont Health Network Porter Hospital, Middlebury, VT 2011-present
- President of Medical Staff, Munson Healthcare Paul Oliver Hospital, Frankfort, MI 2004
- Vice-President of Medical Staff, Munson Healthcare Paul Oliver Hospital, Frankfort, MI 2003
- Secretary of Medical Staff, Munson Healthcare Paul Oliver Hospital, Frankfort, MI 2002

Advisory Committee Experience

- Primary Care Advisory Committee to the Green Mountain Care Board (Technical Advisory Committee) 2018-Present
- Primary Care Advisory Committee to the Green Mountain Care Board (Limited scope) 2017-2018
- One Care Accountable Care Organization Pediatric Advisory Committee, Burlington, VT 2015-present
- Blue Cross Blue Shield Vermont Physician Advisory Committee, Berlin, VT 2014-present
- Addison County Community Health Team, Middlebury, VT 2011-2013

Information Technology Experience

- PRISM superuser 2018-present
- Meditech super-user 2011-2018
- Allscripts Professional super-user and lead physician 2010-Present
- A4 super-user 2002-2004

Academic Appointments

- Clinical Assistant Professor, University of Vermont School of Medicine 2006-present
- Clinical Instructor, University of Vermont School of Medicine 2005-2006
- Clinical Instructor, Traverse City Family Practice Program 2000-2004
- Clinical Instructor, Boston University School of Medicine 1997-1999

Education

- MBA, Business Administration and Health Policy, Brandeis University, Waltham, MA 2019
- Certified Professional in Health Information Exchange (CPHIE) 2013
- Pediatric Residency, University of Michigan Health Sciences Center, Ann Arbor, MI 1997
- MD, University of Colorado Health Sciences Center, Denver, CO 1994
- BA, Biological Psychology, Swarthmore College, Swarthmore, PA 1990

Awards and Honors

- Beta Gamma Sigma 2018 Brandeis chapter: Business honor society

Professional Associations:

- Fellow of the American Academy of Pediatrics 1998-present
- American Board of Pediatrics 1997-present
- AAP Section on Practice Management 1998-present
- Vermont State Medical Society 2016
- American Association for Physician Leadership 1994, 2016

Speaking Engagements

Pediatric Sub-Committee One Care Accountable Care Organization "Pediatric Patients and the ACO model of care" November 2017
Vermont CHAMP Conference 2017 (Child Health Measured in Practices) "Screening for maternal depression in pediatric practices" October 2017
Bi-State Primary Care Association Medical Director's Meeting: "Conceptualizing the shift to Value based care" December 2016
Vermont CHAMP Conference 2016"Developmental screening in Pediatrics" October 2016
Vermont Information Technology Leaders Summit "MACRA, MIPS, and APMs" September 2016
Vermont Information Technology Stakeholder Meeting, "Meaningful Use 3, why it matters to everyone in healthcare" June 2016
Vermont Associations of Hospitals and Health Systems "The role of the Vermont Health Information Exchange in medical practice" September 2015

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: BlueCross and BlueShield Vermont 2021 Individual and Small Group Rate Filing SERFF No. BCVT-131936226	GMCB-005-20rr

PREFILED TESTIMONY OF PAUL A. SCHULTZ

Dated: July 7, 2020

Attachments:

Attachment	Title
A	Paul A. Schultz CV

Mr. Paul A. Schultz, being duly sworn, does hereby depose and say as follows:

What is your current employment?

I am the Chief Actuary at Blue Cross and Blue Shield of Vermont (BCBSVT). I have held that position since January 2015. I joined BCBSVT's actuarial team in 2013.

Please describe your primary job responsibilities.

As Chief Actuary, I oversee BCBSVT's actuarial services and underwriting departments. Those responsibilities include overseeing and participating in the pricing of and preparation of rate filings for all products, including individual and small group products. I also design and oversee the implementation of BCBSVT's actuarial modeling processes. I serve as lead actuary for individual and small group, large group, and Medicare Supplement filings, including pricing, interaction with reviewing actuaries, and testimony at related hearings. Some of my other

responsibilities include: reviewing monthly reserves; serving on our internal Strategic Growth, Healthcare Cost Containment, Regulatory, and Healthcare Reform Oversight committees; developing new product offerings and funding approaches; and participating in Vermont working groups addressing a variety of policy issues, including many related to the individual and small group market.

Please describe your professional experience prior to working at BCBSVT.

I have worked as an actuary in the health care field since 1996. In 2001, I became a Health and Group Benefits Actuary at Mercer Human Resource Consulting, and have worked in oversight roles ever since. I have been a Fellow of the Society of Actuaries since 2001 and a Member of the American Academy of Actuaries since 2000.

Is your current CV attached to this prefiled testimony as Attachment A?

Yes.

Have you given sworn testimony about past rate filings?

Yes. I have testified before the Green Mountain Care Board at hearings from 2014 through 2019 regarding the actuarial analysis supporting BCBSVT's Vermont individual and small group rate filings for plan years 2015 through 2020.

As part of your employment responsibilities at BCBSVT, how do you stay informed regarding actuarial analysis and information that relates to rate development?

The American Academy of Actuaries promulgates Qualification Standards that actuaries must follow for issuing statements of actuarial opinion in the United States. Examples of statements of actuarial opinion include the actuarial memorandum issued as part of this rate filing and the actuarial report on COVID-19 modeling that we released on July 4. The

qualification standards include a requirement to complete at least 30 hours of relevant continuing education annually.

To meet this requirement and to remain current on emerging advances in actuarial practice, I regularly attend a variety of webinars and live conferences sponsored by the Society of Actuaries, the American Academy of Actuaries and the Conference of Consulting Actuaries. I also frequently review binding standards of practice promulgated by the Actuarial Standards Board and non-binding but informative Practice Notes issued by the American Academy of Actuaries. I participate in the Individual and Small Group Market Committee of the American Academy of Actuaries, which discusses and develops publications relating to the Affordable Care Act and other ISG issues. I also participate quite frequently in conference calls organized by the Actuary Forum of the Blue Cross Blue Shield Association, during which many topics relevant to rate development and other actuarial analyses are discussed among actuaries working for Blue plans across the United States.

Since the onset of the Covid-19 pandemic, have you regularly reviewed news and information about the pandemic as it relates to your responsibilities over BCBSVT's rate filings? If so, please describe the materials you have reviewed.

Yes. The American Academy of Actuaries has assembled a compendium of COVID-19 resources, including everything from legislation and regulation to data sources, academic articles and news publications. I have reviewed, and continue to review, a variety of widely available news sources like the New York Times and Kaiser Health News to keep generally informed about the pandemic. I stay abreast of developments in Vermont as reported by the Vermont Department of Health. In addition, I have reviewed, and continue to review, the sources of actuarially relevant information and analysis assembled by the Academy and distributed by the Academy through my participation in the Health Payment Reform listserv. These include published studies, data sources, and actuarial research concerning the pandemic. In particular, I review information related to COVID-19 trends and modeling, such as white papers published by

actuarial consulting firms such as Milliman and Oliver Wyman and research briefs and other materials published by the Society of Actuaries. Finally, the Blue Cross Blue Shield Association Actuary Forum has organized weekly or biweekly conference calls specifically to share the results of actuarial research and analysis sponsored by the Association or conducted by other Blue plans.

What materials did you review and rely on in preparing this prefiled testimony?

I reviewed and relied on the following materials:

- 2021 Vermont Individual and Small Group Rate Filing, SERFF Tracking Number BCVT-132371410 (May 8, 2020)
- BCBSVT 2021 Vermont Individual and Small Group Rate Filing Actuarial Memorandum (May 8, 2020)
- BCBSVT's Responses to all Lewis & Ellis Objection Letters in this matter
- BCBSVT's Responses to the GMCB's Non-Actuarial Questions in this matter
- BCBSVT Supplemental Actuarial Memorandum (July 4, 2020)
- The materials discussed in this Prefiled Testimony immediately preceding this question, at page 3, lines 3 through 17
- The materials listed at page 18 lines 13-27 and page 19 lines 1-19 of this Prefiled Testimony

Were you responsible for preparing BCBSVT's 2021 Vermont Individual and Small Group Rate Filing (the Filing), which is the subject of this proceeding?

Yes. The Filing was prepared under my supervision, and, at the time of filing, I certified that it meets all relevant actuarial standards and that it complies with all applicable state and federal laws and regulations. That certification holds true today.

Are you fully familiar with all aspects of the Filing, as well as all of the documents and information BCBSVT has submitted to the Green Mountain Care Board (Board) over the course of this proceeding?

Yes. The Filing and all other documents and information that BCBSVT has submitted over the course of this proceeding in response to all of the actuarial and non-actuarial questions posed by the Board also meet all relevant actuarial standards and comply with all applicable state and federal laws and regulations.

What is the purpose of the Filing?

The purpose of the Filing is to provide the rates and a description of the rate development for the ACA-compliant plans for the Vermont Individual and Small Group merged market that BCBSVT proposes to offer for the 2021 benefit year. The Filing applies to plans both On-Exchange and Off-Exchange.

What were your objectives in developing the rates reflected in the Filing?

Our goal was to develop rates that will cover our policyholders' 2021 health care costs and result in the minimum contribution to policyholder reserves needed in the long term to (1) maintain an appropriate level of reserves relative to projected health care claims and potential unforeseen adverse events and (2) keep BCBSVT on a trajectory towards growing its policyholder reserves into the acceptable range ordered by the Department of Financial Regulation. We did so by using assumptions that are reasonable both individually and in the aggregate, and methodology that is in compliance with state and federal rules and instructions. Our goals did *not* include using the assumptions that would lead to the highest possible actuarially reasonable rate, nor to make up for the losses BCBSVT has experienced over time in this line of business due to underfunded rates.

In your previous response, you mentioned "the highest possible actuarially reasonable rate." Does an actuarially appropriate rate development process always yield a single, correct rate?

No. By its nature, the rate development process always results in a range of actuarially reasonable results. Our approach in the Filing was to develop rates that will result in a contribution to member reserves that is in line with the long-term assumption that allows us to maintain solvency within the range that our solvency regulator has ordered.

Please describe the rate changes BCBSVT is requesting in the Filing.

BCBSVT is requesting an average increase of 6.3 percent. Increases for specific plans range from -0.7 percent to 13.3 percent. The range of increases is due to changes to the actuarial values and plan designs. Apart from the Catastrophic plan and the Vermont Select CDHP Gold, the increases range from 3.4 percent to 7.2 percent.

Did you submit an Actuarial Memorandum in support of the proposed rates?

Yes. The Actuarial Memorandum submitted as part of the Filing sets forth and explains the development of and rationale for the proposed rates, including: the facts, data, analysis, and methodology used to calculate the AV Metal Value for each Qualified Health plan and Reflective plan offered by BCBSVT in 2021; the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based; that the Index Rate is developed in accordance with federal regulations; and that the Index Rate along with allowable modifiers is used in the development of plan-specific premium rates.

Please define the term "Index Rate."

The "Index Rate" is the allowed claims costs for providing Essential Health Benefits (EHBs) within the single risk pool of that market expressed on a per member per month basis.

Does the projected Index Rate reflected in the Filing comply with all applicable state and federal law?

Yes. The projected Index Rate reflected in the Filing complies with all applicable state and federal law, including 45 C.F.R. §§ 156.80 & 147.102, was developed in compliance with the applicable Actuarial Standards of Practice, is reasonable in relation to the benefits provided and the population anticipated to be covered, and is neither excessive nor deficient. The development of the Index Rate is explained in detail in the Actuarial Memorandum, at §§ 3.3, 3.7, 3.8.

Please describe in general how the Filing was prepared.

The objective of any rate filing is to project the cost of insurance coverage in some future period. In the case of an ongoing product, we do this by observing recent experience in the product and applying generally accepted actuarial standards of practice to estimate how the rate components are likely to change in the future period. In the broadest terms, we apply actuarial science in order to project the claims costs, taxes and fees, and the cost of insurance we will incur on behalf of our policyholders, and then develop rates designed to generate sufficient premiums to cover those amounts.

Before attempting to project claims costs and cost of insurance, is it necessary to rebase prior rate calculations? If so, please explain what rebasing means in this context.

No. Prior rate calculations play no role in the current rate development. Each year's rate development is an independent process.

In order to minimize the unknowns and to start from the best possible information, we use the most recent available 12 months of data as a basis for the projection as long as the population is fully credible. The BCBSVT VISG population is easily credible, so we update our base period each year to use only the most recent data. In this sense, we always "rebase" to the

most recent credible data. In the Filing currently under review, we use actual 2019 experience as a basis upon which to project 2021 experience. The previous filing used actual 2018 experience to project 2020 experience.

Once we have developed our projection, federal rules and our own goal of transparency dictate that we should compare projected rates to those currently in force so we can calculate and report an average percent increase.

An actuarially sound analysis of the reasons for rate increase must start with an assessment of actual to expected experience results.

Actual 2019 claims experience was slightly favorable compared to the expected experience built into the 2020 filing thanks to a 1.3 percent improvement resulting from BCBSVT cost containment programming that exceeded expectations. That, combined with a favorable risk adjustment transfer, results in a net decrease to 2021 rates of 1.4 percent when we "rebase" to the actual 2019 claims experience.

Please describe what "allowed claims costs" are and generally how you projected them.

The most significant rating component is, by a wide margin, the projection of allowed claims costs, meaning the total cost of health care, including cost sharing, for Vermonters expected to enroll in these plans. The process by which we projected allowed claims costs is covered in detail in Section 3 of the Actuarial Memorandum. *See also* Actuarial Memorandum §§ 1.5 & 1.7.

In order to craft this projection, we started with the 2019 allowed claims experience of members in BCBSVT VISG. These members represented over 500,000 (exactly 520,581) member months of experience. We then need to anticipate how that claims experience might be different in 2021. The two key drivers of differences are increases in the cost and use of health care and anticipated changes in the population. These drivers are reflected through the trend and population morbidity assumptions, respectively.

Changes to the regulatory environment could impact trend, the population that is likely to be covered, or both, so we also reflect any such regulatory changes in our projection.

After we project allowed claims, we then separate that projected amount into a portion that is paid by BCBSVT, and therefore must be part of the premium rates, and a portion that will be paid out-of-pocket by the members via cost sharing. This division is accomplished by applying a set of "allowable adjustments" to the allowed claims. Primary among these are paid-to-allowed factors calculated using a standard population, and a benefit richness adjustment, based on federal factors, which reflects the fact that members in richer plans tend to use more services. Paid claims—that is, payments made by BCBSVT to providers as compensation for care provided to Vermonters—account for over 88 percent of premium dollars.

State and federal taxes and fees are then added to the projection. Because the federal Health Insurer Tax was repealed (after a one-year return last year), taxes and fees decrease the change in premiums by 2.0 percent this year.

What is a "medical loss ratio" (MLR)?

It is the proportion of premium revenues spent on clinical services and quality improvement, as defined by federal and state law.

What is the MLR of the proposed rates?

The rates proposed in the Filing are subject to a minimum MLR requirement of 80 percent. 45 C.F.R. § 158.210(b)-(c). As shown in Section 3.8.9 of the Actuarial Memorandum, BCBSVT projects a MLR at the combined market level of 90.2 percent. Therefore, the anticipated MLR significantly exceeds all applicable legal requirements. This means that the cost of insurance—that is, the portion of premium that will cover expenses other than medical care and health care quality improvement—is less than half the level deemed unaffordable by state and federal MLR requirements.

What is the cost of insurance?

The cost of insurance is the amount of money an insurance company requires in order to support the infrastructure and operations necessary to cover the claims costs of its policyholders. Our cost of insurance comprises two components: administrative costs and contributions to policyholder reserves, which include an amount necessary to cover the cost of bad debt (i.e. the shortfall that arises when policyholders stop paying their premiums while still collecting benefits).

Please explain how you projected the cost of insurance in preparing the Filing.

First, we developed our projected administrative costs using an experience period of calendar year 2019. After adjusting actual administrative costs downward for the exclusion of non-recurring expenses, we trended them forward for increases due to inflation and personnel cost increases. We assumed that administrative costs would increase by 2.2 percent per year. This translates to total administrative charges equating to 7.9 percent of premium. These figures are extremely competitive, in Vermont and nationwide. Section 3.8.7 of the Actuarial Memorandum describes these calculations.

Next, we included a contribution to policyholder reserves of 1.5 percent at the direction of management. This is the minimum required contribution to policyholder reserves needed in the long term to maintain an appropriate level of reserves relative to health care claims increases and potential unforeseen adverse events. Attachment C to the Actuarial Memorandum explains in detail how we arrived at this figure.

Finally, as explained in Section 3.8.7.2 of the Actuarial Memorandum, we include 0.3 percent for the cost of bad debt. This small amount is based on the average uncollectible premiums we have experienced over the last several years.

Our total cost of insurance—administrative costs plus contribution to policyholder reserves plus bad debt—represents 9.7 percent of premium. As Ms. Greene's prefiled testimony

explains, and as previously recognized by the Department of Financial Regulation (our solvency regulator) and by Lewis & Ellis (the Board's actuary), BCBSVT's cost of insurance is very low compared to the industry. It is also less than half of that allowed under federal and state law.

Did you include a profit in developing the rates reflected in the Filing?

No. BCBSVT is a local Vermont non-profit company. There is no profit in our proposed rates.

Above, you identified trend and morbidity as the two most important assumptions in figuring out how to project your 2021 claims costs from your 2019 experience. First, please explain how you addressed trend in the Filing.

For medical trend, we examine its two constituent components: *utilization trend*, which we define as the number of services used along with the mix of those services, and *unit cost trend*, which are increases in the amounts providers are paid for a particular service. For retail pharmacy trend, we analyzed cost and utilization for non-specialty drugs and, separately, overall cost for specialty medications. The development of our trend factors is laid out in detail in Section 3.4.7 of the Actuarial Memorandum.

Please describe how you calculated the medical unit cost trend.

We consider medical unit costs in three categories: (1) medical VISG claims dollars incurred at facilities and providers falling under the jurisdiction of the GMCB hospital budget review process (comprising just over half of total medical VISG claims dollars); (2) medical VISG claims dollars incurred with providers outside the Board's hospital budget jurisdiction with whom BCBSVT contracts directly; and (3) medical VISG claims dollars incurred with out-of-area providers contracted and accessed through the Blue Card network. Unit costs for these final two categories are based on an analysis of historical patterns, augmented by knowledge we have of ongoing contracting efforts, as applicable. For facilities and providers whose commercial

rates are regulated by the Board, we assumed that the Board would approve commercial increases identical to those approved in the 2019 cycle. We project a total annual cost trend for all provider categories of 3.6%.

Did the Board make any changes in its hospital budget review process that could affect the trend projection?

Yes. At its May 27, 2020 public meeting, the Board decided that it would consider hospitals' requests for a temporary Net Patient Revenue/Fixed Prospective Payment (NPR/FPP) adjustment to compensate for FY20 utilization that was not realized due to COVID-19, in addition to the 3.5% NPR/FPP growth target it had approved at its March 18, 2020 meeting.

Did BCBSVT make any assumptions about those potential temporary adjustments in developing the proposed rates?

No. We intend to analyze the information the hospitals submit on or before July 31, 2020, and, as quickly as possible, submit the results of that analysis—including any rate impact that would result if the requested temporary adjustments were granted—in this proceeding.

Please describe how you calculated the medical utilization trend.

We estimate utilization trend by observing historical and emerging patterns of care. We assess each component of medical utilization (facility, professional and other, and pharmaceutical) and apply a number of statistical analyses to recent experience. We make appropriate adjustments for one-time shifts in patterns of care. We also assessed professional utilization by site of care and pharmaceuticals by specific medications. When many of these methodologies arrive at a similar result, we feel comfortable that we've reached a solid trend estimate. This year, we project an overall medical utilization trend of 3.6 percent. That total comprises 1.1 percent trends for inpatient and outpatient care; 2.2 percent for professional, with a

1.1 percent trend for year 1 and 3.4 percent for year 2; and 18.5 percent for pharmaceuticals dispensed in a medical setting (as opposed to a retail pharmacy or through the mail).

Please explain the pharmacy cost and utilization trends reflected in the Filing.

We assessed pharmacy trend, again analyzing utilization and unit cost. We made specific adjustments for brands expected to lose their patent protection and experience a shift to lower-cost generics. We conducted an analysis specific to specialty drugs, which are very high cost and a strong majority of the current drug pipeline, meaning there are new specialty drugs continually being introduced to the market. These miracle drugs in some instances cure previously incurable diseases and typically make huge improvements in quality of life, but they can be enormously expensive. We assumed a total pharmacy trend, after contract changes, of 13.4 percent.

Did you make any additional adjustments to trend to reflect BCBSVT initiatives?

BCBSVT contracted with a lab benefit manager as of August 2019. This arrangement dramatically reduced both the fee schedule for independent laboratories and, through the application of rigorous clinical protocols, the number of services that policyholders incurred. We adjusted the number of services we assume will be utilized in calendar year 2021 to reflect the level for the last four months of 2019. Implicit in that adjustment is an assumption that clinical protocols will hold utilization trend for these services to zero.

Above, you testified that population morbidity is another key assumption driving your 2021 projected claims costs. Please explain how you addressed population morbidity in the Filing.

Population morbidity comprises a set of assumptions designed to quantify the expected differences between the experience period population (that is, 2019) and the projection period population, 2021. Those assumptions include:

- the impact of employers who moved from AHPs to VISG products in 2020;
- the differences between the experience period population and the projection period population due to individuals and small groups choosing to disenroll from BCBSVT plans;
- the anticipated change in average utilization due to the change in average cost sharing between the experience and projection periods; and
- changes in demographics, including the natural progression of our membership block over time, as members get older, newborns arrive, and some members attain Medicare eligibility or choose to retire if they had already gained Medicare eligibility.

The aggregate impact on claims of these population morbidity factors is -1.1 percent.

Did risk adjustment play a role in developing the population morbidity assumptions?

Yes. Risk adjustment transfers are closely related to population morbidity. The risk adjustment program was established to attempt to level the playing field between carriers who attract a disproportionately healthy population and those attracting a population that tends to make greater use of their health benefits. We projected the 2021 risk adjustment transfer from MVP to BCBSVT based upon the information available to us at the time of the filing. Important to this projection is an assumption that the distribution of members by age and risk profile would be similar in 2021 as it is in 2020 for both carriers, with the exception of specific adjustments for population changes.

Did you make any assumptions regarding BCBSVT's participation in the OneCare VT ACO Program?

Yes. We estimate that there will be no shared savings or shared risk transfer for 2019. Further, we expect that 2021 will be a recovery year with no projected savings for the program due to the pandemic's impact on providers, members, and payers. Therefore, we included no projected savings or losses from health care reform initiatives in the Filing.

MODELING THE IMPACT OF THE COVID-19 PANDEMIC

How did BCBSVT account for the impacts of the COVID-19 pandemic in the Filing?

Based on the information available when we submitted the Filing on May 8, 2020, it was difficult to estimate even so much as an overall directional impact of the COVID-19 pandemic. Based on information known at the time of filing, we saw no reason to believe that the pandemic was likely to decrease claims costs in 2021. Meanwhile, BCBSVT has clearly and firmly stated that any increase in claims costs due to the pandemic would be paid from policyholder reserves rather than through premium increases. We therefore included a COVID-19 impact of zero in the proposed rates reflected in the Filing.

Since submitting the Filing on May 8, has BCBSVT attempted to gain an understanding of the impact of COVID-19 on health care claims costs?

Yes.

Please describe how BCBSVT did so.

BCBSVT's actuarial team, under my direct supervision, created a model that simulates paid claims under varying scenarios for the Vermont Individual and Small Group (VISG) merged market, BCBSVT insured large groups, and TVHP insured large groups, in order to examine the possible variance in paid claims in 2020 and 2021. The model and results are

intended to quantify the impact varying scenarios have on BCBSVT's risk based capital ratio (RBC). BCBSVT submitted this information, including a Supplemental Actuarial Memorandum describing the model in detail, in response to Question 2 of the July 1, 2020 Inquiry Letter 4 from Lewis & Ellis in this docket.

Does this modeling show COVID-19's impact on the rates proposed in the Filing by showing the amount by which COVID-19 will increase or decrease BCBSVT's health care claims costs in 2021?

No. It is impossible to answer that question without knowing the future course of the COVID-19 pandemic. As Dr. McIntosh describes in great detail in her testimony, there is no way to accurately predict future infection rates, the state or federal governmental response to the pandemic as it progresses, the timing and cost of an effective vaccine or treatment, and other relevant factors.

However, it is possible to make assumptions about a reasonable range of possible outcomes for these unknownsos, and then use actuarial techniques to model how those outcomes would affect BCBSVT's health care claims costs and, in turn BCBSVT's policyholder reserves over time. That is what BCBSVT's COVID-19 modeling does.

Please describe how BCBSVT developed the COVID-19 model.

Dr. Kate McIntosh, BCBSVT's Senior Medical Director and Director of Quality, the actuarial team, and I analyzed 33 categories of care and, using our best medical and actuarial judgment, developed assumptions about how much deferred care in each category was likely to return. Wherever possible, we reviewed publicly available data and literature to inform those assumptions.

We also developed assumptions reflecting a range of possible outcomes related to the severity and timing of a potential second wave of the pandemic and the timing and efficacy of a

vaccine. The Methodology section of the Supplemental Actuarial Memorandum provides a description of all inputs to the model.

For each input item, we created appropriate parameters or instructions for the model by programming a range of possible values (for example, a mean value and a standard deviation) and a distribution (e.g., normal, uniform, lognormal, or in some cases a defined set of probabilities rather than a statistical distribution). Those parameters are described in the Methodology section of the Supplemental Actuarial Memorandum.

We created a stochastic model with the above-described assumptions as inputs. We designed the model to output the magnitude and direction of the change in RBC basis points that results from each simulation, along with a number of other key values showing the impact on claims costs of each of the input items. The methodology we used to develop the model is explained in detail in the Supplemental Actuarial Memorandum.

Please describe the time, personnel, and resources BCBSVT invested in this modeling process.

BCBSVT actuarial staff worked intensely for six weeks to develop the model, interpret results, perform quality assurance reviews, and draft accompanying documentation. We began immediately after submission of the VISG rate filing with a phase of information-gathering and conceptualization. The construction of the model began in early June, first with a deterministic version that was soon expanded to a stochastic model. This effort was led by a credentialed actuary on staff at BCBSVT who worked full-time on the initiative for much of the month.

The analysis of deferred and returning care, which was a key assumption within the model, had been in process since early April as BCBSVT grappled with the magnitude of the downturn. The data and analytic aspects were spearheaded, at my direction, by an actuarial analyst who also worked full-time on the project from June forward. We worked closely with our Senior Medical Director in several meetings over a period of two weeks in June to develop and hone the assumptions by service level.

We used the final two weeks of June to review the literature and refine modeling assumptions, assess results for reasonability, and enhance the model. Another credentialed actuary on staff spent the last week of June providing quality assurance and peer review. I spent approximately half my own time on the model in the first half of June and was entirely dedicated to the modeling effort in the second half of the month.

The entire team worked virtually around the clock over the 10 days leading up to publication of the model to finalize scenarios, review results, and assemble the actuarial report.

Did you review any materials in connection with this modeling work?

Yes. I and the actuarial team reviewed as much publicly available information bearing on this work as possible. We have been actively engaged at the national level in monitoring emerging actuarial topics related to COVID, whether it be through the Society of Actuaries, the Blue Cross Blue Shield Association, or actuarial consulting firms including Milliman. Over the course of this process, I reviewed the following materials (all of which are cited as sources in the Supplemental Actuarial Memorandum):

- https://www.nytimes.com/interactive/2020/science/coronavirus-vaccine-tracker.html
- https://www.ahip.org/wp-content/uploads/AHIP-COVID-19-Modeling.pdf
- https://www.soa.org/globalassets/assets/files/resources/research-report/2020/illustrative-forecasts-covid-19.pdf
- https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/NHIS-2016.html
- https://www.latimes.com/california/story/2020-06-11/coronavirus-covid-vaccine-development-speed-fauci
- https://www.nytimes.com/interactive/2020/04/30/opinion/coronavirus-covid-vaccine.html
- https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf

- https://www.soa.org/globalassets/assets/files/resources/research-report/2020/covid-19-trends-hospital-referral-region.pdf
- https://www1.nyc.gov/site/doh/covid/covid-19-data.page
- https://www.scribd.com/document/455265955/Gov-Cuomo-April-6-Coronavirus-Presentation
- https://www.healthvermont.gov/response/coronavirus-covid-19/current-activity-vermont
- https://www.cdc.gov/nhsn/covid19/report-overview.html
- https://www.ahip.org/wp-content/uploads/AHIP-COVID-19-Modeling-Update_Wakely-2020.06.pdf
- https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/estimating-the-financial-impact-covid19.ashx
- https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032013-182435
- https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/ResumingCalifornia%E2%80%99sDeferredandPreventiveHealthCare.aspx
- https://www.washingtonpost.com/opinions/2020/04/08/covid-19-pandemic-will-end-americas-next-health-crisis-is-already-starting/
- https://www.healthleadersmedia.com/clinical-care/coronavirus-how-dartmouth-hitchcock-reopening-paused-services

What data did you use to develop the model?

To project 2020 and 2021 claims, we used projected claims, trend, actuarial value (AV), and membership information from the BCBSVT 2021 Vermont Individual and Small Group Rate Filing and claims, trend, and AV projections presented in or underlying the BCBSVT and TVHP Q3 2020 Large Group Rating Program Filing (SERFF: BCVT-132350241). The large group filings do not project membership, so we used membership from internal reporting for these lines of business as of January 31, 2020 to approximate 2020 and 2021 membership. We included direct costs incurred in March through May 2020 and paid through June 25, 2020.

To calculate the level of deferred care, we used claims incurred from January 2019 through May 2020 for all BCBSVT members. We applied completion factors developed from the monthly financial reporting process (best estimates before margin and before blending with trended estimates). Shelter in place restrictions were put in place in March 2020 and therefore the slowdown period was defined as the incurred period from March 2020 through May 2020. This slowdown period was quantified by comparing the PMPM of the slowdown period relative to a benchmark PMPM.

Did the model include additional operational costs incurred by BCBSVT related to the COVID-19 pandemic?

No. BCBSVT has implemented programming to enhance access to and affordability of retail pharmaceuticals during the crisis, extended grace periods and offered premium flexibility to customers, cancelled the recoupment of certain overpayments to providers, waived any deductible amounts applying to generic wellness drugs and insulins, suspended claims audit activity, and provided over $10 million in advances to Vermont hospitals and provider groups. These costs are addressed separately in the RBC projection included in our response to L&E Inquiry Letter No. 4 (July 1, 2020).

Considering all 33 of the categories of health care services you modeled, what percentage of deferred care does BCBSVT estimate will eventually return?

Overall, our best estimate is that 56.1 percent of the services that were deferred during the slowdown period will be made up. Support for this assumption is in Appendix B of the Supplemental Actuarial Memorandum.

We note the independent BCBSVT analysis is closely aligned with industry sources, which lends additional credence to our assumption. *See* https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/estimating-the-financial-_impact-covid19.ashx;

https://www.soa.org/globalassets/assets/files/resources/research-report/2020/illustrative-forecasts-covid-19.pdf.

Please describe the results the model generated.

We found that the presence and severity of a second wave is the most impactful assumption. We examined the cumulative claims impact of each of four second wave severity scenarios (described in the Treatment Costs section of the Supplemental Actuarial Memorandum), as well as a scenario with no second wave of illness necessitating an economic shutdown. For each of these five scenarios, we ran 10,000 simulations using the inputs described above and in the Methodology section of the Supplemental Actuarial Memorandum and assessed the impact to RBC. The results, categorized by these five second-wave scenarios are summarized below:

Assumption re: disease prevalence within a second wave	**Summary of results**
No second wave necessitating an economic shutdown	Large majority of scenarios generate an RBC change of +/- 25 percentage points relative to benchmark projections without COVID-19
Same as Vermont's first wave	Nearly all scenarios generate an RBC change of -25 to +50 percentage points relative to benchmark
Same as Suburban Southeastern New York's first wave	Virtually all scenarios result in a decrease of at least 75 percentage points of RBC
Same as Capital Region of New York's first wave	Large majority of scenarios result in an RBC change of +/- 25 percentage points
Same as Boston's first wave	Large majority of scenarios result in an RBC decrease of up to 75 percentage points

We also calculated how the average result of each of the five second-wave scenarios impacts RBC as of December 31, 2020 and December 31, 2021. For all five scenarios, the model shows a positive change to RBC as of December 31, 2020 (ranging from +33 to +98), significant deterioration in 2021 (-41 to -117) and a tail of further, but lesser, deterioration that takes place in 2022 (-22 to -31) but, if estimable at the time, could impact December 31, 2021 financials. The average change in paid claims for each of the five scenarios through 2021 ranges from an impact of a significant decrease of 115 percentage points of RBC to a modest increase of 18 percentage points of RBC. In sum, the model shows that there is virtually no likelihood that COVID-19 will lead to a claims impact that significantly increases RBC over a two-year time horizon, and that the most likely impact lies somewhere between a small decline and a modest increase in RBC by year-end 2021.

The results are explained in more detail in the Analysis & Results section of the Supplemental Actuarial Memorandum.

Why did you model certain expenses that drift into 2022?

2022 costs for vaccine administration and returning care stemming from a 2020 or 2021 deferral of services can be viewed as the tail of the claims impact of the 2020 and 2021 course of the pandemic—failing to consider this tail would lead to misleading or incomplete conclusions about BCBSVT's financial position as of December 31, 2021. Because BCBSVT is committed to covering pandemic-related costs from policyholder reserves rather than through premiums, financial reporting requirements would mandate that these 2022 costs, if estimable, should be included in December 31, 2021 financials as a premium deficiency reserve. It is therefore consistent and appropriate to include the 2022 tail of these pandemic-related costs in our assessment of BCBSVT's financial position in response to Inquiry Letter 4 and for purposes of informing review of the 2021 VISG filing.

Do the results of the modeling warrant any change in the rates proposed in the Filing?

No. Based on the best information known at the time this modeling was performed, the COVID-19 pandemic is likely to have an impact on claims costs ranging from modestly favorable to substantially unfavorable, with the majority of simulated results being fairly neutral. The modeling also shows that the likelihood of a significantly favorable impact on claims costs resulting in a "windfall" to BCBSVT is vanishingly small. While a significant deterioration of BCBSVT's financial position due solely to escalated COVID-related claims costs may not be the most likely outcome, it would be imprudent to ignore the very real potential for such a scenario in considering possible rate actions. For this reason, and in light of the more complete RBC development provided in the separate documentation submitted in response to the Board's July 1 Inquiry Letter No. 4, BCBSVT cannot responsibly reduce the rates requested in the Filing below the actuarially sound levels reflected in the Filing.

COMPLIANCE WITH LEGAL AND PROFESSIONAL REQUIREMENTS

Does the Filing comply with all of the state and federal statutes, regulations, rules, and other regulatory requirements listed in Section 1.3 of the Actuarial Memorandum?

Yes.

Does the Filing comply with all relevant actuarial standards of practice?

Yes.

Do all of the steps BCBSVT took in preparing the Filing and developing the rates reflected in the Filing comply with all relevant actuarial standards of practice?

Yes.

In particular, do actuarial standards of practice define what it means for health insurance rates to be "adequate" and "excessive"? If so, please explain those definitions.

Yes. Actuarial Standard of Practice No. 8 defines rates as "adequate" if they provide for payment of claims, administrative expenses, taxes, and regulatory fees and have reasonable contingency or profit margins. Rates are "excessive" if they exceed the amount necessary for these items. As explained above and as documented in the Filing and other information submitted by BCBSVT during this proceeding, the rates proposed by BCBSVT are adequate and not excessive.

Do actuarial standards of practice provide definitions for any other regulatory benchmarks? If so, please identify and define these criteria?

Yes. Actuarial Standard of Practice No. 8 defines rates as "unfairly discriminatory" if "the rates result in premium differences among insureds within similar risk categories that: (1) are not permissible under applicable law; or (2) in the absence of an applicable law, do not reasonably correspond to differences in expected costs." These rates follow applicable Vermont law regarding tier structure and applicable federal guidance regarding market-wide adjustments that lead to rate differences among plans. These rates are therefore not unfairly discriminatory.

Are you aware of the Vermont statutory criteria the Board must consider in reviewing the Filing?

Yes.

What are those criteria?

Under Vermont law, the Board must consider whether the proposed rates are affordable, promote quality care, promote access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State.

Do the rates proposed in the Filing satisfy those criteria?

Yes. The proposed rates satisfy, and strike an appropriate balance among, the statutory criteria. As explained above, the proposed rates reflect the revenue BCBSVT has reasonably concluded is necessary to cover: (1) the projected claims costs of its members, taking into account the choices BCBSVT has made in order to promote robust access to high quality health care services for its members in the Vermont individual and small group market; (2) BCBSVT's projected costs of doing business; and (3) the contribution to member reserves necessary to comply with the Vermont Department of Financial Regulation's 2019 order and to cover uncertainties. *See* In the Matter of Blue Cross and Blue Shield of Vermont Risk-Based Capital Range Study, No. 19-007-1 (Vt. Dep't of Fin. Reg. Feb. 7, 2019). As substantiated throughout the Filing, the Actuarial Memorandum, and the other information BCBSVT has provided during this proceeding, BCBSVT has incorporated reasonable and actuarially sound projections of the three elements mentioned above into the proposed rates.

Therefore, the proposed rates strike the appropriate balance among affordability, promoting high quality care, and promoting access to that care, while also protecting BCBSVT's solvency. In addition, the proposed rates comply with all applicable state and federal requirements as well as all applicable actuarial standards of practice and thus are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State.

Does this conclude your Prefiled Testimony of July 7, 2020?

Yes.

REMOTE NOTORIAL ACT CERTIFICATE

State of Vermont, County of Washington

Sign or sworn remotely before me through a secure communication link on July 7, 2020 by Paul A. Schultz.

Executed by Paul A. Schultz on Jul 7, 2020
Paul A. Schultz *Date*

Signature of notary public: 7/7/20

Printed name of notary public Alan Cunningham

Commission number: 157.0004452

Commission expiration date: 01/31/2021

Title of office is Notary Public.

CERTIFICATE OF SERVICE

I certify that I have served the above Prefiled Testimony of Paul A. Schultz on Michael Barber, Amerin Aborjaily, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Kaili Kuiper and Eric Schultheis, counsel for the HCA, by electronic mail, Delivery Receipt requested via Microsoft Outlook, on July 7, 2020.

/s/ Michael Donofrio
Michael Donofrio

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28 Elm St, 2d Floor
Montpelier, VT 05602
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michael.donofrio@strismaher.com

Attachment A

Prefiled Testimony of Paul A. Schultz

Paul A. Schultz, F.S.A., M.A.A.A.

Chief Actuary
Blue Cross and Blue Shield of Vermont
schultzp@bcbsvt.com

Experience

Blue Cross Blue Shield of Vermont, Berlin, VT — March 2013 to present

Chief Actuary — *January 2015 to present*

Responsible for oversight of the actuarial and underwriting functions: develop pricing and filings for all BCBSVT products; forecasting; lead actuary for Vermont individual and small group, large group, AHP and Medicare supplement filings, including pricing, interaction with reviewing actuaries, and testimony at related hearings; review monthly reserves; serve on internal Strategic Growth, Healthcare Cost Containment, Regulatory, and Healthcare Reform Oversight committees; develop new product offerings and funding approaches; review large group rating process; direct team of five credentialed actuaries and four actuarial students; direct team of four underwriters. Participant in Vermont working groups, including Federal Issues Working Group and Vermont 1332 Waiver Working Group.

Director, Actuarial Services — *March 2013 to December 2014*

Responsible for oversight of the actuarial function: developed pricing and filings for all BCBSVT products; acted as lead actuary for Qualified Health Plan, large group, and Medicare Supplement filings; led task force assessing viability of senior markets products; participated with State task force reviewing cost projection assumptions for Green Mountain Care.

Coventry Health Care, Pittsburgh, PA — December 2006 to March 2013

Actuarial Director, Medicare Part D — *December 2008 to March 2013*

Responsible for design, pricing, reserving, and reporting for Medicare Part D suite of products: identification and exploration of alternative market strategies; proposed design and pricing of product alternatives; identification and measurement of broad array of cost savings measures; development of pricing assumptions; oversight of bid development process; primary contact for CMS actuarial desk review and bid audit; reserving; analysis of emerging experience; forecasting; group pricing.

Director, Actuarial Services — *December 2006 to December 2008*

Led cross-geographical corporate modeling team responsible for creation, distribution and maintenance of various models used throughout actuarial organization: created and oversaw development of pharmacy benefit relativity model; directed group maintaining and enhancing internal provider contracting and unit cost analysis tool; spearheaded studies to develop geographical area factors for both medical and pharmacy claims; reformulated medical benefit relativity tool; completed study of QHDHP experience leading to implementation of selection factors used in pricing; designed and rolled out normative stop loss model to smooth catastrophic claims for application in provider contracting and pricing analyses.

National Medical Health Card (NMHC), Pittsburgh, PA — April 2005 to December 2006

Director, Actuarial Services

Provided analysis to support new PBM client bids and client renewals; led design, development and support of predictive modeling tool to demonstrate net spend impact of pharmacy plan design alternatives. Solely responsible for creation of organization's national set of Medicare Part D bids; prepared RDS attestations for nearly fifty clients annually; conducted analyses for numerous clients to identify superior alternatives for integrating with Medicare Part D.

Mercer Human Resource Consulting, Pittsburgh, PA — July 2001 to March 2005

Health and Group Benefits Actuary

Consulted with clients on retiree medical strategy, design, and funding issues, including total benefit redesigns, merger/acquisition situations, early retirement incentives; reviewed assumptions and methodology for active welfare budget and accrual rates and employee contributions; conducted and reviewed pricing analyses for prescription drug

benefit changes and financial proposals; regional resource for retiree medical valuations: set assumptions, managed and reviewed claims cost development, reviewed valuation results, reviewed and signed actuarial reports; presented topics relating to Medicare Reform at multiple local employer roundtable discussions; spearheaded development of national model for financial analysis of various employer options relating to Medicare Reform.

Education & Professional Credentials and Activities

Purdue University, West Lafayette, IN B.S. With Distinction in Actuarial Science, 1996

Actuarial credentials:

- Attained Fellowship in the Society of Actuaries May 2001
- Member of the American Academy of Actuaries (AAA) since January 2000
- Passed all necessary exams to attain Enrolled Actuary designation
- Currently meets all qualification standards needed to render actuarial opinions in the area of health and group benefits; to render actuarial opinions on (company) health reserves and NAIC annual statement actuarial opinions

Professional Activities:

- Active participant in American Academy of Actuaries Individual and Small Group Markets Committee
- Multiple-year volunteer for CSP-GH Exam Committee
- Past member of AAA Medicare Steering Group and Joint Committee on Retiree Health
- Participant with Actuarial Equivalence Subgroup, project team responsible for publication of 2006 actuarial practice note "Attestation of Actuarial Equivalence for Plan Sponsors Accepting a Retiree Drug Subsidy Under the Medicare Drug Program"

Expert Testimony:

- Provided expert testimony before Green Mountain Care Board at hearings from 2014 through 2019 regarding actuarial analysis for BCBSVT Vermont individual and small group rate filings.