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July 6, 2021

VIA EMAIL

Michael Barber
Laura Beliveau
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Re: Blue Cross and Blue Shield Vermont's Prefiled Testimony in *In re Blue Cross and Blue Shield Vermont 2022 Vermont ACA Market – Individual and Small Group Rate Filings*, GMCB-005-21rr & GMCB-006-21rr

Dear Michael and Laura,

Consistent with the scheduling order in this matter, we are filing and serving prefiled testimony for the following Blue Cross witnesses: Dr. Kate McIntosh, Ruth Greene, and Paul Schultz. Their prefiled testimony and attachments are included with this letter.

As we discussed at the May 21, 2021 status conference, Blue Cross expects, and reserves the right, to offer further testimony at the hearing to respond to or otherwise address ongoing developments, including the Lewis & Ellis actuarial memorandum, DFR's solvency opinion, and any expert report or testimony filed by the HCA. 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.

Pursuant to the Scheduling Order, Blue Cross may submit supplemental prefiled testimony on or before July 12, 2021. The short turnaround period between the July 6 submissions by Lewis & Ellis and DFR means that supplemental prefiled testimony can only serve a limited point. Therefore, Blue Cross expects, and reserves the right to, offer additional testimony in response to the points raised by Lewis & Ellis's and DFR's July 6 submissions live at the hearing.

A final point on the enclosed documents: For Ms. Greene's and Mr. Schultz's testimony, we are enclosing PDFs versions of their prefiled testimony with only the signed and notarized signature page included as a scanned PDF. For Dr. McIntosh, we enclose a scanned PDF of her notarized prefiled testimony. We will retain the hard copies that each witness physically signed in the presence of a notary in our files. Please advise if you would prefer that we file those originals with the Board or take any other steps beyond those described here.

Dated: July 6, 2021

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Enclosed: Prefiled testimony of Ms. Ruth Greene
Prefiled testimony of Dr. Kate McIntosh
Prefiled testimony of Mr. Paul Schultz

cc: Kaili Kuiper, Esq.
Eric Schultheis, Esq.
Jay Angoff, Esq.

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield Vermont 2022 Vermont ACA Market – Individual Market Rate Filing	))))	GMCB-005-21rr SERFF No. BCVT-132829271
In re: Blue Cross Blue Shield Vermont 2022 Vermont ACA Market – Small Group Market Rate Filing	))))	GMCB-006-21rr SERFF No. BCVT-132829562

PREFILED TESTIMONY OF RUTH GREENE

Dated: July 6, 2021

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 7, 2021
D	NEBC v. Allianz et al, Complaint
E	DVHA Presentation June 2, 2021

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 (Blue Cross) and have served in that position for 8.5 years, since 2012.

What are your responsibilities as treasurer and chief financial officer?

I am responsible for Corporate Accounting, Treasury, Actuarial, Underwriting, Customer Billing and Enrollment Services. I provide on-going strategic and operational financial support and leadership, to enable Blue Cross 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 our day-to-day operations and strategic future. I have testified before the Green Mountain Care Board at hearings from 2014 through 2020 regarding our Vermont individual and small group rate filings.

Please provide a brief description of your professional and educational background before joining Blue Cross 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 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 Blue Cross's mission?

We are "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 Blue Cross's business guided by its mission and vision?

Yes.

Is Blue Cross a for-profit company?

No, Blue Cross is a not-for-profit organization.

When Blue Cross 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 Blue Cross's financial operations?

Yes, I am responsible for managing all aspects of our financial operations.

Are you familiar with Blue Cross's financial results and reserves?

Yes.

Ms. Greene, did you direct Paul Schultz, the chief actuary for Blue Cross, to file a contribution to policyholder reserves (CTR) of 1.5% for both the 2022 Vermont Individual and Small Group Rate Filings?

Yes. I explained the basis for filing a 1.5% CTR in my memorandum to Paul Schultz dated May 7, 2021, which is Attachment C to this prefiled testimony and was provided to the Board as part of our 2022 Individual and Small Group Rate Filings.

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

Policyholder reserves—which we also call member reserves, and can be referred to as surplus—are the funds that the Vermont Department of Financial Regulation (DFR) insists we hold to make sure we can meet our obligations and pay our members' claims in any circumstances. As DFR has stated on many occasions, their primary responsibility as a consumer protection agency is to ensure that insurance companies are able to weather losses and remain solvent. Guided by our mission and our fiduciary responsibility to policyholders, we share that view. Reserves are the buffer that protects against operational losses and unexpected contingencies. We may have to draw on reserves when, for example:

- we experience years when premiums are underfunded because claims are higher than expected;
- we experience regulatory changes that increase our costs or affect our funding—for example, when the federal government failed to make payments that were required and expected under the Affordable Care Act;
- we need capital to invest in innovative solutions that will improve quality and lower the cost of care—for example implementing Vermont Blue Rx;
- we want to better serve our community by expanding our offerings, such as our Medicare Advantage offering, Vermont Blue Advantage, which required use of

$3.6 million from reserves to develop and offer and requires additional reserves to support its growth;

- we have unexpected financial demands, such as the need to meet our pension funding obligations following losses within the National Retirement Trust's pension asset investments in 2020;
- we cover members' health care costs related to extraordinary circumstances such as the COVID-19 pandemic;
- we offer payment flexibility in an effort to preserve coverage and benefits during times of economic uncertainty and stress, as we did in 2020 as part of our pandemic response;
- we respond to an economic crisis by making interest-free advances available to providers in our service area, as we also did in 2020 as part of our pandemic response;
- we respond to a customer looking for Blue Cross to assume more of their risk because of their own changing economic realities.

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).

Does Blue Cross have any regulatory requirements that govern its risk-based capital (RBC)?

Yes. DFR has ordered Blue Cross to maintain sufficient reserves such that our 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.*

The risk taken on by Blue Cross as of December 31, 2020 requires reserves between $127 million and $161 million. The point in our RBC range from which we are least likely to move outside the target range within the subsequent 12 months is 690 percent. That requires $149 million in reserves.

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

I explained our CTR philosophy in detail at pages 1-2 of my memorandum to Paul Schultz, dated May 7, 2021, which is attached to this prefiled testimony as Attachment C. I incorporate that discussion here.

The key point I want to emphasize is that we believe CTR should be managed to an adequate long-term level rather than fluctuating significantly from year to year. The recent past illustrates how short-term impacts can have a yo-yo-like effect on reserves. Consider, for example, the broader impacts flowing from the pandemic: market volatility caused by the pandemic contributed to losses in the pension assets, which in turn decreased reserves; deferred care in 2020 contributed modestly to a larger CTR; our policy of paying pandemic-related costs out of reserves draws down reserves; our investment income on our reserves suffered from early losses in the financial markets and was boosted by the later recovery; and we are now expecting

increased membership because of the American Rescue Plan Act's increased subsidies, which in turn requires a higher level of reserves. When we filed our 2020 proposed rates, no one had any idea that a global pandemic was on the horizon, much less how the pandemic would impact health care, the economy, and the financial markets.

Even beyond the pandemic there are numerous examples of events causing unusual volatility in RBC during 2020, including the subscriber lawsuit settlement by the national Blue Cross Blue Shield Association; a substantial deficiency reserve driven by extreme competition in the self-funded market requiring multi-year rate guarantees to retain our largest customers; very low discount rates driving higher defined benefit pension liabilities; and positive impacts from a significant shift in the population mix of our ACA market segment. We have seen an unprecedented level of volatility in the last 18 months.

We believe that managing CTR to an adequate long-term level is the appropriate way to manage these short-term fluctuations, ensure long-term solvency and reduce volatility in premium rates. 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 maintain reserves within our established, modest target range. The Board's consulting actuary, Lewis & Ellis, agreed in 2020 that a 1.5% CTR was reasonable. Hearing Tr. 398. In fact, Mr. Dillon of Lewis & Ellis noted that "uncertainty is something that actuaries would tend to increase a CTR for, and we're obviously living in a, in a very high, high uncertain environment right now." *Id.* Mr. Dillon further observed that our assumed base CTR of 1.5% ranked 630th out of the 783 QHP filings in 2020. L&E Opinion at 21 (July 7, 2020).

Although we continue to operate in this uncertain environment, we are adhering to our long-term approach to CTR. Our approach provides stability and means that our members have not been whipsawed by the ups and downs of this volatile period.

What is Blue Cross's current RBC ratio?

As of December 31, 2020, our RBC ratio is 480.

How does that compare to the required range?

It is significantly below the minimum of the required range.

Is DFR monitoring Blue Cross's RBC ratio?

Yes. Blue Cross met regularly with DFR throughout the pandemic providing updates on the outlook for RBC. Blue Cross also provided actuarial modeling to show the potential impacts of the COVID-19 pandemic on our reserves over a multi-year period. Our latest RBC plan is summarized in Attachment C and has been subsequently updated as part of DFR's current review process.

Please briefly describe the most significant factors affecting Blue Cross's RBC outlook.

I describe and summarize our current RBC outlook in Attachment C, and incorporate that discussion here. Briefly, although our RBC as of December 31, 2020 is significantly below the required range, we expect two positive one-time receivables to significantly increase our RBC this year, namely our remaining $20.4 million AMT refund and an anticipated $6.5 million net judgment in litigation to recover cost-sharing reduction payments. [redacted]

Our RBC outlook is not a static projection; it changes frequently as we experience changes in actual results, membership growth, market fluctuations, and other contingencies. In fact, after we [redacted]

[redacted] Our updated RBC outlook is as follows:

RBC position as of December 31, 2020	**480%**
[redacted]	[redacted]
$20.4 million AMT Refund expected Q3 2021	+99%
Anticipated $6.5 million CSR litigation settlement (net)	+31%
[redacted]	[redacted]
Impact of reforecast 2021 results	[redacted]
Expected RBC position as of December 31, 2021	[redacted]
Projected COVID costs not included in premiums	-23%
Projected statutory impact of change in admin allocation basis for pricing purposes	-49%
Expected RBC position as of December 31, 2022	[redacted]

We project that our RBC will drop in 2022. That projected decrease is partly attributable to higher paid claims and COVID-19 costs not included in 2022 rates. The projected decrease is also based in part on our decision to change how we allocate overhead among lines of business. Going forward, we are allocating overhead as a consistent percentage of premium or premium equivalent. That approach reduces our base administrative cost for this filing. However, we cannot adjust premiums and fees for other lines of business to absorb a greater portion of overhead. We will thus absorb some administrative costs out of reserves, decreasing RBC. As further explained in Attachment C and shown in our updated RBC outlook above, we expect to be within our target range at the end of 2022 assuming no significant insured membership growth.

Importantly, we also now anticipate that our RBC will drop further in 2022 due to likely additional membership increases, an estimate for which is not included in the outlook above.

Please explain why membership increases cause RBC to decrease.

RBC is a ratio. It compares the amount of risk taken on by an insurer to its available reserves. When membership increases, our risk increases. That is, with each new member added to our rolls, we take on the additional financial risk of paying for that member's health care costs. But in the short-term, our reserves remain the same. So the immediate impact of membership growth is a decrease in RBC.

Over time, of course, with more covered lives contributing a modest 1.5% CTR, we can also gradually increase reserves. But that doesn't happen immediately. We need our existing reserves to be a sufficient buffer against the risks of future membership growth.

This point is critical: for Blue Cross to expand its membership—including its market share in the ACA market—our reserves must be adequate to support that growth.

The RBC outlooks in Attachment C and in your testimony above both assume a certain amount of membership growth in the individual market based on increased premium tax credits made available through the American Rescue Plan Act. Have any recent developments affected your expectation for membership growth?

Yes. Our RBC outlook assumes membership growth due to more generous tax credits, but does not assume any shift in overall ACA market share. However, our only competitor in the individual and small group markets, MVP, filed for a much higher rate increase than we did. If the rates are approved as filed for both carriers, our rates will be at or close to parity with MVP. That is, consumers will be able to purchase Blue Cross plans for the same price as MVP plans, or close to it. We expect that will drive additional membership growth and increase our market share. To provide a historical comparison, the last time our rates were on par with MVP, Blue

Cross had a 90% market share. We are not expecting to return to a 90% market share this year, but we do expect to see membership growth.

I can illustrate the potential impact of membership growth on RBC with some concrete examples. [redacted]

In supporting our CTR request and explaining the importance of insurer solvency, we have often noted that remaining in the middle of the target RBC range decreases the likelihood of falling out of the range in a single year. Membership increases of this kind are the type of event that can cause a sudden drop in RBC. This is yet another reason why it is important that our rates are adequately funded and build in adequate CTR every year.

In its June 17, 2021 filing, the HCA asserted that "BCBSVT is quick to ask the Board to disregard for ratemaking purposes all one-time events that have had a positive effect on BCBSVT's surplus." Do you agree or disagree with this assertion? Please explain.

I disagree, because this assertion is demonstrably inaccurate. We have consistently included both federal lawsuit settlements and AMT credits (which we still have not received) in our 2021 and 2022 RBC outlooks. And we have consistently explained that it is critical to take a long-term view of RBC and solvency. We insist on the same long-term approach this year. Although we project that RBC will rise significantly from year-end 2020 to year-end 2021 and then fall again in 2022, we remain committed to the adequate and not excessive 1.5% CTR.

Please explain why a CTR of 1.5% is appropriate for this filing.

I explained the basis for the requested CTR in Attachment C and incorporate that discussion here. To summarize: 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 and I explained above, we believe 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. Blue Cross 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. We accordingly file a CTR consistent with our long-term target.

Second, under current circumstances it would be imprudent to reduce our CTR from our long-term rate. Our current projections put us within our required RBC range at the end of 2022. As I mentioned above, a shift in market share in the ACA market could push our RBC lower. It remains critically important that we maintain adequate reserves to provide a financial buffer and ensure that we remain solvent and able to meet our obligations to pay for our members' health care costs.

Third, although Blue Cross may face additional costs in 2022 due to the pandemic, including ongoing costs for vaccines, continued return of deferred care and expected change in morbidity, 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. Blue Cross has long maintained that a pandemic is one reason to maintain reserves. We thus adhered to our long-term 1.5% CTR in this filing.

Given your instruction to Mr. Schultz to file a 1.5% CTR and not include COVID-related claims in 2022 rates, what is your expected outcome for the individual and small group markets in 2022?

We expect that this business will yield less than a 1.5% return in 2022. Taking into account estimated 2022 COVID-related claims and assuming the approved rates provide for 1.5% CTR, we expect that the business will yield zero return in 2022.

In your view, is a 1.5% CTR in the filed rate adequate and not excessive?

Yes.

Blue Cross experienced a reduction in claims in 2020 and made a 5.2% contribution to reserves from its ACA business, which is higher than the 1.5% CTR approved in the 2020 rate filing. Is Blue Cross using those funds to benefit ratepayers in this market?

Yes. The difference between the filed 1.5% CTR and the realized 5.2% CTR generated surplus $11.3 million above our expectation. As we have testified elsewhere, reserves are intended to buffer volatility during a pandemic and as such we have lowered 2022 ACA premiums by excluding direct COVID-related claims and reducing the administrative cost allocation. We expect this to cost an estimated $11.9 million, all of which will be funded from reserves.

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

From 2014 to 2020, Blue Cross has sustained losses of over $7 million in the individual and small group market. We anticipate a further litigation recovery that will reduce that figure to just under $1 million. Even with litigation recoveries and 2020's unexpected gain, our overall experience in this market has been a loss.

You mentioned that Blue Cross has a lawsuit pending against the federal government. Please briefly describe the status of that suit.

We are suing the federal government for unpaid cost-sharing reduction payments. We received a judgment in our favor that was affirmed by the Federal Circuit. We expect to receive payment of this judgment in 2021.

You also noted that AMT tax refunds affect Blue Cross'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, we expected to receive refunds of AMT over a four-year period from 2019 to 2022. The CARES Act of 2020 included provisions for accelerating the timing of the outstanding AMT refund. We expect to receive a final payment of $20.4 million (the full remaining balance of the AMT credit). Assuming that the credits are refunded in accordance with the provisions set out in the Tax Cuts and Jobs Act and the CARES Act, these funds will be added to member reserves to mitigate future rate increases. Originally, we expected payment in late 2020, but it is now our understanding that the IRS review process is longer because we were required to file amended returns for previous tax years to maximize the refund. Though we are actively monitoring the review process at the IRS, it is not certain that the AMT refund will be received in 2021.

Attachment C references "catastrophic" losses within pension assets that reduced Blue Cross's RBC by 163 points. Please update the Board on the losses within pension assets.

To briefly summarize: Blue Cross offers a noncontributory defined benefit retirement plan to its employees. Our plan participates in the National Retirement Trust administered by the National Employee Benefits Committee (NEBC) of the Blue Cross Blue Shield Association. The Trust holds funds from separate pension benefit programs of several Blues organizations, including Blue Cross Blue Shield of Vermont, that have opted to participate in the Trust. The Trust allows participating programs to obtain certain economies of scale through the consolidated management of funds and administration of the plans. The Trust experienced a substantial decline in value in February and March 2020 due to the poor performance of assets invested in a series of funds managed by Allianz Global Investors. Measured as of June 2, 2020, our pension assets had lost $40.6 million; a substantial portion of that loss reflects these specific

investment losses, which are distinct from general market losses that resulted from the onset of the COVID-19 pandemic in the winter and spring of 2020.

Blue Cross Blue Shield of Vermont did not decide how to invest the pension assets. We participate in the Trust and have only limited discretion to choose allocations among broad asset classes. The NEBC follows its investment guidelines and relies on investment advisors in making investment decisions.

Since last year's hearing, the NEBC has filed suit against Allianz Global Investors and Aon Investments U.S. Allianz was a fiduciary investment manager for the Trust and Aon was a registered investment adviser who acted as a fiduciary in providing investment advice. The 68-page complaint filed in that litigation outlines the NEBC's claims of fiduciary breach and other misconduct against Allianz and Aon. *See* Attachment D. We support NEBC's efforts to aggressively pursue recovery of these losses from the responsible parties.

The loss in pension asset value attributed to the failed Allianz strategy as of December 31, 2020 was $35.2 million. That loss reduced year-end RBC by 163 percentage points.

What is the current status of the litigation?

The litigation is still in its early stages, and has been consolidated before a single judge with other lawsuits by pension plans against Allianz. Discovery has begun. Given the nature and complexity of the litigation, it will likely take years to resolve.

Did you direct Mr. Schultz to include any additional CTR in the 2022 rates to account for the pension losses?

No. The proposed 2022 rates reflect the actuarial value of the health care provided, our administrative costs, and a 1.5% CTR. Despite the pension losses, we continue to follow our approach of managing CTR to an adequate long-term level and I have concluded that a 1.5% CTR remains adequate for that purpose. Furthermore, we have chosen to continue to keep direct

COVID-related costs out of premiums and reduced our allocation of administrative overhead to ACA business.

Has Blue Cross made any contributions to the pension fund since sustaining the losses, and if so, how much?

We contributed $13 million to the pension plan on December 23, 2020. Our pension actuaries estimated those amounts to be sufficient for the plan to maintain its 80% Adjusted Funding Target Attainment Percentage (AFTAP) funding level for its January 1, 2022 valuation. Note that this contribution is a cash flow item with no RBC impact; our RBC outlook already incorporates our pension funding obligations.

[redacted]

Are you familiar with the factors that the Board is required to consider in reviewing Blue Cross'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. Reducing insurance rates below what is actuarially justified—that is, below the cost of providing care—does not reduce the cost of health care. Rather, it forces the insurer to operate at a loss, which is unsustainable and risks the stability of the entire system.

Blue Cross 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 implemented a new pharmacy benefit manager that will save Blue Cross ACA customers $15 million in 2022. 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 high-quality health care to Vermonters.

Blue Cross shares the concern of so many Vermonters that health care costs are too high. We championed the successful effort to un-merge the individual and small group markets this year. That step—as we told the Legislature—is significantly reducing the cost of insurance for

many Vermonters. We have filed for an unprecedented rate decrease of 7.8% in the small group market, which will ease burdens on many small businesses and their employees.

It was critically important to un-merge the market this year because ARPA provides substantially increased subsidies for individuals and has eliminated the subsidy "cliff" that previously affected many middle-income consumers. With ARPA's provisions in place, individuals with income up to $94,500, couples with income up to $189,500, single-parent households with income of $182,300, and families with incomes up to $265,500 all now qualify for premium assistance when purchasing insurance through Vermont Health Connect.[1] Although the un-merged market does increase individual rates, subsidy-eligible individuals and families will be insulated from those increases by ARPA's subsidy provisions. Indeed, if the Board approves Blue Cross's and MVP's rates as filed, most Blue Cross members will pay less out of pocket for their plans. Mr. Schultz will address this point in more detail, but generally speaking, that's because the cost of the benchmark silver plan is increasing more than the cost of Blue Cross's standard silver plan.

The Department of Vermont Health Access (DVHA) explained the relationship among the filed rates, the benchmark silver plan, and ARPA's subsidy provisions in its presentation to the Green Mountain Care Board on June 2, 2021. As DVHA showed in its presentation, subsidy-eligible consumers will pay less or the same in 21 out of 26 plans if the Board approves Blue Cross's and MVP's rates as filed. *See* Attachment E. This point is crucial to the Board's rate review process this year and its assessment of the affordability of the filed rates.

Blue Cross is working hard in collaboration with DVHA to publicize ARPA's more generous subsidies and to encourage its direct-enroll members to switch their enrollment to Vermont Health Connect to ensure they receive the subsidies for which they qualify.

[1] These thresholds are approximations based on filed rates. The final dollar amounts depend on the premium of the second-lowest silver plan offered on Vermont Health Connect.

The national Blue Cross and Blue Shield Association (BCBSA) advocated for increased subsidies. While the enhancements are set to end before 2023, the BCBSA will be working with lawmakers to make the changes permanent and will urge additional improvements.

You mentioned that Blue Cross's administrative costs are low. What percentage of the as-filed individual and small group premium reflects administrative costs?

Our projected base administrative charge is 7.6% of premium for both filings combined, which is a decrease from the 7.9% charge for 2021. Our 2022 charge includes new fees for allowing payments with debit or credit card as well as staffing and related costs for taking on the billing function from Vermont Health Connect beginning in 2022. These increases are offset by our revised allocation methodology that resulted in an overall reduction in administrative charges as a percent of premium.

How does that compare with other insurers?

Lewis & Ellis, the Board's actuary, reported last year that our administrative costs "on a percentage of premium basis ranked 57th out of 62 plans assessed. That is, on a percentage of premium basis, BCBSVT had lower expenses than approximately 90% of the Blues plans who sold individual and small group products." Lewis & Ellis also reported that our "administrative costs on a PMPM basis ranked 52nd out of 62 plans assessed. That is, BCBSVT had lower PMPM expenses than approximately 82% of Blues plans." Lewis & Ellis Letter, at 20 (July 7, 2020). 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.

Does the figure for administrative costs in the proposed rate assume a 3% average salary increase for your employees for 2022?

Yes, we are planning for the average increase of 3% in 2022. For 2021, there is no salary increase for salaried personnel. Only hourly staff were given increases in 2021.

Are Blue Cross's administrative expenses reasonable and not excessive?

Yes. 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 and continues to support DFR and the legislative process in adapting payment policies to post-pandemic realities. This requires ongoing analysis and dialogue to find new member-focused protocols that do not increase the cost of healthcare, and therefore do not increase premiums. Our staff adapted processes and provided COVID-related information to 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. We were able to adapt our operations with little net, new administrative cost.

We also implemented our new Medicare Advantage offering in Vermont. We just completed implementation of a new pharmacy program that will save Vermonters significant money. To be successful in serving Vermonters, we need to be sufficiently resourced.

Further, our planned 3% average salary increase is modest and represents a market-driven approach to retain and attract qualified employees. We are currently experiencing difficulty in retaining staff due to our 2021 salary freeze. The post-pandemic labor market is even more challenging as professional staff are able to find opportunities with other companies while working remotely.

We must 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 that 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. For instance, even at the customer service level, it takes eight weeks to train a new representative.

Eliminating this increase would change the average filed rate by about three twentieths of one percent while jeopardizing our ability to maintain a highly skilled workforce. Our employees have worked hard and creatively for the past year and a half to respond to the pandemic and continue serving members and providers under challenging circumstances. We are committed to continuing our usual modest pay increases for our employees.

As part of your professional role at Blue Cross, are you familiar with Blue Cross's contract negotiations with hospitals?

Yes. Although this is not part of my day to day work, our contract negotiations are relevant to my role in providing strategic and operational financial support and leadership to Blue Cross. I have consulted with our director of provider services to be sure that I am informed on this subject.

Are you familiar with the Hospital Price Transparency rule?

Yes.

Does Blue Cross expect that the information made available by hospitals pursuant to the Hospital Price Transparency rule will affect provider contracting?

[redacted]

[redacted]

In your view, is it appropriate to provide further testimony regarding Blue Cross's contract negotiations with hospitals 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. Our teams discuss many difficult issues in negotiations and try to have candid exchanges of views. If I were to disclose these discussions publicly, it would erode that trust and substantially harm our 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 Blue Cross keeps confidential, and disclosure of it would undermine our commercial interests and provide a business advantage to competitors and providers.

Accordingly, if the Board has questions regarding Blue Cross's negotiations with health care providers, or Blue Cross elects to offer such testimony, we will request that the testimony be taken in a closed session at the hearing.

Will you be prepared to answer questions regarding Blue Cross's contract negotiations with hospitals and other providers in a closed session at the hearing?

Yes. Because Andrew Garland will not be participating in the hearing this year, I will be prepared to answer questions on this topic.

Ruth Greene

Ruth Greene

State of Vermont, County of Washington.

Signed and sworn to (or affirmed) before me on July 6, 2021 by Ruth Greene.

Signature of notary public: Alan Cunningham

Printed name of notary public: Alan Cunningham

Commission number: 157.0004432

Commission expiration date: 01/31/2023

Exp 01/31/23

Title of office is Notary Public.

Attachment A

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

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

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

BERLIN HQ
445 INDUSTRIAL LANE
BERLIN, VERMONT 05641

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
802 255 4550

MEMORANDUM

To: Paul Schultz, Chief Actuary

From: Ruth Greene, VP and CFO

Date: May 7, 2021

Subject: Contribution to Policyholder Reserves for 2022 ACA Market Individual and Small Group Filings

Upon consideration of the points documented in this memorandum, I am directing you to file as follows for the 2022 ACA Market Individual and Small Group Rate Filings:

1. A contribution to policyholder reserves (CTR) of 1.5 percent; and
2. Exclude from the filing any claims costs explicitly related to the COVID-19 pandemic.

Overall CTR Philosophy

BCBSVT has found 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, growth, and investment environment allows us to navigate short-term fluctuations in order to maintain surplus levels that are within our mandated target range[1].

The impact of the ongoing pandemic on financial results is one example of a short-term fluctuation. In order to remain in the target range and provide stability to its policyholders, BCBSVT's CTR philosophy looks beyond a single year of experience to establish the required levels.

Should the outlook for BCBSVT's surplus level fail to fall within our target range, we would adjust our filed CTR accordingly. That is, in the event that surplus is projected to materially exceed 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 file a CTR that exceeds the long-term rate should surplus project to fall materially 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

[1] Importantly, 1.5 percent CTR is insufficient to maintain a constant level of Risk Based Capital (RBC) through operations alone. Achieving a 1.5 percent CTR on operations would decrease RBC in the absence of an allocation of investment income.

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.

Adequately funded premiums are the foundation of solvency, the most important element of consumer protection. 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 funding that sustains policyholder reserves for BCBSVT. While any rating program filing is by its nature 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 (for instance, a restricted ability to give payment flexibility to customers during an economic crisis), a need for higher margins in rates in order to avoid further deterioration, and a reduced ability to attract or retain business or to support 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 sound 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.

Current Capital Environment

BCBSVT finances and reserves experienced extreme turbulence in 2020. Between the pandemic, pension losses, and legal and tax settlements, among other positive and negative factors, this has been a year like no other. These are extraordinary one-time situations and illustrate exactly why BCBSVT must maintain adequate reserves.

Our leadership and our regulators must see beyond the current volatility and steer Blue Cross based on underlying trends, while allowing us to maintain reserves that will see policyholders through these tough times. One cannot choose to ignore one significant negative factor and accept all the one-time positive developments in reviewing BCBSVT's financial situation.

As of December 31, 2020, BCBSVT's RBC stood at 480 percent, a decrease driven primarily by catastrophic losses within the pension assets that reduced RBC by 163 percentage points. BCBSVT is pursuing relief through legal action in this matter. While BCBSVT hopes for a successful resolution of this litigation, the defendants strongly dispute any responsibility for the losses, and it is anticipated that the process to bring this to resolution could take several years.

Risk Based Capital Outlook

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 RBC as of December 31, 2020 is 480 percent, significantly below the minimum point of the target range ordered by DFR. However, it is essential to assess the RBC outlook over time rather than focusing on its value at any given moment. That is no less true when RBC is critically low than when it is comfortably within the target range.

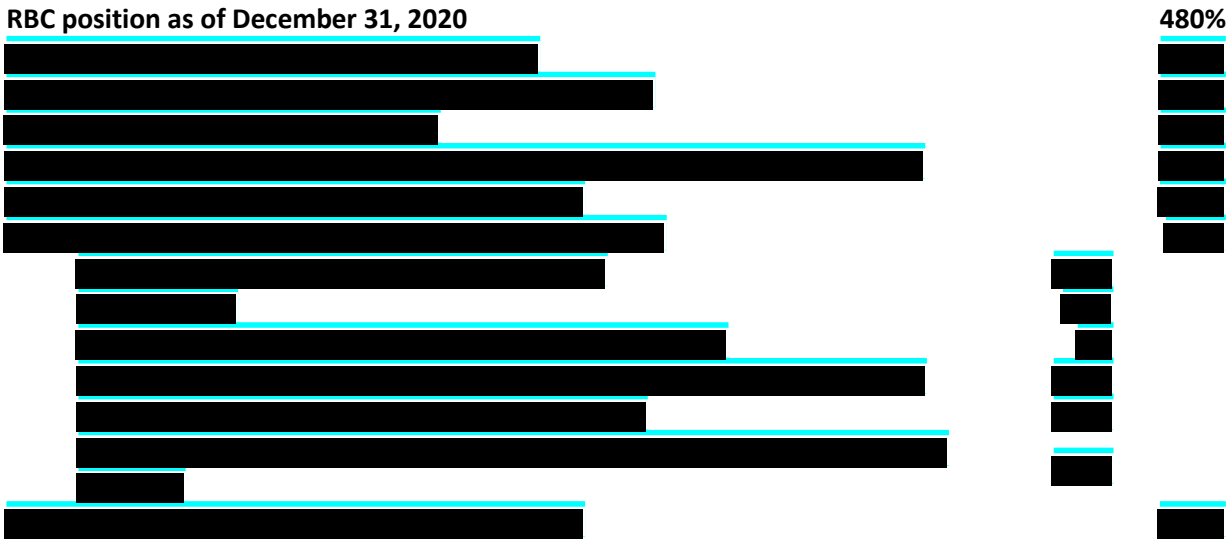
BCBSVT's RBC outlook is materially impacted by two outstanding, one-time receivable items that are not admitted as assets under statutory accounting rules.

First, as a result of the Tax Cuts and Jobs Act enacted in late 2017, BCBSVT's alternative minimum tax (AMT) credit balance continues to be returned by the IRS. The CARES Act of 2020 included provisions for accelerating the timing of the outstanding AMT refund. BCBSVT expects to receive a final payment of the full remaining balance of the AMT credit during 2021. 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 be used for the direct benefit of our customers as they are received from the IRS.

Second, BCBSVT has retained counsel to sue the federal government to recover the unpaid 2017 and 2018 Cost Share Reduction (CSR) funding. This lawsuit has been decided in our favor, but the speed to recovery has yet to be determined. The federal government currently has two months to decide on next steps, meaning that resolution of this payment may linger into late 2021.

[redacted]

With the addition of these items that are accretive to surplus, BCBSVT's RBC outlook through 2022 is as follows, including the impact of these ACA rate filings if approved as submitted:



BCBSVT expects to be within the target RBC range at the end of 2022. 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[2].

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, assuming that we achieve our target investment income. Because BCBSVT expects to be within its mandated RBC range by year-end 2022, we are comfortable holding to a long-term approach to CTR.

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 2020 to 2021. Our competitor in this market enjoys a pricing advantage that is expected to persist into 2022. While we will continue to strive to grow our market share within the ACA market, 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 currently well below the target range.

COVID-19

During this difficult time, 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 flexibility to customers and providers who are struggling financially.

[2] 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.

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 costs in 2021 and 2022 due explicitly to the COVID-19 pandemic will be funded through policyholder reserves. Specifically, we do not intend to pass ongoing vaccine costs through to policyholders in 2022. 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 directly responsible for 2022 claims increases beyond those projected in the filing.

Conclusion

In consideration of all the above, I direct you to file a 1.5 percent CTR for the 2022 ACA Market Individual and Small Group Rate Filings and to exclude direct COVID-19 costs from claims projections.

Attachment D

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

BLUE CROSS AND BLUE SHIELD ASSOCIATION NATIONAL EMPLOYEE BENEFITS COMMITTEE, Plaintiff, v. ALLIANZ GLOBAL INVESTORS U.S. LLC and AON INVESTMENTS USA INC. f/k/a AON HEWITT INVESTMENT CONSULTING, INC., Defendants.	Case No. 20 Civ. 07606 **COMPLAINT** **DEMAND FOR JURY TRIAL**

Plaintiff Blue Cross and Blue Shield Association National Employee Benefits Committee (the "Committee") brings this Complaint against Defendants Allianz Global Investors U.S. LLC ("Allianz") and Aon Investments USA Inc. f/k/a Aon Hewitt Investment Consulting, Inc. ("Aon").

NATURE OF THE CLAIMS

1. The National Retirement Trust of the Blue Cross and Blue Shield Association (the "Trust") is a master trust holding the assets of the employee defined benefit pension plans (the "Plans") that participate in the National Retirement Program of the Blue Cross and Blue Shield Association.

2. Acting in its role as the Plans' named fiduciary, the Committee invested a portion of the Trust's assets in various Structured Alpha funds managed by Allianz. These funds were AllianzGI Structured Alpha Multi-Beta Series LLC I (the "Multi-Beta Series"), AllianzGI

Structured Alpha Emerging Markets Equity 350 LLC ("Emerging Markets Equity 350"), and AllianzGI Structured Alpha 1000 LLC ("Structured Alpha 1000") (collectively, the "Structured Alpha Funds" or the "Funds"). Allianz was the managing member of each of the Funds.

3. The Committee invested in the Funds and maintained that investment based on assurances from Allianz that "structural risk protections" were the cornerstone of the Structured Alpha strategy. While the Funds would generate returns through an options trading strategy, Allianz promised that hedges would be in place "at all times" to cap the downside risk of that strategy. Allianz claimed these hedges would cabin investment losses to a "defined maximum loss," afford "reinsurance" against a market crash, and ***eliminate*** the risk of a margin call. Allianz also assured the Committee that Structured Alpha's investment strategy was "non-directional" and would "perform whether equity markets are up or down, smooth or volatile."

4. These claimed protections were critical to the Committee's decision to invest in Structured Alpha and maintain that investment, especially given the risk profile the Committee desired for the Trust. Allianz knew this to be true, emphasizing these very aspects of its professed investment strategy to allay the Committee's concerns about the potential risk the strategy might pose to the Trust.

5. Yet when equity markets declined, volatility spiked, and the Funds' option positions were exposed to a heightened risk of loss in February and March 2020, those promised protections were absent. Unbeknownst to the Committee, and in violation of Allianz's stated investment strategy and the duties it owed as an investment manager and a fiduciary under the Employee Retirement Income Security Act of 1974 ("ERISA"), Allianz had abandoned the hedging strategy that was the supposed "cornerstone" of Structured Alpha, leaving the portfolio almost entirely unhedged against a spike in market volatility. And to make matters worse,

Allianz had placed a directional bet that volatility would remain relatively low, the equivalent of a ticking time bomb if its forecast (one it had promised "never" to make) proved false.

6. As Allianz has since admitted, it constructed the portfolio to offer no downside protection against the market decline and volatility spike that occurred in February and March 2020. Contrary to its promise that it would always purchase hedges as "reinsurance" for the options it sold, Allianz had purchased ***no*** hedges for an entire segment of the portfolio. Meanwhile, the so-called hedges that Allianz did purchase were not the hedges Allianz said it would buy. Whereas Allianz had said it would buy hedges at a strike price 10% to 25% below the market, the hedges it actually held at the end of February 2020 were as much as 60% below the market. Given these and other departures from Structured Alpha's purported investment strategy, Allianz had constructed the portfolio not to pursue "risk-managed returns" as it had promised but instead to earn marginal returns selling insurance against market volatility while maintaining no meaningful protection against the downside associated with the large tail risk of a market collapse—a strategy that has been aptly described as picking up pennies in front of a steamroller.

7. In further derogation of its duties and scrambling to address the fallout from its imprudent management, Allianz added yet more risk to the portfolio in February and March 2020. Whereas Allianz said it would purchase ***and maintain*** hedges that would automatically cap the "maximum loss" the Trust could sustain in a market downturn, Allianz ***sold*** the hedges that could have protected the Trust's investment and then added more risk-bearing positions in an apparent bet that the market would recover. These new risk-bearing positions were also built without an appropriate hedge in place, exposing the Funds to further, catastrophic losses and ultimately the margin call that Allianz had said could never happen.

8. Allianz's reckless actions, both in constructing the portfolio to bear excess, undisclosed risk and in restructuring the portfolio to chase returns rather than preserve investor capital, reveal that Allianz placed its own interests in generating performance fees ahead of its duty to safeguard the Plan assets against undue risk. Allianz committed the same breaches with respect to each of the Funds, which were subject to substantially the same failed options strategy.

9. The resulting losses to the Trust are staggering. As of January 31, 2020, the Trust had approximately $2.9 billion invested in the Structured Alpha Funds. Six weeks later, the Trust faced a margin call, leaving no choice but to liquidate the investment. The Trust ultimately suffered a realized loss exceeding $2 billion, far beyond what the Trust would have lost had Allianz managed the Funds prudently or had the Trust been invested in the equity markets or in a comparable, prudently managed investment strategy. As a result of Allianz's breaches, a substantial portion of Plan assets meant to provide retirement security to thousands of employees and their beneficiaries was wiped out.

10. Aon, the Committee's fiduciary investment adviser, is also to blame. The Committee delegated to Aon—and Aon accepted—the specific duty to render investment advice regarding Allianz and Structured Alpha. Aon agreed to conduct "active, ongoing monitoring" of Allianz to "identify any forward-looking" risks "that could impact performance." Aon undertook further to "inform itself" of any information necessary to discharge its duty to monitor, including information about the actual options positions Allianz had constructed. The Committee was entitled to rely upon (and did in fact rely upon) Aon's investment advice, including advice Aon offered based on its purported monitoring of Allianz.

11. Aon violated these duties it undertook as a fiduciary. Aon repeatedly recommended that the Committee invest the Trust's assets in Structured Alpha, advising the

Committee that the strategy was appropriate in light of the Trust's character and investment aims. As recently as June 2019, Aon assured the Committee that Structured Alpha remained one of its "highest conviction strategies." By that time, however, Allianz had strayed from the hedging strategy that should have been in place to protect the Trust's investment—something Aon would have known (and advised the Committee of) had it properly discharged its duties. A prudent investment adviser entrusted with the duties Aon undertook would have monitored the Funds' ***actual*** holdings to verify that Allianz was managing the strategy as it said it would. Aon assured the Committee it did just that. But Aon never alerted the Committee that Allianz had strayed from the hedging strategy that should have been in place, leaving the portfolio exposed to the risk of catastrophic losses. Instead, Aon repeatedly (and falsely) described Structured Alpha as operating just as Allianz said it would, assuring the Committee that Structured Alpha added little incremental risk to the Trust's portfolio of investments.

12. Aon also breached its fiduciary duties when it recommended that the Committee maintain a much greater percentage of pension assets invested in Structured Alpha than Aon's other clients did, despite pointed inquiries from the Committee about whether that concentration might create undue risk in a declining market. When the Committee raised concerns in 2018 and 2019 about the concentration of Plan assets invested in the Structured Alpha Funds and how the strategy would perform in a market dislocation, Aon falsely advised the Committee that only a small portion of the Plan assets invested in Structured Alpha were at risk and that the strategy contributed little incremental risk to the Trust. Had Aon informed the Committee of the actual risks posed by Structured Alpha, the Trust would have avoided the staggering losses it sustained in February and March 2020.

13. Allianz and Aon breached their obligations as ERISA fiduciaries and the duties they otherwise owed to the Committee and the Trust. Those breaches caused the Trust to suffer devastating losses, which the Committee now seeks to recover on behalf of the Trust.

JURISDICTION AND VENUE

14. This Court has jurisdiction over this action under 28 U.S.C. §§ 1331, 1332, 1367 and under ERISA § 502(e)(1) (29 U.S.C. § 1132(e)(1)).

15. Venue in this judicial district is proper under ERISA § 502(e)(2) (29 U.S.C. § 1132(e)(2)) and 28 U.S.C. § 1391(b).

PARTIES AND OTHER ENTITIES

16. Plaintiff Blue Cross and Blue Shield Association ("BCBSA") National Employee Benefits Committee is the plan administrator and named fiduciary of the Plans under ERISA §§ 3(16)(A), 402(a)(2) (29 U.S.C. §§ 1002(16)(A), 1102(a)(2)).[1] The assets of the Plans, which are employee pension benefit plans under ERISA § 3(2)(A) (29 U.S.C. § 1002(2)(A)), were held at all relevant times in the Trust, of which the Committee is also a fiduciary. BCBSA is an Illinois not-for-profit corporation headquartered in Chicago, Illinois. It established the Committee to oversee the administration of the Plans as well as other employee benefit plans. The Committee, in turn, established an Investment Subcommittee (the "Subcommittee") to enhance the Committee's deliberations regarding investment issues. The Committee's charter vests it with the authority to prosecute any action concerning the Plans.

[1] The Plans that suffered losses are those sponsored by BCBSA, Blue Cross Blue Shield of Arizona, Blue Cross and Blue Shield of Florida, Blue Cross and Blue Shield of Kansas City, Blue Cross and Blue Shield of Kansas, Blue Cross & Blue Shield of Mississippi, Blue Cross and Blue Shield of Nebraska, BlueCross and BlueShield of South Carolina, BlueCross BlueShield of Tennessee, Blue Cross and Blue Shield of Vermont, Blue Cross Blue Shield of Wyoming, Excellus BlueCross BlueShield, Hawaii Medical Service Association, NASCO, Triple-S Management Corporation, and BCS Financial Corporation.

17. Defendant Allianz Global Investors U.S. LLC is a Delaware limited liability company and registered investment adviser under the Investment Advisers Act of 1940 with its principal office in New York, New York. In 2011, Allianz became a fiduciary investment manager within the meaning of ERISA § 3(21)(A)(i), (38) (29 U.S.C. § 1002(21)(A)(i), (38)) for the Trust's investment in the Structured Alpha Funds. As of December 31, 2019, Allianz managed more than $140 billion in client assets. It is a direct, wholly owned subsidiary of Allianz Global Investors U.S. Holdings LLC and part of "Allianz Global Investors," the marketing name for a global asset management business operating through affiliated entities around the world.

18. Defendant Aon Investments USA Inc.[2] is an Illinois corporation and registered investment adviser under the Investment Advisers Act of 1940 with its principal office in Chicago, Illinois. Beginning in 2009, the Committee retained Aon—known then as Ennis, Knupp & Associates, Inc. before its acquisition by Aon—to provide investment advice as a fiduciary within the meaning of ERISA § 3(21)(A)(ii) (29 U.S.C. § 1002(21)(A)(ii)). Aon is a direct, wholly owned subsidiary of Aon Consulting, Inc., which is a New York corporation.

19. The Blue Cross and Blue Shield Association National Employee Benefits Administration ("NEBA") is a department of BCBSA. Consistent with its obligations under ERISA, the Committee delegates to NEBA the responsibility for day-to-day administration of the Plans.

[2] On March 25, 2020, Aon declared in the "Material Changes" section of its Form ADV Part 2A Brochure filed with the Securities and Exchange Commission that it had changed its name to Aon Investments USA Inc. from Aon Hewitt Investment Consulting, Inc.

FACTUAL ALLEGATIONS

Allianz Markets the Structured Alpha Strategy

20. The Structured Alpha strategy consists of alpha and beta components. The beta component is intended to provide broad market exposure to a particular asset class through investments in financial products (like an exchange-traded fund ("ETF")) that replicate the performance of a market index (like the S&P 500). The alpha component is an options trading strategy that Allianz claimed would seek "targeted positive return potential" while nonetheless maintaining "structural risk protections."

21. Allianz described Structured Alpha as consisting of an "option overlay" (*i.e.*, the alpha component) "designed to exhibit low correlation to the underlying equity or fixed income beta exposure."

22. The options strategy was largely the same regardless of the Fund or its underlying beta(s). Allianz touted the strategy as "non-directional," meaning it "is not predicated on correctly taking a view on the direction of equities, interest rates or any other fundamental factor." Thus, Allianz represented the alpha strategy would "never make a forecast on the direction of equities or volatility."

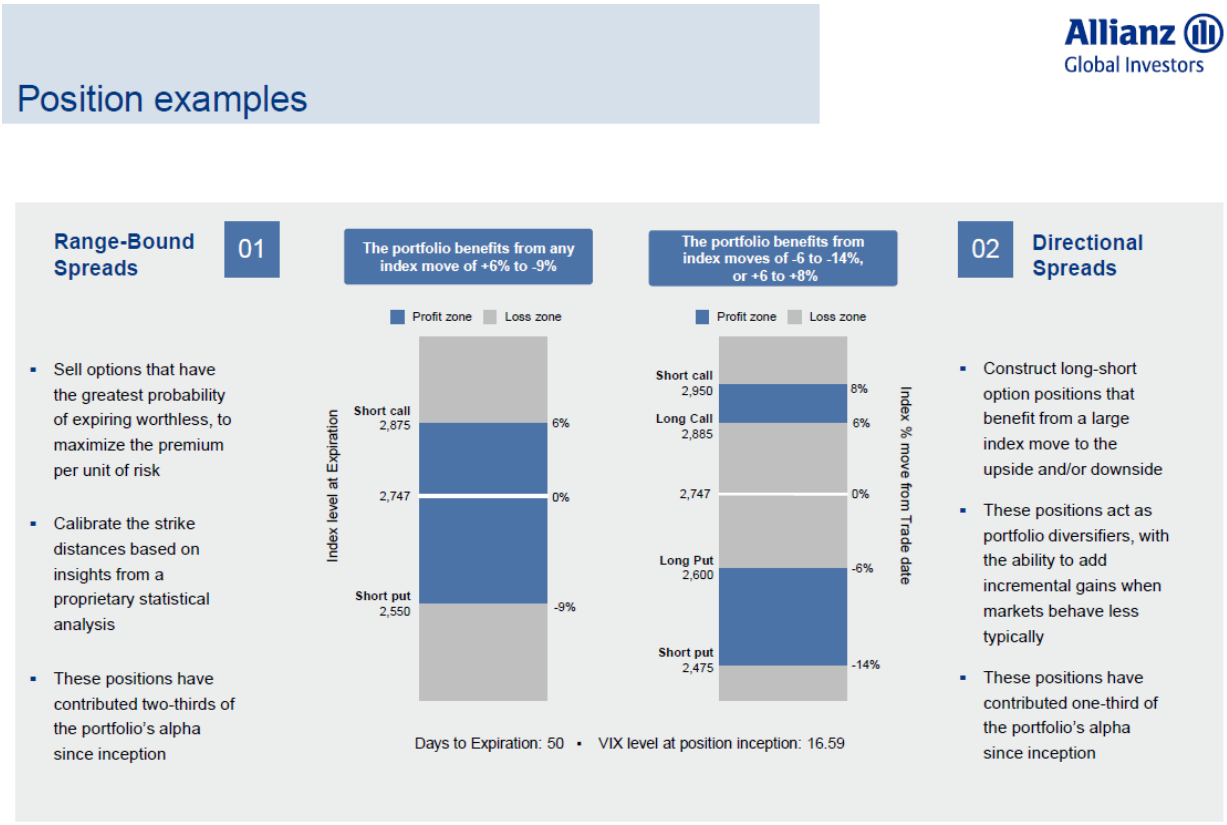
23. As for the "structural risk protections" supposedly inherent in the strategy, Allianz claimed that Structured Alpha would "combine[] both long- and short-volatility positions at all times." While the strategy would "capitalize on the return-generating features of selling options (short volatility)," it would "simultaneously benefit[] from the risk-control attributes associated with buying options (long volatility)," Allianz said.

24. The "building blocks" of Allianz's strategy were supposed to be three types of positions: (1) range-bound spreads; (2) directional spreads; and (3) hedging positions.

25. The range-bound spreads, Allianz represented, are "short-volatility positions" that are "designed to collect option premium and to generate excess returns in normal market conditions." "Based on detailed, proprietary statistical analysis," Allianz explained, "put and call options are sold to create 'profit zones' that have a high probability of success upon expiration of the options." The "profit zones aim to catch the underlying equity index inside their upper and lower bands at expiration." If "the equity index finishes inside the profit zone at expiration, the strategy will profit," according to Allianz. Allianz claimed these range-bound spreads generated roughly two-thirds of the strategy's returns.

26. The directional spreads, Allianz represented, are "combination long-short volatility positions designed to generate excess returns when equity indexes are rising or declining more than usual over a multi-week period." They "are built by buying and selling options to both the upside and downside to create profit zones several percentage points away from current equity index levels." These spreads "are set up to capture larger equity-market movements" and to "act as portfolio diversifiers." Allianz claimed they accounted for roughly one-third of the strategy's returns.

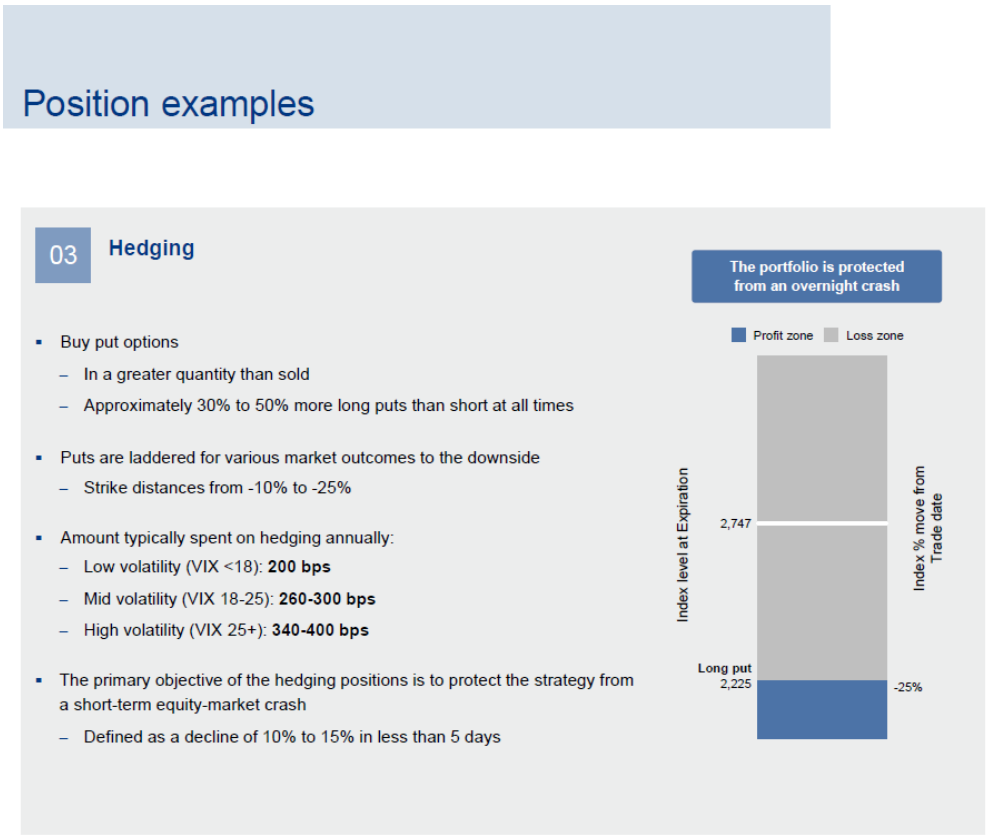
27. Allianz depicted the range-bound spreads and directional spreads as follows, with the so-called "profit zones" in blue compared to the "loss zones" in gray:



28. Allianz represented that the hedging positions would be the third component of Structured Alpha and a "cornerstone" of the strategy. These are "long-volatility positions" that Allianz told the Committee are "designed to protect the portfolio in the event of a market crash." Allianz claimed it would purchase the hedges "out of the money at various levels to the downside, and always in a greater quantity than the amount of puts sold for the range-bound positions." Allianz emphasized that the "long puts are in place ***at all times***" and "***exclusively*** for risk-management purposes."[3]

29. Allianz depicted the long-put hedging positions as follows, illustrating (as Allianz commonly represented) that it would purchase the hedging positions "-10% to -25%" out of the market:

[3] All emphases are added unless otherwise noted.



30. Allianz regularly analogized Structured Alpha's three-pronged, long-short investment design to selling "insurance" against market volatility (referring to the range-bound and directional components of the strategy) and buying "reinsurance" to protect in the event such volatility was experienced (referring to the hedging component of the strategy).

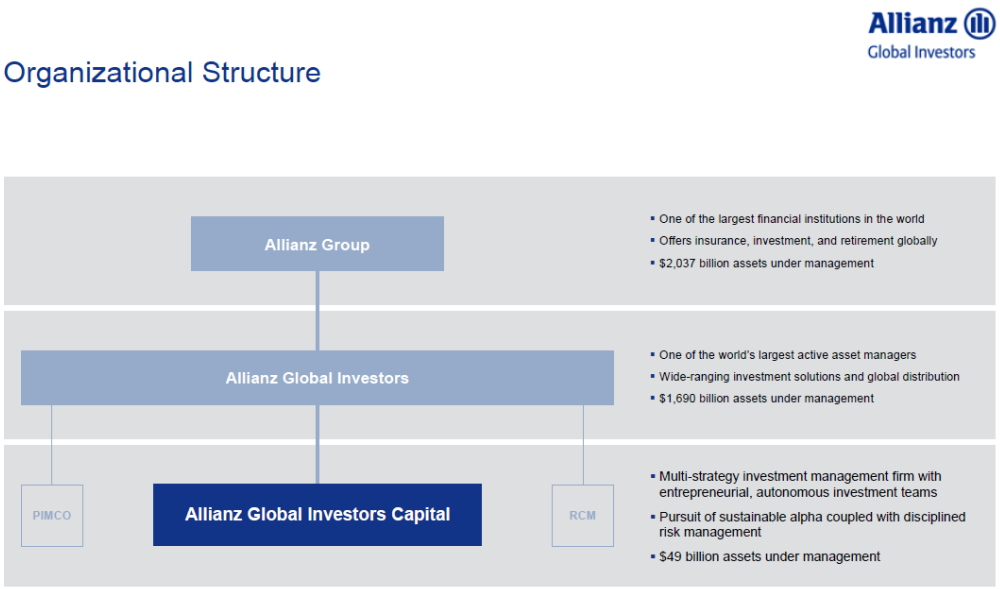
31. Allianz explained that the "seller of the option is the insurance company" while the "buyer of the option is the insurance policyholder." Allianz promised to be a "buyer and seller of options at the same time, at all times." "We are always *both* the insurance company and the insurance policyholder," Allianz represented. (Emphasis in original.)

32. Greg Tournant, Allianz's chief investment officer for U.S. structured products and the architect of Structured Alpha, consistently used the insurance/reinsurance analogy to describe the strategy he developed. In a May 2016 interview, Tournant said that Allianz is "acting like an

insurance company" when it "collect[s] premium" by selling options. Although Allianz may have to "pay very much like an insurance company" if a "catastrophic event" occurs, Tournant reassured the audience that Structured Alpha's hedging positions would act as "reinsurance" to "protect the portfolio."

33. The Committee received the same message. It was told repeatedly that Structured Alpha was "insurance protection from the world's largest insurance company," a reference to Allianz SE, the ultimate corporate parent of Allianz.

34. Allianz promoted the relationship with its parents in marketing Structured Alpha to the Committee. In May 2010, about a year before the Committee first voted to invest in Structured Alpha, Allianz (then known as Allianz Global Investors Capital) advertised Structured Alpha as being backed by Allianz SE, "one of the largest financial institutions in the world":



35. Likewise, Allianz trumpeted that what makes Structured Alpha "different" from other portable alpha strategies is its "oversight from the parent." Indeed, Allianz claimed, consistent with the unified risk management framework that Allianz SE touts in its annual reports, that risk was "continuously managed and monitored" at the "firm level." Assisting these

risk management efforts, Allianz told the Committee, was IDS GmbH, a "wholly-owned subsidiary of Allianz SE," that supposedly provided "a comprehensive range of ongoing and consistent performance and risk analysis reports." Allianz's direct parent, Allianz Global Investors U.S. Holdings LLC, purportedly oversaw Allianz's "day-to-day portfolio management and investment operations," including risk management.

36. In recommending the strategy to the Committee, Aon highlighted the "benefits" to Structured Alpha of the "deep resources" offered by Allianz's parent companies. Those benefits, according to Aon, included "multiple layers of independent risk management functions within the firm."

Aon Advises the Committee to Invest Trust Assets in Structured Alpha

37. In 2009, the Committee retained Aon (then called Ennis Knupp) to provide investment advice regarding the investment of Plan assets held in the Trust.

38. The Committee's charter authorizes it to enlist the services of professional investment advisers such as Aon to assist the Committee in the selection and oversight of the Trust's investments. The Committee, according to its charter, "shall be entitled to rely upon" the investment advice of professionals like Aon.

39. The Trust's Investment Policy Statement—which Aon helped draft as one of the services it provided to the Committee and which features Aon's logo on its cover page—documents Aon's fiduciary role. It provides that Aon would "advise the Committee on the management of the Trusts' assets." "The Committee," in turn, would "utilize and rely upon the advice and services" of Aon "in carrying out its responsibilities." The Investment Policy Statement specifies that Aon would provide investment advice to include "recommending appropriate strategic policy and implementation structure and conducting manager due-diligence,

searches and selection," as well as "aid[ing] the Committee and NEBA in adhering to the guidelines of the Investment Policy Statement."

40. The charter further grants the Committee "the broadest possible authority and discretion to delegate to itself or to any other entity or any other person or persons any of its authority and discretion." Pursuant to that broad authority, the Committee delegated to Aon specific duties that Aon undertook to fulfill, including a duty to recommend investment managers to the Committee and a duty to monitor those managers that had been entrusted with Plan assets.

41. In the contract between the Committee and Aon, Aon agreed that it would "recommend the selection of managers or custodians it deems most capable of carrying out the [Trust's] investment objectives." Once an investment manager was selected, Aon undertook the specific duty to "engage in active, ongoing monitoring" of that manager to "assess evolving strengths, weaknesses and issues" and "identify any forward-looking" risks "that could impact performance." Aon agreed further to "inform itself" of any information necessary to discharge this duty to monitor, including whatever information Aon needed to properly advise the Committee whether the manager was acting prudently with Plan assets.

42. Aon undertook to provide additional types of investment advice to the Committee. For example, Aon agreed to give "recommendations to [the Committee] regarding asset allocation" within the Trust, "recommendations to [the Committee] regarding the specific asset allocation and other investment guidelines" for the Trust's investment managers, and advice "regarding the diversification of assets" held in the Trust.

43. Aon promised to discharge all of these "fiduciary duties with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a

like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims."

44. Acting in its fiduciary capacity, Aon recommended in 2011 that the Committee invest Plan assets held in the Trust in Structured Alpha. As part of its recommendation, Aon emphasized that Structured Alpha's "risk management approach" was "deeply embedded into the investment process," giving investors "significant market crash protection." Aon lauded "the multiple layers of independent risk management functions" and described risk management as "a core element to the strategy." Aon also assured the Committee that the strategy included "tail protection" against "large market declines." According to Aon, these long-put hedges were "designed to automatically protect the portfolio" if the market crashed.

45. In accordance with Aon's recommendation, and understanding the strategy to employ the robust risk management that Aon endorsed, the Committee voted on June 21, 2011, to approve an investment of Trust assets in Structured Alpha.

46. The Committee's initial investment was in Structured Alpha U.S. Large Cap Core LLC. This fund, like the Structured Alpha Funds in which the Trust later invested, was organized as a limited liability company for which Allianz was the managing member. The Trust's investment in each Fund was governed by a Private Placement Memorandum and Limited Liability Company Agreement, as well as the Subscription Agreement by which Trust assets were invested (collectively, the "Fund Documents").

47. Allianz and the Committee also entered into a separate Investment Management Side Agreement in conjunction with the Trust's investment in Structured Alpha. The parties updated the contract in May 2014, when they executed the Amended and Restated Investment

Management Side Agreement to reflect Allianz's creation of the new Multi-Beta Series in which the Trust was invested.

48. Under that agreement, Allianz promised to undertake duties as a fiduciary vested with "full discretion" to manage the Plan assets that the Committee invested in Structured Alpha. For example, Allianz agreed as an "ERISA fiduciary" to "discharge its duties with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." Allianz further assumed the other responsibilities of a fiduciary under ERISA § 404(a) (29 U.S.C. § 1104(a)), including the duty of loyalty, the duty to diversify Plan investments, and the duty to follow Plan documents.

49. Under the Amended and Restated Investment Management Side Agreement, Allianz also undertook the same fiduciary duty of care "regardless of whether the underlying assets of any Series constitute 'plan assets' within the meaning of Section 3(42) of ERISA." Under this "Contractual Fiduciary Standard of Care," Allianz agreed "that it shall act in good faith and carry out its duties to each Series with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."

50. Should Allianz breach any of these fiduciary duties, it promised to "indemnify and hold harmless the Trust" for, among other things, any losses or damages "directly resulting from" Allianz's breach.

51. Allianz agreed, moreover, to "act in accordance with" the Investment Policy attached to the contract. Under that policy, Allianz promised to manage the Trust's investment

pursuant to certain investment objectives, including the establishment of "structural risk protections."

Allianz and Aon Reassure the Committee About Structured Alpha's Risk-Managed Investment Strategy

52. By 2018, the Trust's investment in Structured Alpha had expanded. The Multi-Beta Series now included five Structured Alpha series: U.S. Large Cap Series, U.S. Small Cap Series, International Equity Series, U.S. Fixed Income Series, and U.S. Long Credit Series. Each had a different index—the S&P 500 for U.S. Large Cap, for instance—whose results Allianz sought to replicate in the beta component and outperform using the alpha component. The targeted outperformance for each series varied based on the level of the Chicago Board Options Exchange Volatility Index (the "VIX"), an index measuring the market's expectation of volatility, when Allianz was building its option positions. The lower the VIX, the lower the excess return Allianz was supposed to target.

53. The Committee had also approved investments in two other Structured Alpha Funds: Emerging Markets Equity 350 and Structured Alpha 1000.

54. Allianz managed each of the Funds in substantially the same way regardless of the Fund's beta or, in the case of the Multi-Beta Series, regardless of the beta underlying each series.

55. In February 2018, Structured Alpha underperformed relative to its beta benchmarks. Those short-term investment losses were recouped in the following months, in accordance with how Allianz and Aon had advised the strategy would work in a market downturn. Nevertheless, the Committee sought to reevaluate the Structured Alpha strategy and the size of the Trust's investment in it.

56. In April 2018, the vice chair of the Committee directed NEBA's investment team to have Allianz and Aon explain the worst-case scenario for the strategy. "The key question" the Committee vice chair wanted answered was "how the strategy will perform in a declining market situation." Specifically, if the Trust would "experience substantially higher losses than the market i[n] such a situation," then the Committee would likely "need to wind down our exposure to this strategy to a percentage of the portfolio closer to 10% than 50%."

57. Allianz responded to the Committee's questions with written representations about how Structured Alpha would work and how it would protect against the risk of losses in a declining market. Against the backdrop of the Committee's inquiry about whether Structured Alpha would expose the Trust to "substantially higher losses than the market," Allianz described its hedge positions as the "cornerstone" of the strategy. Allianz represented that these hedges would be "in place at all times, exclusively for risk-management purposes" in order "to protect the portfolio in the event of a market crash." Allianz emphasized that this "tail-risk protection" included "both hedging primarily for a single-day market crash" and "protection in the event of multi-day or multi-week significant declines."

58. But Allianz went even further in describing the hedging positions. According to Allianz's written response to the Committee, Structured Alpha's hedging strategy ***eliminated*** the risk of an "ill-timed margin call," a common concern among investors in options strategies and a particular concern of the Committee's. "***We do not have this risk***," Allianz touted, because of Structured Alpha's "hedging positions." Allianz claimed further that the lack of margin-call risk was a "key benefit of our hedging positions." These statements were consistent with representations Allianz had made elsewhere about the strategy's supposed immunity to margin calls. For instance, in an April 2017 pamphlet, Allianz proclaimed that "***under no scenario*** can

an equity-market decline cause our portfolio to experience a margin call, a crucial differentiator from many option strategies."

59. Allianz's written response contained several other critical representations about how Allianz managed the Structured Alpha Funds. For example, Allianz emphasized that it would need only "between 10% and 20%" of the beta investment for collateral for the alpha component, suggesting that only a small portion of the Trust's investment was potentially at risk in a market decline. Allianz also touted "the proprietary tools and models we have built over many years of research and development" that Allianz claimed allowed it "to stress-test the entire portfolio for ***any*** market scenario." These tools, Allianz claimed, enabled it to protect the Trust's investment from "two risks: the overnight market crash and the multi-week market correction." And as for the "worst-case drawdown scenario" the Committee had asked about, Allianz represented that its lower-target strategy "could be expected to deliver short-term underperformance of 100 to 300 basis points," *i.e.*, underperformance of only 1% to 3% relative to the benchmark.

60. Elsewhere, Allianz downplayed even that risk by explaining that the period of increased volatility that typically accompanies a market downturn would provide an attractive environment in which to deploy its options strategy. It claimed that any short-term underperformance would be recouped in a rebound once the initial downturn had been weathered. Of course, Allianz's claim assumed that the Funds would in fact survive the market downturn.

61. In the same time frame, the Committee also asked Aon to reevaluate Structured Alpha and provide its investment advice as a fiduciary on whether and to what extent the Committee should remain invested. Aon's advice echoed Allianz's reassuring representations.

Because Aon was the fiduciary tasked with the specific duty to monitor Allianz's management of Plan assets, its advice was also critical to the Committee's decision to maintain the Trust's investment in Structured Alpha.

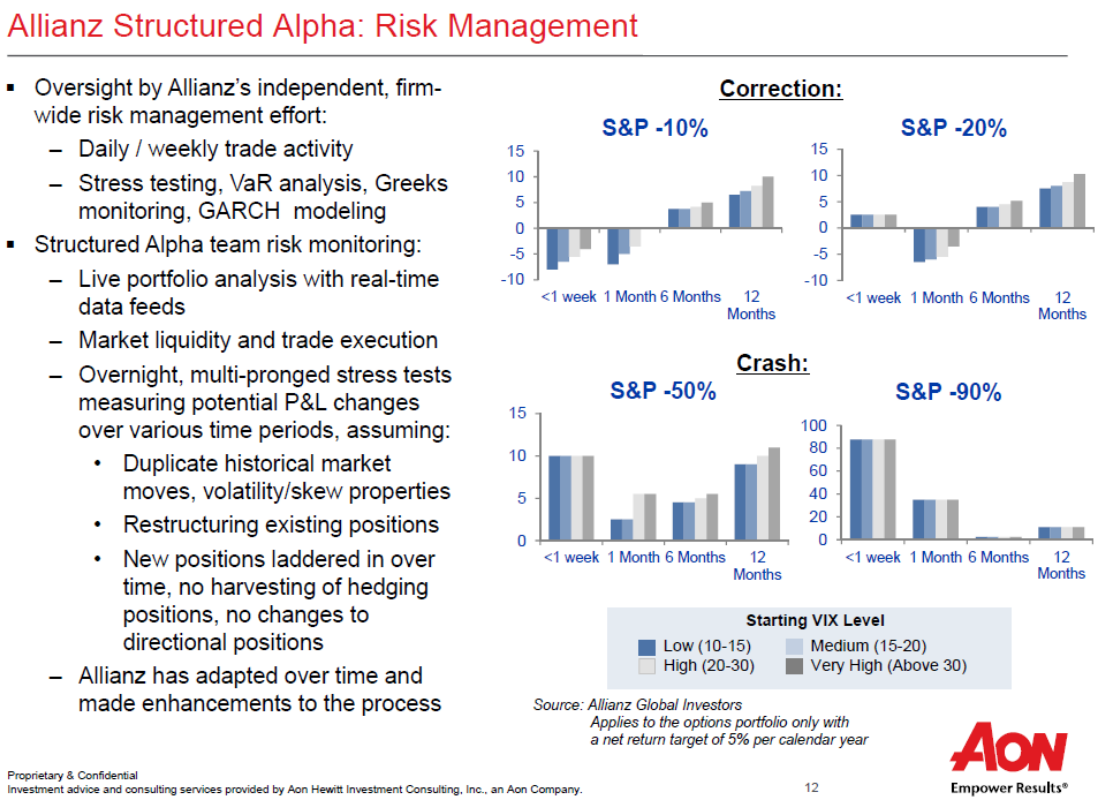
62. On June 18, 2018, Aon presented its analysis and recommendations to the Committee. Consistent with Allianz's own description of the strategy, Aon advised the Committee that Structured Alpha was "Financial Insurance to the Options Market." The hedging positions, which Aon said were "always in place to protect against a crash scenario," were supposedly the strategy's "Reinsurance."

63. Aon undertook to answer two specific questions the Committee had posed to it: (i) did the Structured Alpha Funds add incremental risk to the Trust's investment portfolio? and (ii) what is the worst-case scenario that could result from the Trust's investment in those Funds?

64. Aon purported to answer the first question by presenting what it claimed was the "active risk" associated with the strategy and assuring the Committee that the risk was not significant. Aon further understated Structured Alpha's risk by repeating Allianz's claim that "only a small portion of the underlying assets are used to implement the options strategy." Aon's representation suggested that only a small amount of the Trust's investment with Allianz was exposed to the options strategy and therefore at risk if the strategy failed. Aon's advice obscured the truth from the Committee that the entire investment could be at risk.

65. Aon's explanation of its presentation, made orally to the Committee in June 2018, also understated the risks associated with Structured Alpha. Addressing concerns the Committee had raised that there may be an "undue concentration" of the Trust invested with Allianz, Aon falsely advised that "Allianz' alpha seeking transactions only impact a small portion of this beta seeking portfolio."

66. The second question the Committee asked was similar to the one it had posed to Allianz: what is the worst-case scenario for the strategy? To address this question, Aon presented purported stress testing by Allianz, which Aon represented it had reviewed, indicating that Structured Alpha would not only protect against losses but actually generate a positive return in times of severe market dislocation. Although Aon's presentation included in fine print that Allianz was the source of the charts presented, its accompanying remarks to the Committee in June 2018 referenced Aon's own independent "projections." The charts, which were meant to show how Structured Alpha would perform in a variety of market scenarios, suggested that the alpha component of the strategy would perform very well—generating positive returns—even if the equity markets crashed as much as 50% or 90%. Indeed, the charts and Aon's explanation of them indicated that the most the Trust could lose in a worst-case scenario was less than 10%. If there were a scenario in which the Trust could expect to lose more, Aon did not present it:



67. In presenting these materials, Aon advised the Committee that the "hedging would protect the portfolio in the face of 'black swan' events such as sharp and deep market meltdowns." The hedging positions, Aon advised further, "should permit the strategy to actually produce strong positive returns in the face of such extreme market declines." Aon cited the stress testing charts as evidence "that in the face of a 50 percent market meltdown the strategy should produce a positive return of 10 percent."

68. What Aon did not tell the Committee is that the Allianz stress testing included several assumptions that did not fit the Trust's investment in the Structured Alpha Funds. Aon did not disclose, for example, that the model assumed Treasury Bills were the underlying beta. That omission was problematic for several reasons, including that only one of the Funds had Treasury Bills as its underlying beta. In fact, the U.S. Large Cap Series, which held a much larger portion of the Trust's investment, used S&P 500 ETFs as its beta. Aon did not explain how that series could withstand a 90% decline in its beta component and still collateralize the alpha strategy that Aon claimed would generate positive returns (while maintaining risk protection) in such a severe market dislocation. Aon instead gave the Committee the false impression that the stress testing results it endorsed were applicable to the Trust's entire investment in Structured Alpha, although much of it was collateralized by something other than the Treasury Bills the model assumed.

69. Aon also advised the Committee that it would in fact be ***riskier*** to exit the strategy than to remain invested in it. The hedging positions were the main reason why. This "reinsurance," Aon told the Committee, would protect the Plan assets in the face of a market decline and position the portfolio to rebound from any temporary losses. In this regard, Aon's advice echoed the characterization of the strategy that Allianz had provided.

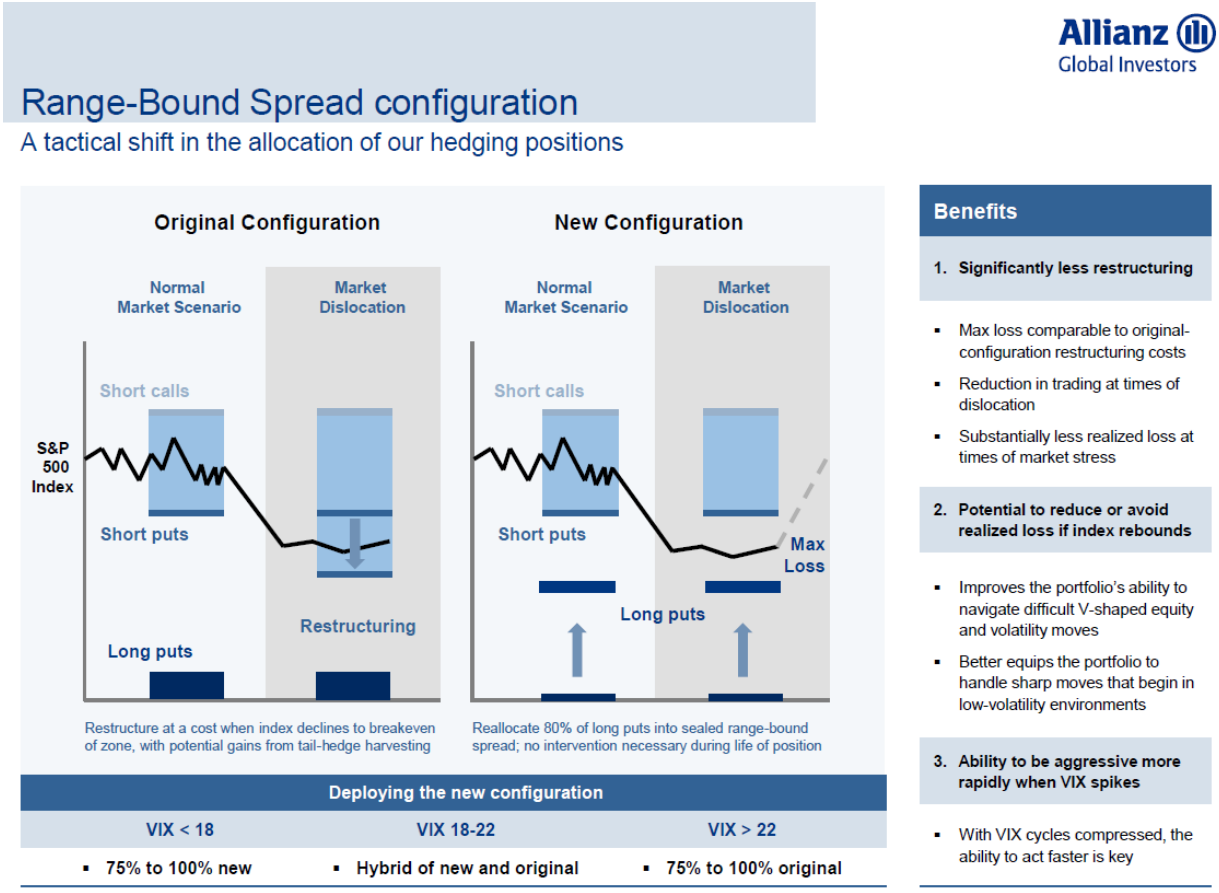
70. A similar review process occurred months later, after the Structured Alpha Funds again underperformed relative to their beta benchmarks. The negative returns in December 2018 were more severe than they had been in February of that year. The losses hit some of the Plan sponsors especially hard because they occurred at the end of the year, leaving them scrambling to revise their balance sheets and identify any unfunded liabilities.

71. Those losses were recouped in the ensuing months, as Allianz and Aon had advised could be expected in the event Structured Alpha sustained a loss. But the Committee again directed Aon to reevaluate the Trust's investment in Structured Alpha and to provide advice on whether that investment remained appropriate.

72. In January 2019, Aon advised that Allianz was implementing a new hedging configuration that Aon claimed would "better protect the options portfolio and guard against costly restructuring when equity markets experience steep declines."

73. Aon's presentation on the new hedging configuration mirrored the one Allianz would provide in April 2019. The gist of the "newly developed configuration," as Allianz represented it, was to purchase fewer hedges but buy them closer to the money when building positions in a low-VIX environment. By doing so, Allianz claimed it would "create ***self-hedged*** range-bound spreads with a ***defined maximum loss***." Thus, rather than restructure short positions, as Allianz had at times done when markets fell in the past, Allianz would now leave the new-configuration positions alone—they would become "hands-free" and require "no intervention."

74. Allianz included a diagram representing that the "tactical shift" in its hedging positions would create a defined "Max Loss" for the portfolio:

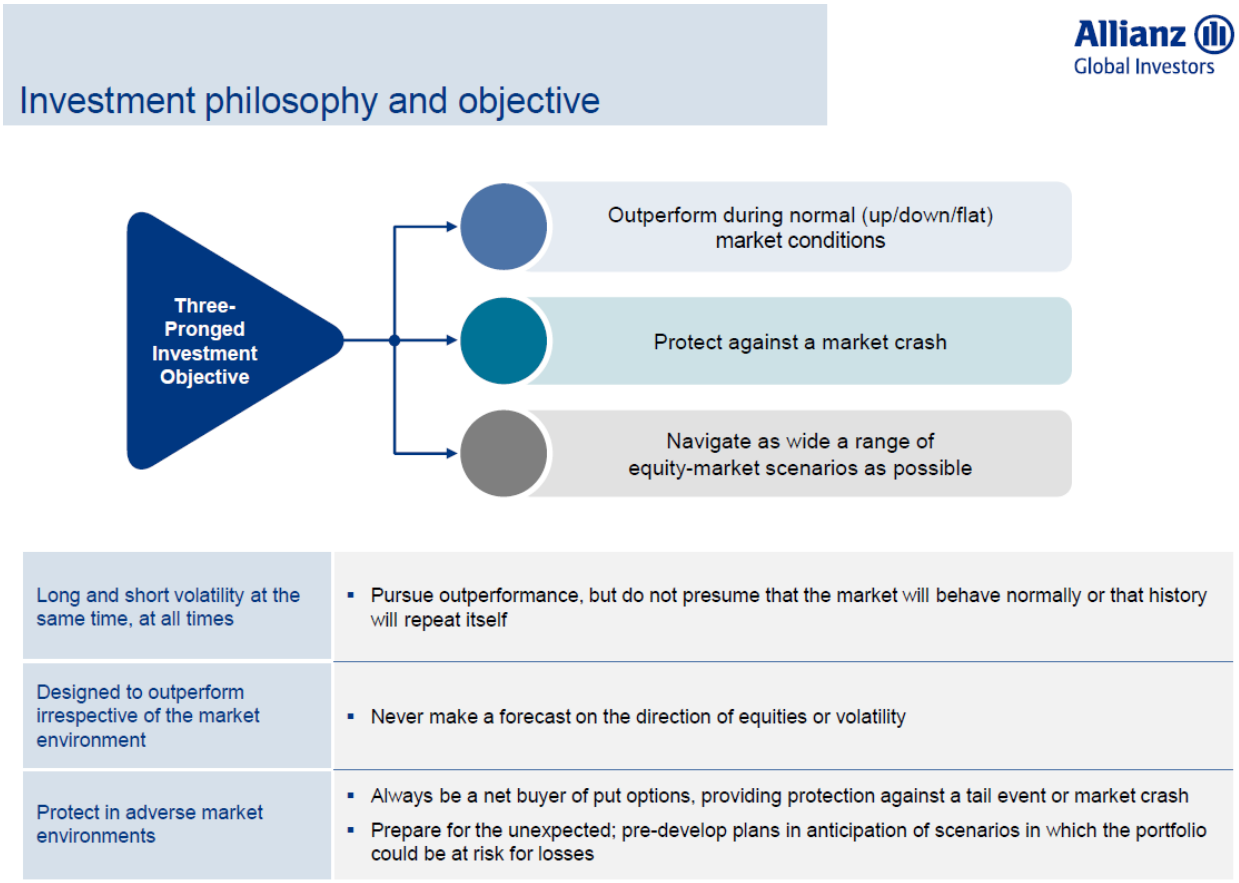


These new "sealed" spreads, Allianz claimed, would "Improve[] the portfolio's ability to navigate difficult V-shaped equity and volatility moves" and "Better equip[] the portfolio to handle sharp moves that begin in low-volatility environments." According to Allianz, the new configuration was the product of "almost two years" of research and development.

75. Allianz's description of a "Max Loss" was consistent with the representations that Aon had made to the Committee in June 2018, when Aon said (using Allianz's stress testing as its basis) that the most the Trust could lose in a worst-case market-crash scenario from Structured Alpha's options strategy was about 10%.

76. Allianz made additional representations about Structured Alpha in the April 2019 presentation. For example, Allianz summarized the strategy as pursuing "risk-managed returns." "Risk is continuously managed and monitored," Allianz claimed, "at both the portfolio level by

the investment team and the firm level." On the subject of "Leverage," Allianz emphasized that it engaged in "No borrowing." Allianz made that claim even though it was leveraging the Trust's beta investment to collateralize the options strategy. And Allianz repeated aspects of its investment philosophy that it claimed to follow, including the mantras "Never make a forecast on the direction of equities or volatility" and "Prepare for the unexpected; pre-develop plans in anticipation of scenarios in which the portfolio could be at risk for losses":



As Allianz had represented on the subject of "Accountability" in the past, "No excuses – it is our job to pursue the strategy's objectives regardless of the market environment."

77. A couple months later, in June 2019, the Committee again had Aon present its recommendation on Structured Alpha. Among the questions the Committee asked Aon to answer were whether "anything changed in the investment strategy to alter our expectations" and

whether "anything changed with the market conditions to alter our expectations." In response, Aon repeated many of the themes Allianz had itself used to describe the strategy, again describing Allianz's hedging positions as "reinsurance" that would contain the strategy's risks.

78. Aon also echoed Allianz's representation about there being a "Max Loss" the portfolio could suffer. To illustrate the concept, Aon provided the Committee a hypothetical in which Allianz had sold a put 10% out of the money. "In order to protect or hedge risk" in that scenario, Aon said Allianz would "buy a put . . . 15% below market." "That way," Aon claimed, the "***risk of loss is capped*** at 5%."

79. Based on Allianz's and Aon's representations, the Committee reasonably understood that Allianz was not selling "naked" options, *i.e.*, options without any corresponding hedge in place. Rather, Allianz and Aon indicated that for every option Allianz sold, Allianz bought a corresponding hedge as "reinsurance" to limit the risk of loss in case the market dropped. Both Allianz and Aon gave the Committee the impression that the hedging positions placed to protect against downside losses would be appropriately matched to the risk-bearing positions (*i.e.*, they would "reinsure" the same risk) and that Allianz would never sell any "naked" options.

80. The Committee also asked Aon whether it still maintained "the same conviction in the strategy." In response, Aon advised the Committee that it "continues to have a strong conviction that the portable alpha strategy is sound and pointed out that should a market decline persist over a longer period, Allianz' hedging strategy could be expected to produce an even greater rebound in [Trust] performance." Aon again rated Structured Alpha one of its "highest conviction strategies."

Allianz Abandons the Risk-Managed Investment Strategy It and Aon Had Represented to the Committee

81. Allianz often touted its supposed fidelity to Structured Alpha's stated investment strategy. For instance, in one update on the Trust's investment, Allianz congratulated itself for its "willingness to be flexible ***without straying from our investment philosophy***," saying this was one of its "biggest strengths," and emphasized that "part of staying true to Structured Alpha's investment philosophy is ***maintaining the risk profile of our option portfolio***." Going further still, Allianz claimed that it managed Structured Alpha to "***preserv[e] our risk objectives even at the expense of performance***."

82. Yet at least by 2019, Allianz had abandoned the investment strategy it professed to follow. Rather than "maintain[] the risk profile" it knew was critical to the Committee's investment of Trust assets, it was taking imprudent actions that added excess and undisclosed risk to the portfolio—in effect, leaving the portfolio unhedged in certain market scenarios and placing a directional bet against market volatility—in hopes of chasing additional return, all unbeknownst to the Committee.

83. Juicing the strategy's returns would increase Allianz's fees. Allianz did not charge a management fee to operate Structured Alpha. Rather, Allianz received 30% of any gains relative to its benchmark index. If Allianz underperformed, it received nothing.

84. Aon touted Allianz's fee structure in advising the Committee to invest in Structured Alpha and to remain invested in it. Aon advised that "the incentive fee-only structure creates a strong alignment of interests" that would benefit the Trust. Aon did not, however, appropriately monitor Allianz in light of that fee structure, which provided Allianz an incentive to take undue risk with Plan assets in hopes of boosting the strategy's returns and thus Allianz's compensation.

85. One example of Allianz's imprudence was its decision to purchase hedging puts further out of the money than Allianz had represented to the Committee. Allianz claimed time and again that its long puts would be struck "-10% to -25%" below the market. When Allianz diagramed the hedging component, it depicted a hedge at the bottom end of that range—25% below the market—even in the "original configuration" where (unlike in the "new configuration") the long puts were expected to be further out of the money. Aon reproduced those diagrams in its presentations to the Committee.

86. In fact, Allianz was purchasing hedging puts that were significantly further out of the money than Allianz had represented they would be. Those puts were cheaper and therefore less of a drag on the fee-generating returns Allianz could hope to produce. By purchasing cheap puts that were far out of the money, Allianz could inflate profits from its range-bound and directional spreads, thereby increasing Allianz's fees, and still claim that it was buying hedges (though those hedges had the potential to be virtually worthless in certain market scenarios when they would be most needed). But the gulf between Allianz's offensive, premium-generating positions and its defensive ones left the portfolio effectively unhedged and exposed the Trust to potential losses far beyond those Allianz and Aon had presented as possible.

87. Another example of Allianz's imprudence was its decision to buy hedging puts that expired sooner than the risk-bearing options it sold. Allianz and Aon had represented that the long puts would be of the same or similar duration as the short puts.

88. In reality, the puts Allianz was purchasing as supposed "reinsurance" expired far earlier than many of the puts it was selling, meaning there was, as Allianz later admitted, a "duration mismatch" between the options Allianz was short and those it was long. Allianz bought these shorter-dated puts because, again, they were cheaper. By purchasing less

expensive, shorter-dated puts and selling more expensive, longer-dated puts, Allianz essentially bought less "reinsurance" than it had promised. Doing so allowed Allianz to increase the profits from its range-bound and directional spreads, thereby increasing Allianz's fees.

89. Again, Allianz departed from the strategy it had represented to the Committee and, in doing so, Allianz layered excess and undisclosed risk on the portfolio. Allianz was apparently betting that it would be able to effectively replace the hedges as they expired, even in a declining market. That bet left the portfolio exposed to the risk that in a deteriorating market Allianz would be unable to backfill the hedges it should have had in place all along.

90. Perhaps the most glaring example of Allianz's imprudence, however, was its decision not to acquire any hedges for the return-generating options it sold on volatility indexes. In addition to buying and selling options on an equity index like the S&P 500, Allianz also disclosed that as part of the Structured Alpha strategy it may buy and sell options on volatility indexes such as the VIX or the iPath Series B S&P 500 VIX Short-Term Futures ETN ("VXX"). Because these options would be part of the return-generating portions of the strategy (and introduce risk as a result), they would also need to be appropriately hedged. In the same way that Allianz bought long puts on the S&P 500 to hedge against a decline in the equity markets, it would need long positions on the VIX to hedge properly against a spike in volatility.

91. Allianz, however, was taking on the risk of selling VIX options without buying any corresponding hedge. To borrow from Allianz's analogy, it was selling insurance against market volatility without any reinsurance against the risk that entailed. Far from "never" making a forecast on the direction of volatility—a supposed pillar of the Structured Alpha investment philosophy, according to Allianz—Allianz was gambling that the VIX would remain relatively low so its unhedged short positions would not be exposed to catastrophic losses.

92. Allianz was making that bet despite knowing that the VIX was becoming increasingly sensitive to market movements. In a December 2019 quarterly update, Allianz claimed that the recent "sensitivity of the VIX" was "advantageous" for Structured Alpha. A "typical response," Allianz explained, "is for the VIX to rise 10 to 20 times more than the S&P 500 declines." But in early December 2019, Allianz observed a VIX increase "100 times larger than the index move." Even though Allianz had identified that the VIX was becoming prone in late 2019 and early 2020 to sudden, larger-than-expected increases, Allianz continued to short volatility options—betting that the VIX would remain relatively low—without any corresponding long positions to hedge against a spike in the VIX.

93. In all cases—whether purchasing puts too far out of the money or purchasing puts with shorter expiration dates than the puts it sold or shorting the VIX without any corresponding hedge in place—Allianz's motivation was self-interest, not the best interest of the Plans' participants and beneficiaries. And in all cases, Allianz had departed from the prudent strategy it had represented to the Committee, adding excess and undisclosed risk out of line with the risk parameters that were a predicate for the Committee's decision to invest Trust assets in Structured Alpha.

94. The Committee did not know that, going into the market dislocation of February and March 2020, Allianz had departed from its professed investment strategy and was instead layering excess risk into each of the Funds. The strategy was performing as Allianz and Aon said it would, with any short-term losses being recovered in subsequent months. And Allianz and Aon both represented that the portfolio was, if anything, better positioned to handle a market downturn than it had been in the past.

95. As to Allianz, the most significant modification to the Structured Alpha investment strategy that Allianz had brought to the Committee's attention was one that purportedly ***enhanced*** the portfolio's ability to navigate a market decline. In its quarterly strategy updates in 2019 and early 2020, Allianz described one portfolio modification (the "new configuration" hedges), which Allianz said gave the portfolio an "improved ability to navigate sharp market declines that are preceded by low-volatility environments" and "made the option portfolio more resilient." Although it trumpeted this "refinement[]" to the investment strategy, Allianz did not tell the Committee of its other changes to Structured Alpha's investment strategy—namely, that it was making a directional bet that volatility would remain low, selling naked options, and buying hedges much further below the market than it should have under its professed investment strategy.

96. Meanwhile, Allianz continued to make all the same representations it had in the past about Structured Alpha's supposed investment strategy. For instance, when Allianz presented on the strategy in January 2020 to Blue Cross Blue Shield of Arizona, whose chief financial officer also sits on the Committee and Subcommittee, Allianz repeated many of its common representations about Structured Alpha even though, by that time, these representations were untrue. As before, Allianz represented that Structured Alpha seeks "risk-managed" or "risk-controlled" returns; that it was "designed to perform whether equity markets are up or down, smooth or volatile"; that it would "never make a forecast on the direction of equities or volatility"; that it involved "no borrowing"; that it would "pre-develop plans in anticipation of scenarios in which the portfolio could be at risk for losses"; and that its hedging positions would "protect the portfolio in the event of a market crash." Allianz buttressed its confidence by repeating several of its more specific representations about how it would manage the strategy

prudently. For example, Allianz again claimed that its long puts were struck "-10% to -25%" from the market, that its short puts and long puts would have roughly the same duration, and that it employed "long VIX calls" as a "helpful complement to long S&P 500 puts" for "hedging purposes." Indeed, Allianz claimed to be "as prepared as ever in the event of a severe market dislocation." None of these representations was true.

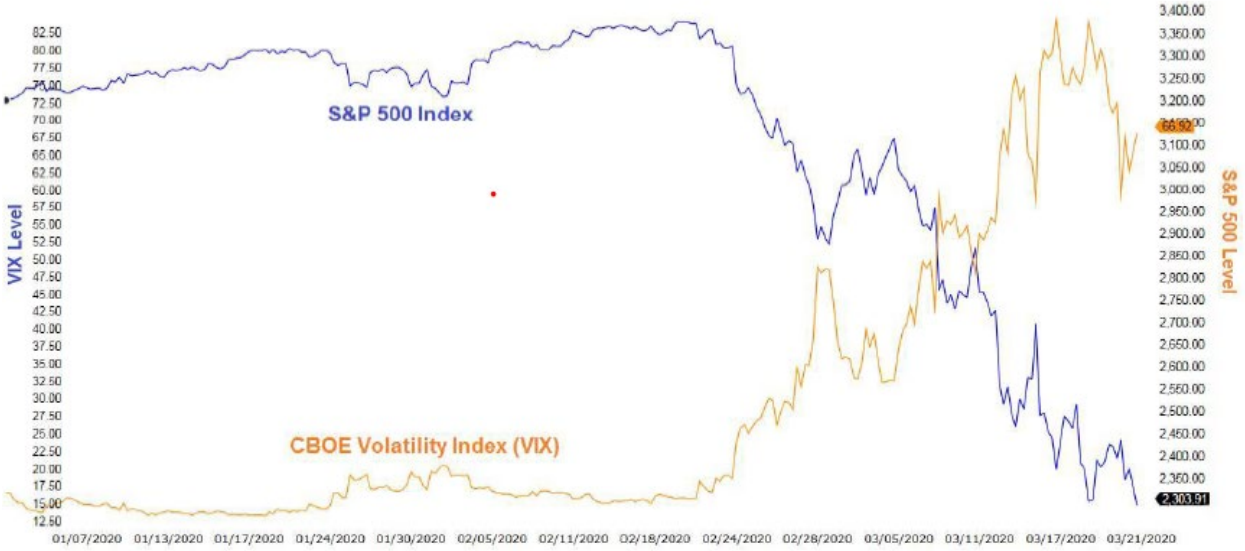
97. Because the Committee relied on Aon to monitor Allianz and to advise the Committee of any risks that could impact performance, the Committee did not uncover Allianz's departure from its professed investment strategy prior to the disastrous events of February and March 2020. Aon could and should have warned the Committee of Allianz's imprudent construction of the portfolio at least by 2019. Yet Aon never sounded the alarm. It never advised the Committee of the excess risk Allianz was layering into the portfolio, it never advised the Committee that Allianz was using the Trust's assets to gamble on the direction of the market and volatility, and it never advised the Committee that Aon's prior advice about Structured Alpha was (at least by 2019) untrue. It failed to bring these risks to the Committee's attention, despite the Committee's specific questions at the time about the continued advisability of investing in the Funds.

98. Aon either noticed the red flags and failed to inform the Committee of the potentially disastrous risks they posed to the Trust's investment in Structured Alpha, or Aon failed even to appreciate them. Regardless, Aon's failure was in derogation of its fiduciary duties and left the Committee with the false impression that Allianz was managing Plan assets in the manner Allianz and Aon had represented. That failure, along with Allianz's mismanagement, led to the devastating losses the Trust suffered in early 2020.

Allianz's and Aon's Breaches Cause the Trust to Suffer Catastrophic Losses

99. Going into the market turmoil of February and March 2020, Allianz did not have in place appropriate hedging positions to protect the portfolio (as it claimed it would) and then it sold many of the hedges it did have (as it claimed it would not do). As a result, Allianz caused the Trust to suffer catastrophic losses in a matter of weeks.

100. Throughout January and into late February 2020, the VIX remained relatively low and the S&P 500 remained relatively stable before the market began to decline and volatility spiked in the second half of February and March 2020:



101. By March 6, the Trust's investment in Structured Alpha had already declined by a double-digit percentage. Yet in communications with NEBA investment staff, Allianz reported optimism about the portfolio's ability to rebound. Although Allianz acknowledged that some restructuring had taken place, it reported that the "cost of these moves was well contained."

102. Contrary to the rosy picture Allianz was painting, the Trust's investment was plummeting. On March 12, Allianz reported on a phone call with NEBA investment staff and Aon that the hedges—the "reinsurance" that Allianz and Aon had said would be in place "at all times" to protect the portfolio—were "not working." Allianz also reported that the Trust's investment would soon face a margin call, the very risk that Allianz had told the Committee it would never face. ("We do not have this risk," Allianz had represented.)

103. The next morning, Friday, March 13, Allianz emailed Aon with additional details about the Trust's investment. Those details reveal what Aon, in conducting its specific monitoring duties of Allianz, should have already known: that Allianz had added excess and undisclosed risk to the portfolio in February and March 2020 and that it had been making other imprudent decisions, unbeknownst to the Committee, for some time. Aon waited until Sunday afternoon, March 15, to forward that email to NEBA.

104. If Allianz had been managing the portfolio in the manner it claimed it would, Allianz would (among other things) have constructed the hedging positions closer to the market and left those hedges in place to secure the defined "Max Loss" if the market declined. That was the "new configuration" strategy—touted as the product of "almost two years" of research and development—that Allianz had promised to deploy in a low-VIX environment like the one that existed for the first six weeks of 2020.

105. Yet, as Allianz acknowledged in its March 13 email, it had sold the new-configuration hedges—*i.e.*, the hedges that were supposed to be "hands-free" and locked in to contain potential losses. According to Allianz, it had struck the puts "7% to 9%" out of the money. But when the market declined, these "new-configuration puts were shifted," meaning Allianz sold them and replaced them with long puts much further out of the money. Allianz, as

Aon later put it, chose not to "accept modest losses and aim to recover in a reasonable time period," opting instead to gamble that the market would rebound immediately and "expos[ing] the portfolio to further downside risk." "In hindsight," Allianz admitted, "***we should have left those positions as is***."

106. Allianz would not have sold the new-configuration hedges were it acting in the best interests of the Plans' participants and beneficiaries. Were it doing so, it would have accepted modest losses. Instead, motivated by the fact that it would earn no compensation until those losses were recovered, Allianz removed the hedge that was supposed to protect the Trust's investment and gambled (with the Trust's money) that markets would soon recover. In doing so, Allianz not only abandoned Structured Alpha's supposed hedging strategy but also its purported tenet not to bet on the direction of the market.

107. As Allianz acknowledged in its March 13 email, these active management decisions also created a "duration mismatch" between the short and long puts that contributed to the portfolio's losses. This mismatch, Allianz explained, meant that the long puts "couldn't be harvested because they were shorter-dated" and about to expire. The resulting "theta decay reduced their value," and the puts "did not pay out." Another problem was that the cost to replace the expiring long puts increased dramatically as the market declined and volatility spiked. "We are continually rolling into new long puts as they expire," Allianz wrote, "but there still is a duration mismatch that causes a continued equity decline / vol increase to hurt the mark and vice versa." Had Allianz purchased and maintained the proper downside protection that it had represented would be in place at all times, it would have had no need to replace expiring long puts at the critical time when, as Aon later put it, they became "prohibitively expensive."

108. In addition to what Allianz admitted to in its March 13 email, at least two other imprudent decisions by Allianz inserted excessive risk into the portfolio and contributed to its collapse.

109. First, Allianz had been chasing additional returns by purchasing cheap puts much further out of the money than Allianz had represented. Many of those long puts, Aon reported after the fact, "expired worthless in early March." As Aon told the Committee when asked later why the hedges proved ineffective, "they were too far 'out of the money' to begin with."

110. Second, though Allianz was selling puts and calls on volatility indexes like the VIX, Allianz had purchased ***no*** long positions on the volatility indexes it was shorting. Allianz left the portfolio at the mercy of a surge in volatility, which is exactly what happened in February and March 2020.

111. Allianz left these short positions "naked" even though it knew that the VIX had been displaying increased "sensitivity" to market moves and was therefore prone to sudden, larger-than-anticipated spikes. The net result was that the portfolio, going into the volatility spikes of February and March 2020, was ***short*** volatility—reflecting Allianz's gamble that the VIX would remain relatively low. Allianz made this reckless directional bet despite the supposed pillar of its investment strategy that it would "never make a forecast on the direction of equities or volatility."

112. The combination of these and other imprudent actions by Allianz, which Allianz took with respect to each of the Structured Alpha Funds, caused the Trust's investment in each Fund to suffer staggering losses by the time the market opened on Monday, March 16. After Allianz notified NEBA and Aon that the portfolio was facing a margin call the next day, there was no choice but to liquidate the Trust's investment to protect what was left.

113. Three of the five series in the Multi-Beta Series—U.S. Large Cap, U.S. Small Cap, and International Equity—each lost about 80% or more in a matter of weeks. Structured Alpha 1000 did even worse. The best-performing Fund, Emerging Markets Equity 350, fell nearly 50%. These losses far exceed those incurred by the strategy's benchmark indexes, the equity markets more generally, and comparable investment strategies in which the Trust could have invested.

114. After the Trust's investment in the Structured Alpha Funds was liquidated and redeemed, it received only about $540 million as compared to the nearly $3 billion it had invested in the Funds at the start of the year.

115. The Committee was not alone in liquidating its investment. On March 25, Allianz announced that it was liquidating Structured Alpha 1000, which had lost about 90% or more of its value. Allianz also liquidated the Structured Alpha 1000 Plus fund.

116. For Aon's part, after years of lauding Allianz's "sound investment philosophy" and "multiple layers of independent risk management functions," endorsing Allianz's claims about the hedges as "reinsurance," and rating Structured Alpha one of its "highest conviction strategies," it has now done an about-face in the wake of the strategy's failure.

117. On March 27, more than ten days after the Trust's investment had collapsed, Aon advised the Committee, for the first time, that Structured Alpha suffered from "flawed portfolio construction" and a "lack of appropriate independent risk controls." Aon, as a fiduciary adviser, should have uncovered these failings and warned the Committee about them at least by 2019, rather than touting Structured Alpha as its highest conviction strategy.

118. Aon claimed after the fact that it had done a "fair amount of stress testing" to determine how Structured Alpha would behave in various market conditions. But Aon never

provided any independent stress testing to the Committee. The only stress testing Aon shared was what Allianz had supposedly done based on assumptions that Aon should have known did not apply to the Trust's investment. So either Aon never actually did any of its own stress testing or it did but for some reason never shared the results with the Committee.

119. Attempting to defend its oversight of Structured Alpha, Aon also claimed that it had employed a third-party provider, RiskMetrics, to ensure that Allianz was purchasing the hedges it said it would. Aon advised the Committee that it received reports from RiskMetrics on the subject. Moreover, Aon claimed that it had performed "on site" reviews of Structured Alpha's holdings and held "regular discussions" with Allianz regarding the strategy's "positioning." Indeed, Aon's postmortem analysis reflects an apparent understanding of the positions Allianz held in February and March 2020 that led to the strategy's collapse.

120. If Aon had been prudently discharging the duty it undertook to monitor Allianz, it would have discovered the imprudent decisions Allianz had been making. Aon would have found, for example, the duration mismatch Allianz had created, as well as the substantial gap between the range-bound spreads and the deep out-of-the-money puts Allianz had purchased. And if Aon had reviewed Allianz's positional data, as Aon's monitoring duty required it to do, it would have found long before February and March 2020 that Allianz's VIX options were unhedged. Because Aon did none of that, it failed to detect the "flawed portfolio construction" or "lack of appropriate independent risk controls" it belatedly described on March 27 as a basis for divesting from the Structured Alpha Funds. By then it was too late.

Allianz Attempts to Whitewash Its Breaches

121. On July 20, 2020, Allianz published on its website the results of an internal review Allianz claims to have conducted into the "substantial losses" Structured Alpha incurred. The stated purpose of Allianz's review, titled "Structured Alpha March 2020 performance," was "to better understand how the Portfolio's investment and risk management processes operated in the face of the market volatility" experienced at that time.

122. Allianz's account purports to describe certain of its actions in March 2020. "During the eleven trading days between March 2 and March 16," Allianz says, "there were at least four instances" in which it restructured the short puts on the S&P 500 "by both reducing the strike prices of the put options and by decreasing the number of positions held." "Similarly, the portfolio managers replaced short-term short VIX calls with new longer-term short VIX calls at more distant strike prices. An analogous process occurred for short VXX calls," according to Allianz. But "commencing on March 12, 2020, the Portfolio Management team stopped relayering new short puts on the [S&P 500] and [Nasdaq], and short calls on the VIX and VXX to further reduce the risks in the portfolio."

123. These details confirm that Allianz was betting on a market rebound by continuing to relayer short positions during the critical time period when Allianz should have been mitigating risk, not compounding it. What is new, however, is Allianz's admission that it was relayering risk-bearing positions all the way until March 12. Only then did Allianz stop exposing the portfolio to further losses by refraining from selling more insurance against an additional market decline.

124. Allianz claims in its July 2020 report that it was "obligat[ed] to investors to pursue returns" in the first half of March 2020 rather than "convert[] to cash." But Allianz was not obligated to layer additional risk into the portfolio so it could bet on a market rebound.

Allianz could have, for example, converted to cash or cash equivalents (as it had discretion to do under the Fund Documents), especially to assist in the preservation of capital on a temporary basis.

125. The most jarring aspect of Allianz's July 2020 report is how different the strategy Allianz now describes is compared to the one it had represented to the Committee all along.

126. Allianz's report claims that the risks of investing in Structured Alpha were "fully disclosed, including the risk of total loss." That assertion contradicts Allianz's prior representations of how it would manage the portfolio to avoid significant losses. It also contradicts Allianz's specific representation to the Committee that one "key benefit" of the hedges was that they eliminated all risk of a margin call.

127. Allianz's report also claims that the hedges were designed to offer only "some protection" in the event of a market crash. The hedges, Allianz now insists, were "not intended to provide broader protection against all market downturns, particularly downturns that transpire over longer periods of time." Rather, they were "deliberately constructed with options that were both of relatively short expiration and far out of the money" only to "protect against a ***one-day market shock***."

128. Allianz never disclosed these limitations. To the contrary, Allianz characterized the hedges as "reinsurance" that would be "in place at all times" in order to "protect the portfolio in the event of a market crash." It emphasized to the Committee that its investment strategy addressed "two risks: the overnight market crash ***and the multi-week market correction***." Allianz's "tail-risk protection," it told the Committee, "includes both hedging primarily for a single-day market crash as well as better ***protection in the event of multi-day or multi-week significant declines***." Allianz bolstered these claims about protection against multi-week

declines with stress testing purporting to show, for instance, that the strategy would yield positive returns during market shocks that took weeks or even months to transpire. Allianz's after-the-fact description of the hedges as a partial backstop—protecting only against a "one-day market shock" but nothing else—is inconsistent with its prior representations to the Committee.

129. Allianz's July 2020 report claims that because the hedges were constructed to protect only "against a one-day market shock," Allianz properly "mitigated" portfolio risk through restructuring.

130. Yet Allianz told the Committee that when it was building positions in a low-VIX environment (like that which existed at the start of 2020), the new-configuration hedges would not only protect against a market decline but predefine a set "maximum loss." According to Allianz, these new-configuration hedges were supposed to create "hands-free spreads" that would need ***no restructuring*** during "the life of the position." Allianz's postmortem omits any mention of the new-configuration hedges that should have been locked in place to define a "Max Loss."

131. Allianz's July 2020 report claims further that Allianz's "Enterprise Risk Management function" stress tested the portfolio against "***single day*** scenarios" only.

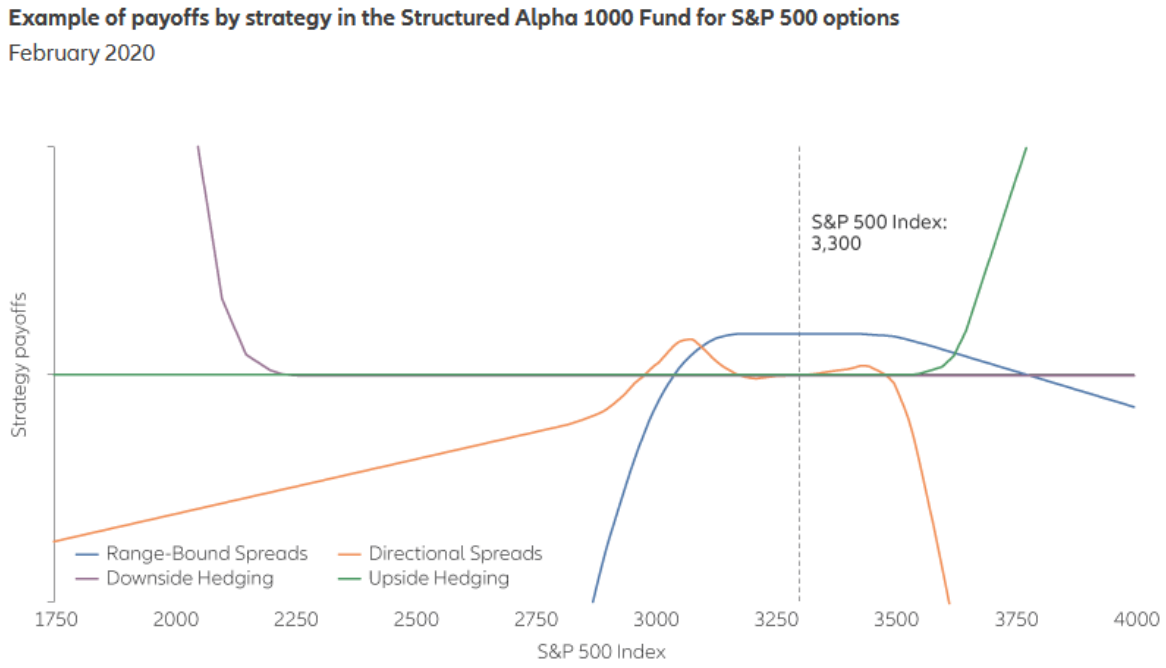
132. If single-day stress testing were all Allianz was doing, its imprudence speaks for itself: such testing would not permit Allianz to evaluate, let alone manage, risk in a multi-day or multi-week market decline. Contrary to Allianz's July 2020 report, Allianz had previously assured the Committee that the same "Enterprise Risk Management" team was responsible for "weekly risk profiles" and that Allianz's "proprietary tools and models" enabled it to "stress-test the entire portfolio for ***any*** market scenario"—models Allianz claimed were "integral to the

successful day-to-day management of Structured Alpha." And when the Committee had asked about potential worst-case scenarios, Allianz responded:

> We ***continually focus*** on two risks: the overnight market crash and ***the multi-week market correction***. Our ongoing ***objective is to protect the profit/loss profile of the option portfolio across a broad set of stress-test parameters***. We manage the option portfolio for its ability to withstand and ***navigate as wide a range of potential market scenarios*** as possible.

Again, Allianz's postmortem is inconsistent with the risk profile of Structured Alpha that Allianz disclosed to the Committee.

133. Allianz also included in its July 2020 report a graph providing a "representative depiction of a portion of the composition of the Structured Alpha 1000 fund" as of "February 2020":



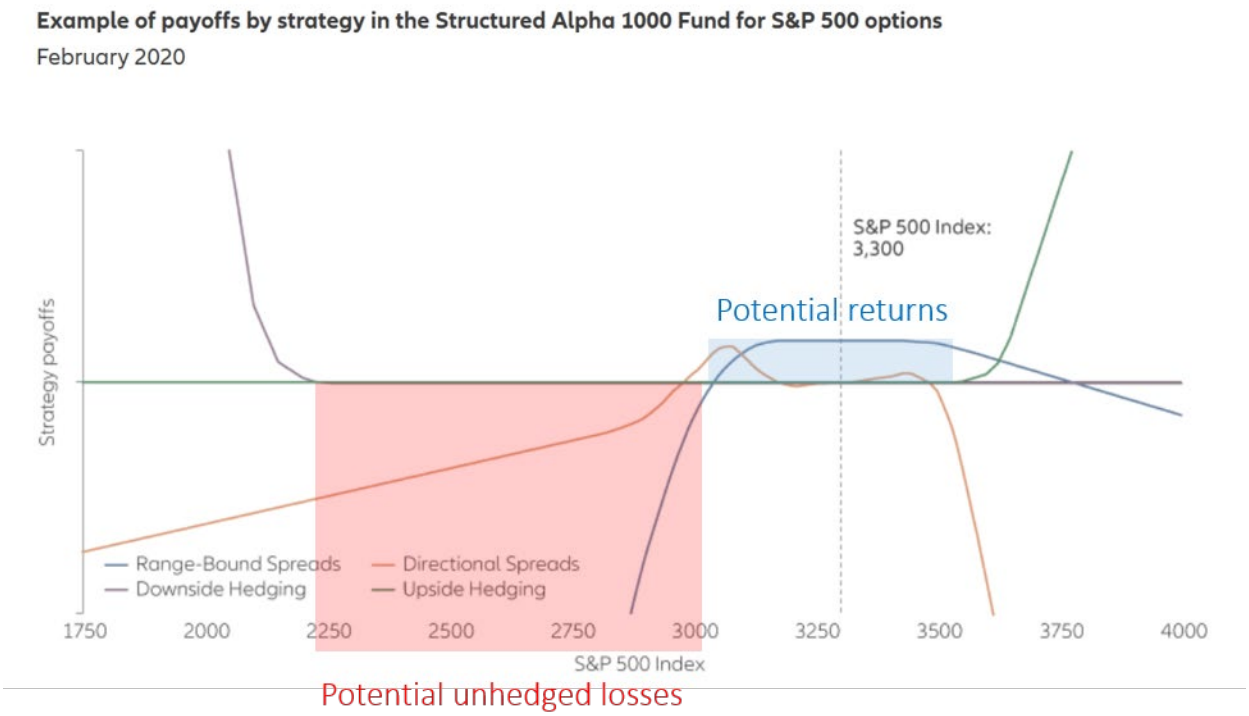
134. This graph depicts an investment strategy that is inconsistent with the one Allianz assured the Committee it would follow to pursue "risk-managed returns." Allianz never disclosed this graph—or anything like it—to the Committee before Structured Alpha's disastrous

results in 2020. If it had, the Committee would not have maintained the Trust's significant investment in Structured Alpha.

135. Allianz's July 2020 graph illustrates that Allianz bought downside hedges well beneath the strike price (*i.e.*, "-10% to -25%" below-the-market level) at which it said it would buy hedges. While Allianz inexplicably claims this was "deliberate[]," its failure to buy the hedges it said it would added excess risk to the portfolio, leaving the Funds exposed to the catastrophic losses that occurred in February and March 2020.

136. Allianz's July 2020 graph also illustrates the absence of any new-configuration hedges, *i.e.*, the hedges that Allianz said it would buy closer to market levels in order to lock in a "Max Loss" in the case of a market decline. These are nowhere to be found in Allianz's graph (just as all discussion of them is missing from Allianz's commentary), although Allianz had said it had deployed this "refinement" to its investment strategy to make the portfolio "more resilient" to market declines.

137. Allianz's July 2020 graph also shows that potential returns from the options strategy (illustrated in blue in the annotated version of Allianz's graph below) came at the cost of potentially massive, unhedged losses (illustrated in red below) if the market declined. The downside exposure depicted in Allianz's July 2020 chart is contrary to Allianz's description of Structured Alpha's investment strategy to the Committee, including its representation that the hedging positions eliminated all risk of a margin call.



138. Importantly, Allianz's graph depicts only equity index options on the S&P 500. In its July 2020 report, Allianz chose not to illustrate the "strategy payoffs" from the short volatility options it sold on the VIX and VXX in violation of its promise "never" to make a bet on the direction of volatility. Had it included a graph of that strategy, it would show the potential for limited, modest payoffs if Allianz bet correctly and ***unlimited*** losses if it did not. Allianz has offered no explanation for why it made that wager with the Trust's money or how the disastrous losses it caused the Trust as a result were consistent with the investment strategy Allianz claimed to pursue.

COUNT I: BREACH OF FIDUCIARY DUTY – ERISA § 404
(AGAINST ALLIANZ)

139. The Committee restates and realleges paragraphs 1-138 as though fully set forth herein.

140. The Committee brings this Count under ERISA §§ 502(a)(2), (a)(3), and 409(a) (29 U.S.C. §§ 1132(a)(2), (a)(3), and 1109(a)). The Committee has the authority to bring this Count under these provisions because it is a fiduciary under ERISA of the Plans whose assets are held in the Trust. The Committee's charter, which the Plan sponsors have adopted, further authorizes the Committee to bring this Count.

141. At all relevant times, Allianz was a fiduciary within the meaning of ERISA § 3(21)(A)(i) (29 U.S.C. § 1002(21)(A)(i)) because it exercised authority or control with respect to the management or disposition of Plan assets held in the Trust.

142. At all relevant times, Allianz was also an investment manager within the meaning of ERISA § 3(38) (29 U.S.C. § 1002(38)). Allianz was a fiduciary with the power to manage or dispose of Plan assets held in the Trust. Allianz was a registered investment adviser under the Investment Advisers Act of 1940. And Allianz acknowledged in writing that it was a fiduciary with respect to the Plans whose assets are held in the Trust. Allianz did so, for example, in its contracts with the Committee, including the Amended and Restated Investment Management Side Agreement that Allianz signed in May 2014 and in various of the Funds' Limited Liability Company Agreements and Private Placement Memoranda.

143. By executing the contracts establishing Allianz as an investment manager within the meaning of ERISA, the Committee appointed Allianz to manage Plan assets under ERISA § 402(c)(3) (29 U.S.C. § 1102(c)(3)). That appointment entitles the Committee to the benefits and protections of ERISA § 405(d)(1) (29 U.S.C. § 1105(d)(1)).

144. At all relevant times, the Structured Alpha Funds were "plan assets" under ERISA § 3(42) (29 U.S.C. § 1002(42)) because 25% or more of the total value of each class of equity interest was held by benefit plan investors within the meaning of ERISA and its implementing regulations. Substantially all of the equity interests in the Multi-Beta Series and in Emerging Market Equity 350 were held by benefit plan investors. Aside from Allianz's own holdings as the managing member, the Trust held all or substantially all of the members' capital and equity interests in the five series comprising the Multi-Beta Series—U.S. Large Cap, U.S. Small Cap, International Equity, U.S. Fixed Income, and U.S. Long Credit—as well as in Emerging Markets Equity 350. Likewise, on information and belief, more than 25% of the total value of each class of equity interest in Structured Alpha 1000 was held by benefit plan investors at all relevant times.

145. At all relevant times, Allianz was managing the Structured Alpha Funds holding or containing Plan assets and acting in a fiduciary capacity.

146. As a fiduciary, Allianz owed a duty of care under ERISA § 404(a)(1)(B) (29 U.S.C. § 1104(a)(1)(B)). That duty required Allianz to manage Plan assets "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."

147. As a fiduciary, Allianz owed a duty of loyalty under ERISA § 404(a)(1)(A) (29 U.S.C. § 1104(a)(1)(A)). That duty required Allianz to manage Plan assets "solely in the interest" of and for the "exclusive purpose of providing benefits" to the participants and beneficiaries of the Plans whose assets are held in the Trust. The duty of loyalty also required Allianz to not mislead the Committee about Structured Alpha or Allianz's management of the

strategy and to disclose material facts whose omission would create a false impression about the strategy or Allianz's management of it.

148. As a fiduciary, Allianz owed a duty of diversification under ERISA § 404(a)(1)(C) (29 U.S.C. § 1104(a)(1)(C)). That duty required Allianz to ensure the Trust's investments were adequately diversified "so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so."

149. And as a fiduciary, Allianz owed a duty to follow Plan documents under ERISA § 404(a)(1)(D) (29 U.S.C. § 1104(a)(1)(D)). That duty required Allianz to manage Plan assets "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with" ERISA.

150. The fiduciary duties under ERISA are "the highest known to the law." *Donovan v. Bierwirth*, 680 F.2d 263, 272 n.8 (2d Cir. 1982).

151. Allianz breached its fiduciary duties. Allianz's breaches include, without limitation, the following:

(a) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it did not put the appropriate hedges in place to protect the assets during a market decline. This failure added excess and undisclosed risk and was contrary to the representations Allianz had made to the Committee and others that the hedges would be in place "at all times" as "reinsurance" for the Trust's portfolio.

(b) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it sold the new-configuration hedges and took on new risk-bearing positions starting in late-February 2020.

These discretionary restructurings exposed the Trust's investments to further downside risk and were contrary to Allianz's representations, including that it would not sell the new-configuration hedges that should have been locked in to safeguard the Plan assets.

(c) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it represented that it had constructed the portfolio in a way that would ensure a defined "Max Loss" and then managed the strategy in a way that exposed the Trust to unlimited losses.

(d) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it either failed to have adequate risk management measures in place or abandoned such measures.

(e) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it represented that it would manage the Structured Alpha strategy in such a way to eliminate the risk of margin calls yet implemented a strategy in which that very risk materialized.

(f) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it, unbeknownst to the Committee, decided to purchase puts that were further out of the money than the maximum range Allianz had disclosed, thus adding excess and undisclosed risk to the Trust's portfolio, in an apparent effort to increase Allianz's fees.

(g) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it, unbeknownst to the Committee, decided to purchase puts that expired sooner than the puts it sold. This practice was contrary to Allianz's representations that its short and long positions

would be of relatively equal duration and added excess and undisclosed risk to the Trust's portfolio. Allianz created this "duration mismatch" not because it was in the best interests of the Plans' participants and beneficiaries, but because doing so allowed Allianz to enhance its fees.

(h) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it, unbeknownst to the Committee, decided to sell volatility index options without buying any corresponding hedge, adding excess and undisclosed risk to the Trust's portfolio, again in an apparent effort to enhance its fees.

(i) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it caused the Committee to believe that Structured Alpha's risk profile was consistent with Allianz's stated investment strategy rather than the actual risk profile, either by making false or misleading representations about Structured Alpha or failing to disclose information necessary to correct prior representations that were inconsistent with how Allianz was actually managing the strategy.

(j) Allianz breached its duty to ensure the Trust's investments were prudently diversified when it operated a strategy that was unduly weighted towards being short volatility in February and March 2020 (contrary to its pledge not to make directional bets) and created excess and undisclosed correlated risks across the Structured Alpha Funds.

(k) Allianz breached its duty to prudently manage the Plan assets or manage them in accordance with the Plan documents when it acted contrary to the Trust's Investment Policy Statement, which reflects the character and aims of the Trust. The Investment Policy Statement provides, for example, that Plan assets held in the Trust "shall be invested" consistent with the duties of care, loyalty, and diversification listed in ERISA § 404(a)(1)(A)-(C) (29

U.S.C. § 1104(a)(1)(A)-(C)). Allianz violated those duties for at least the reasons stated above. "Investment fund managers" like Allianz, the Investment Policy Statement continues, "have the responsibility for managing the underlying assets by making reasonable investment decisions consistent with its stated approach and reporting investment results." Allianz did not meet that responsibility, either, for at least the reasons stated above.

152. As a direct and proximate result of Allianz's breaches of fiduciary duty, the Plans suffered devastating losses, with the exact amount to be proven at trial. Allianz's breaches, including actions taken in its own self-interest, also caused it to earn substantial fees and profits.

COUNT II: BREACH OF FIDUCIARY DUTY – ERISA § 404 (AGAINST AON)

153. The Committee restates and realleges paragraphs 1-152 as though fully set forth herein.

154. The Committee brings this Count under ERISA §§ 502(a)(2), (a)(3), and 409(a) (29 U.S.C. §§ 1132(a)(2), (a)(3), and 1109(a)). The Committee has the authority to bring this Count under these provisions because it is a fiduciary under ERISA of the Plans whose assets are held in the Trust. The Committee's charter, which the Plan sponsors have adopted, further authorizes the Committee to bring this Count.

155. At all relevant times, Aon was a fiduciary within the meaning of ERISA § 3(21)(A)(ii) (29 U.S.C. § 1002(21)(A)(ii)) because it was rendering or had the authority or responsibility to render "investment advice for a fee" to the Committee with respect to Plan assets held in the Trust.

156. The individualized investment advice Aon provided the Committee was based on Aon's knowledge of the Trust's particular needs and overall investment portfolio and included, without limitation, "mak[ing] recommendations as to the advisability of investing in, purchasing,

or selling securities," with the mutual understanding that the Committee would and did rely primarily on such recommendations. 29 C.F.R. § 2510.3-21(c)(i). For example, Aon recommended in June 2011 that the Committee invest Plan assets held in the Trust in Structured Alpha, and in the ensuing years Aon regularly recommended that the Committee make and maintain additional investments in Structured Alpha. The Committed relied on Aon's advice in implementing Aon's recommendations, and Aon knew the Committee was so relying.

157. Aon provided this individualized investment advice to the Committee with respect to Plan assets held in the Trust on a regular basis and pursuant to a mutual agreement, arrangement, or understanding that the advice, which Aon rendered for a fee, would serve as a primary basis for the Committee's investment decisions. On several occasions, including in March 2011, April 2013, and June 2018, Aon provided the Committee written analysis giving Structured Alpha a "buy" rating. Aon attended the quarterly meetings of the Committee and Subcommittee and provided those bodies its recommendations to invest initially in Structured Alpha, to expand that investment into new Funds, to remain invested to the same degree the Trust had been even after the strategy underperformed its benchmarks in February and December 2018, and to classify the investments according to each Fund's underlying beta(s) for purposes of conforming with the Trust's Investment Policy Statement. Aon provided this regular investment advice pursuant to a written contract between it and the Committee, another fiduciary, which contract details many of Aon's duties related to its provision of investment advice to the Committee with respect to Plan assets held in the Trust. For example, Aon agreed to provide "recommendations to [the Committee] regarding asset allocation" within the Trust, "recommendations to [the Committee] regarding the specific asset allocation and other investment guidelines" for the Trust's investment managers such as Allianz, and advice

"regarding the diversification of assets" held in the Trust. The Committee relied on this advice in implementing Aon's recommendations, and Aon knew the Committee was so relying. In exchange for Aon's investment advice regarding the Trust specifically, the Committee agreed to pay Aon a fixed fee per quarter from Plan assets.

158. Aon also provided investment advice pursuant to an understanding that the Committee would endeavor to make major investment decisions only after receiving Aon's analysis and recommendation. The Committee's practice, recorded in its meeting minutes, reflected this understanding that Aon's advice was a primary basis for the Committee's investment decisions. So did the Trust's Investment Policy Statement, which Aon helped draft and endorsed by placing its logo on the cover page. According to that document, Aon had a duty to "advise the Committee on the management of the Trusts' assets." That duty "includes, but is not limited to, recommending appropriate strategic policy and implementation structure and conducting manager due-diligence, searches and selection." The Committee was "entitled to utilize and rely upon the advice" of Aon.

159. At all relevant times, Aon was providing or had the responsibility to provide investment advice to the Committee with respect to Plan assets held in the Trust and was therefore acting in a fiduciary capacity.

160. As a fiduciary, Aon owed a duty of care under ERISA § 404(a)(1)(B) (29 U.S.C. § 1104(a)(1)(B)). That duty required Aon to advise the Committee regarding the Plans or Plan assets held in the Trust "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." Because Aon provided investment advice to the Committee about diversification of the Trust's investments,

the duty of care also required Aon to render that advice prudently "so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so." ERISA § 404(a)(1)(C) (29 U.S.C. § 1104(a)(1)(C)).

161. As a fiduciary, Aon owed a duty of loyalty under ERISA § 404(a)(1)(A) (29 U.S.C. § 1104(a)(1)(A)). That duty required Aon to advise the Committee regarding the Plans or Plan assets held in the Trust "solely in the interest" of and for the "exclusive purpose of providing benefits" to the Plans' participants and beneficiaries. The duty also required Aon to not mislead the Committee about Structured Alpha or Allianz's management of the strategy and to disclose material facts whose omission would create a false impression about the strategy or Allianz's management of it.

162. And as a fiduciary, Aon owed a duty to follow Plan documents under ERISA § 404(a)(1)(D) (29 U.S.C. § 1104(a)(1)(D)). That duty required Aon to advise the Committee regarding the Plans or Plan assets held in the Trust "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with" ERISA.

163. The fiduciary duties under ERISA are "the highest known to the law." *Donovan*, 680 F.2d at 272 n.8.

164. Aon breached its fiduciary duties. Aon's breaches include, without limitation, the following:

(a) Aon breached its duties to prudently advise the Committee regarding the Trust's investment in the Structured Alpha Funds or advise the Committee according to the best interests of the Plans' participants and beneficiaries when it misinformed the Committee of the actual level of risk Structured Alpha presented to the Plan assets held in the Trust. Aon routinely

gave the Committee the false impression that the strategy was relatively low risk and indeed, a risk management strategy, despite red flags that should have alerted Aon that Structured Alpha was anything but. Aon likewise misstated Structured Alpha's risk by repeatedly advising the Committee that only a small amount of the Trust's investment with Allianz was exposed to the options strategy and therefore at risk in case the strategy failed.

(b) Aon breached its duties to prudently advise the Committee regarding the Trust's investment in the Structured Alpha Funds or advise the Committee according to the best interests of the Plans' participants and beneficiaries when it repeated Allianz's assertions about the operation of the Structured Alpha strategy and how it would perform in various market declines, including in a worst-case scenario, without adequately investigating whether those assertions were accurate and complete or presenting independent stress testing of its own.

(c) Aon breached its duties to prudently advise the Committee regarding the Trust or advise the Committee according to the best interests of the Plans' participants and beneficiaries when it did not appropriately monitor the options positions Allianz had been constructing. If Aon had engaged in "active, ongoing monitoring" of Allianz, as Aon's fiduciary obligations and its contract with the Committee required—and as was essential given the incentives created by Allianz's fee structure—it would have noticed that Allianz had departed from the professed investment strategy and advised the Committee accordingly. The warning signs Aon should have found include, for example, that Allianz was purchasing puts too far out of the money, that Allianz was creating a duration mismatch by buying puts that expired before the ones it sold, and that Allianz was shorting the VIX without corresponding hedges. Each of these red flags, which Aon should have seen, contributed to the catastrophic losses the Plans suffered in February and March 2020. Aon was either not examining the proper data that would

have revealed the warning signs or Aon saw the right data but chose not to advise the Committee of these red flags. Aon violated its duties regardless.

(d) Aon breached its duty to prudently advise the Committee regarding the diversification of the Plan investments when it encouraged the Committee to invest and maintain a majority of the Trust in Structured Alpha—a much higher percentage than Aon's other clients had invested in the strategy. Although Aon undertook to provide investment advice regarding the diversification and allocation of Plan assets held in the Trust, it failed to prudently discharge that duty. Most notably, in response to questions the Committee had asked about whether having a majority of the Trust invested with Allianz was an undue concentration, Aon indicated that the Trust was properly diversified because the Trust's investment in Structured Alpha consisted of multiple beta components, while disregarding (and failing to inform the Committee of) the diversification risk associated with the same or substantially the same alpha strategy overlaying the Trust's entire investment in the Structured Alpha Funds.

(e) Aon breached its duty to prudently advise the Committee in accordance with the Plan documents when it acted contrary to the Trust's Investment Policy Statement, which reflects the character and aims of the Trust. Aon's duties under the Investment Policy Statement include "recommending appropriate strategic policy and implementation structure and conducting manager due-diligence, searches and selection" and ensuring the Committee was "adhering to the guidelines of the Investment Policy Statement and making recommendations regarding changes should they need to be made." Aon failed to meet these obligations for at least the reasons stated above.

165. As a direct and proximate result of Aon's breaches of fiduciary duty, the Plans suffered devastating losses, with the exact amount to be proven at trial. Aon earned substantial fees and profits in connection with the imprudent investment advice it provided.

COUNT III: BREACH OF CO-FIDUCIARY DUTY – ERISA § 405 (AGAINST ALLIANZ)

166. The Committee restates and realleges paragraphs 1-165 as though fully set forth herein.

167. The Committee brings this Count under ERISA §§ 502(a)(2), (a)(3), and 409(a) (29 U.S.C. §§ 1132(a)(2), (a)(3), and 1109(a)). The Committee has the authority to bring this Count under these provisions because it is a fiduciary under ERISA of the Plans whose assets are held in the Trust. The Committee's charter, which the Plan sponsors have adopted, further authorizes the Committee to bring this Count.

168. In addition to any liability a fiduciary may otherwise have under ERISA, a fiduciary "shall be liable" under ERISA § 405(a) (29 U.S.C. § 1105(a)) "for a breach of fiduciary responsibility of another fiduciary" in certain circumstances. Those circumstances include where a fiduciary, by failing to comply with ERISA § 404(a)(1) (29 U.S.C. § 1104(a)(1)), "has enabled such other fiduciary to commit a breach."

169. Allianz is liable under ERISA § 405(a) (29 U.S.C. § 1105(a)), including because through its own breaches of fiduciary duty under ERISA § 404(a)(1) (29 U.S.C. § 1104(a)(1)), Allianz enabled Aon to commit breaches. For example, Allianz's presentations included incomplete and inaccurate information regarding the Structured Alpha strategy that enabled Aon's breaches in providing imprudent investment advice to the Committee regarding the strategy.

170. As a direct and proximate result of Allianz's breaches as a co-fiduciary, the Plans suffered devastating losses, with the exact amount to be proven at trial. Allianz's co-fiduciary breaches also caused it to earn substantial fees and profits.

COUNT IV: BREACH OF CO-FIDUCIARY DUTY – ERISA § 405 (AGAINST AON)

171. The Committee restates and realleges paragraphs 1-170 as though fully set forth herein.

172. The Committee brings this Count under ERISA §§ 502(a)(2), (a)(3), and 409(a) (29 U.S.C. §§ 1132(a)(2), (a)(3), and 1109(a)). The Committee has the authority to bring this Count under these provisions because it is a fiduciary under ERISA of the Plans whose assets are held in the Trust. The Committee's charter, which the Plan sponsors have adopted, further authorizes the Committee to bring this Count.

173. In addition to any liability a fiduciary may otherwise have under ERISA, a fiduciary "shall be liable" under ERISA § 405(a) (29 U.S.C. § 1105(a)) "for a breach of fiduciary responsibility of another fiduciary" in certain circumstances. Those circumstances include where a fiduciary, by failing to comply with ERISA § 404(a)(1) (29 U.S.C. § 1104(a)(1)), "has enabled such other fiduciary to commit a breach."

174. Aon is liable under ERISA § 405(a) (29 U.S.C. § 1105(a)), including because through its own breaches of fiduciary duty under ERISA § 404(a)(1) (29 U.S.C. § 1104(a)(1)), Aon enabled Allianz to commit breaches. For instance, Aon's failure to monitor the Structured Alpha portfolio construction enabled Allianz to continue making imprudent decisions that exposed the Trust's investment to excess and undisclosed risk. If Aon had been properly monitoring Structured Alpha, as Aon said it would, it would have seen several red flags indicating that Allianz was managing a riskier strategy than what had been disclosed to the

Committee. Aon would have found that Allianz was purchasing ineffective puts that were too deep out of the money, that Allianz was buying puts that expired sooner than those it sold, and that Allianz was leaving its VIX options unhedged. As a consequence of Aon's imprudent failure to monitor, Allianz was able to breach (and continue breaching) its own obligations by managing the strategy to add excess and undisclosed risk to the Trust's portfolio in violation of its fiduciary duties. Each of the imprudent actions Aon failed to discover contributed to the catastrophic losses the Plans suffered in February and March 2020.

175. As a direct and proximate result of Aon's breaches as a co-fiduciary, the Plans suffered devastating losses, with the exact amount to be proven at trial. Aon earned substantial fees and profits in connection with the imprudent investment advice it provided.

COUNT V: PROHIBITED TRANSACTION – ERISA § 406
(AGAINST ALLIANZ)

176. The Committee restates and realleges paragraphs 1-175 as though fully set forth herein.

177. The Committee brings this Count under ERISA §§ 502(a)(2), (a)(3), and 409(a) (29 U.S.C. §§ 1132(a)(2), (a)(3), and 1109(a)). The Committee has the authority to bring this Count under these provisions because it is a fiduciary under ERISA of the Plans whose assets are held in the Trust. The Committee's charter, which the Plan sponsors have adopted, further authorizes the Committee to bring this Count.

178. A fiduciary may not engage in certain prohibited transactions under ERISA § 406(b) (29 U.S.C. § 1106(b)). For instance, a fiduciary "shall not deal with the assets of the plan in his own interest or for his own account."

179. Allianz violated ERISA § 406(b) (29 U.S.C. § 1106(b)), including by managing the Plan assets in its own self-interest and not for the exclusive purpose of providing benefits to

the Plans' participants and beneficiaries. Allianz managed the Structured Alpha Funds to maximize its own fees—adding excess and undisclosed risk to the portfolio in the process—rather than for the sole interest of safeguarding the Trust's investment. Allianz did so at least by constructing the portfolio to be largely unhedged in the January and February 2020 timeframe and then, when the market declined in February and March 2020, adding more risk to the portfolio to chase return (and thus fees) rather than safeguarding the Trust's investment.

180. As a direct and proximate result of Allianz's violations of ERISA § 406(b) (29 U.S.C. § 1106(b)), the Plans suffered devastating losses, with the exact amount to be proven at trial. Allianz's violations also caused it to earn substantial fees and profits.

COUNT VI: BREACH OF CONTRACT
(AGAINST ALLIANZ)

181. The Committee restates and realleges paragraphs 1-180 as though fully set forth herein.

182. In connection with the Trust's investment in the Structured Alpha Funds, the Committee and Allianz entered an Amended and Restated Investment Management Side Agreement (the "Investment Management Agreement"). The Trust is a third-party beneficiary of the Investment Management Agreement, including because certain obligations Allianz owes under this agreement are owed "to the Trust."

183. The Trust's investment in the Structured Alpha Funds was also governed by the Fund Documents—*i.e.*, the Limited Liability Company Agreement, Private Placement Memorandum, and Subscription Agreement by which Trust assets were invested in each Fund (together with the Investment Management Agreement, the "Allianz Agreements").

184. The Allianz Agreements are valid and enforceable contracts.

185. The Committee and the Trust have performed their obligations under the Allianz Agreements.

186. Allianz breached its obligations under the Allianz Agreements.

187. Allianz promised in the Investment Management Agreement that it would manage the Trust's investments "in good faith" and with "the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." Allianz agreed it would uphold this "Contractual Fiduciary Standard of Care" regardless of whether the underlying assets it was managing were "plan assets" within the meaning of ERISA.

188. In certain of the Funds' Limited Liability Company Agreements and Private Placement Memoranda, Allianz likewise undertook to comply with the standard of care imposed on ERISA fiduciaries, regardless of whether the underlying assets of the Funds were "plan assets" within the meaning of ERISA.

189. Allianz breached its contractual duty to manage the Funds in a professional manner and with the care, skill, prudence, and diligence of a professional investment manager responsible for the investment of employee benefit plan assets.

190. Allianz's breaches include, without limitation, the following:

(a) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it did not put the appropriate hedges in place to protect the assets during a market decline. This failure added excess and undisclosed risk and was contrary to the representations Allianz had made to the Committee and others that the hedges would be in place "at all times" as "reinsurance" for the Trust's portfolio.

(b) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it sold the new-configuration hedges and took on new risk-bearing positions starting in late-February 2020. These discretionary restructurings exposed the Trust's investments to further downside risk and were contrary to Allianz's representations, including that it would not sell the new-configuration hedges that should have been locked in to safeguard the Plan assets.

(c) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it represented that it had constructed the portfolio in a way that would ensure a defined "Max Loss" and then managed the strategy in a way that exposed the Trust to unlimited losses.

(d) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it either failed to have adequate risk management measures in place or abandoned such measures.

(e) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it represented that it would manage the Structured Alpha strategy in such a way to eliminate the risk of margin calls yet implemented a strategy in which that very risk materialized.

(f) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it, unbeknownst to the Committee, decided to purchase puts that were further out of the money than the maximum range Allianz had disclosed, thus adding excess and undisclosed risk to the Trust's portfolio, in an apparent effort to increase Allianz's fees.

(g) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it, unbeknownst to the Committee, decided to purchase puts that expired sooner than the puts it sold. This practice was contrary to Allianz's representations that its short and long positions would be of relatively equal duration and added excess and undisclosed risk to the Trust's portfolio. Allianz created this "duration mismatch" not because it was in the best interests of the Plans' participants and beneficiaries, but because doing so allowed Allianz to enhance its fees.

(h) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it, unbeknownst to the Committee, decided to sell volatility index options without buying any corresponding hedge, adding excess and undisclosed risk to the Trust's portfolio, again in an apparent effort to enhance its fees.

(i) Allianz breached its duties to prudently manage the Plan assets or manage them according to the best interests of the Plans' participants and beneficiaries when it caused the Committee to believe that Structured Alpha's risk profile was consistent with Allianz's stated investment strategy rather than the actual risk profile, either by making false or misleading representations about Structured Alpha or failing to disclose information necessary to correct prior representations that were inconsistent with how Allianz was actually managing the strategy.

(j) Allianz breached its duty to ensure the Trust's investments were prudently diversified when it operated a strategy that was unduly weighted towards being short volatility in February and March 2020 (contrary to its pledge not to make directional bets) and created excess and undisclosed correlated risks across the Structured Alpha Funds.

191. Allianz also agreed to abide by the Investment Policy attached to the Investment Management Agreement that governed the Trust's investment in Structured Alpha and to manage the Funds according to the Fund Documents, under which Allianz agreed to have "structural risk protections" in place as a component of the Structured Alpha strategy.

192. Allianz breached its obligation to have such structural risk protections in place, including because it failed to purchase and maintain hedges that would afford such protection to the portfolio.

193. Allianz agreed to provide advance notice of any material adverse amendment to the Funds' Limited Liability Company Agreements, which Allianz recognized required advance notice to the Trust of changes to the Funds' investment strategy.

194. Allianz breached its duty to provide advance notice of changes to the Funds' investment strategy (and to obtain the Trust's consent to the same) when it altered the Funds' investment strategies to add excess and undisclosed risk without advance notice to the Committee or the Trust.

195. The Allianz Agreements recognize that Allianz may be liable to the Trust for losses resulting from the Funds' investments where Allianz acted in bad faith or where its action or inaction constitutes negligence or willful misconduct. Allianz's conduct was at least negligent.

196. The Investment Management Agreement provides further that Allianz "shall indemnify and hold harmless the Trust from and against any and all claims, losses, costs, expenses (including, without limitation, attorneys' fees and court costs), damages, actions or causes of action directly resulting from a breach" by Allianz of its "fiduciary duties" delegated to it under this agreement.

197. As a direct and proximate result of Allianz's breaches of the Allianz Agreements, the Trust sustained actual damages, with the exact amount to be proven at trial.

COUNT VII: BREACH OF CONTRACT
(AGAINST AON)

198. The Committee restates and realleges paragraphs 1-197 as though fully set forth herein.

199. The Committee and Aon entered an Investment Consulting Agreement, under which the Committee appointed Ennis, Knupp & Associates, Inc. (now known as Aon Investments USA Inc.) as an investment adviser with respect to the Plan assets held in the Trust (the "Aon Agreement").

200. The Aon Agreement is a valid and enforceable contract.

201. The Trust is a third-party beneficiary of the Aon Agreement, including because the Aon Agreement provides that "this Agreement and each and every provision thereof is for the exclusive benefit of" the Committee and "the Trusts," among others.

202. The Committee has performed its obligations under the Aon Agreement.

203. Under the Aon Agreement, Aon promised to provide various investment consulting and advisory services to the Committee regarding the Trust.

204. Aon agreed to "adher[e]" to and to "provide its advice to [the Committee] pursuant to" various professional standards, including those contained in *Prudent Investment Practices: A Handbook for Investment Fiduciaries* and *Prudent Practices for Investment Advisors*.

205. Aon also agreed to exercise the "skill," "proficiency," and "experience" it claimed to have as a professional investment adviser in performing its duties under the contract.

206. Aon breached its obligation to perform its duties under the contract in a professional manner and according to professional standards applicable to an investment adviser providing investment advice concerning employee benefit plan assets.

207. For instance, the Aon Agreement obligates Aon to engage in "active, ongoing monitoring" of Allianz to "assess evolving strengths, weaknesses and issues" and "identify any forward-looking issues that could impact performance." Aon breached that obligation by, among other things, (i) failing to monitor and inform the Committee of the nature (and inadequacy) of the Structured Alpha hedging strategy, (ii) failing to monitor and inform the Committee of breakdowns in Allianz's risk management protocols, learning only after the catastrophic events of March 2020 that Allianz had inadequate risk management protocols in place; and (iii) failing to monitor and inform the Committee of the level of unhedged risk that Allianz was undertaking to drive returns.

208. Likewise, the Aon Agreement obligated Aon to apply the proficiency and skill it claimed to have as an experienced investment adviser in its monitoring of Allianz. Aon breached that obligation by, among other things, (i) failing to apply its own purported skill, proficiency, or experience in its monitoring of Structured Alpha and instead passing off Allianz marketing materials as the result of its own analysis and evaluation, despite the fact that the Allianz marketing materials recycled by Aon often did not describe the particular Structured Alpha Funds in which the Trust had invested; (ii) providing incomplete and inaccurate characterizations of the risks presented by Structured Alpha; and (iii) failing to discover the breakdowns in Allianz's risk management protocols that it would have uncovered had it exercised the care, skill, or proficiency of an experienced professional investment adviser.

209. The Aon Agreement also required Aon to "inform itself" of any information necessary to discharge its duties, including its obligation to engage in ongoing monitoring and evaluation of Allianz. Aon breached that obligation by, among other things, either not obtaining or disregarding details of the actual hedging positions that Allianz was purchasing as supposed "reinsurance." Had Aon informed itself of the actual hedges Allianz was purchasing—and thus learned of the complete absence of hedges for much of the Trust's portfolio and plainly ineffective hedges for the rest—it never could have described Structured Alpha as including a "reinsurance" component or recommended that the Trust maintain its investment in the strategy.

210. The Aon Agreement also required Aon to evaluate the Trust's Investment Policy Statement and to make at least annual recommendations concerning the appropriate investment policy for the Trust. Among the factors Aon was to consider in making such recommendations was "the risk tolerance" of the Trust and the Committee. Aon breached that obligation by, among other things, not recommending appropriate revisions to the Investment Policy Statement to ensure that the Trust's investment in Structured Alpha was appropriate for the risk tolerance of the Trust and the Committee, as expressed in the Investment Policy Statement.

211. Likewise, Aon promised to advise the Committee regarding asset allocation and diversification of the Plan investments such that the "planned asset allocation" could be "expected." Aon breached that duty by, among other things, improperly advising the Committee about the effect of Structured Alpha on the Trust's planned asset allocation and diversification. For instance, while Aon advised the Committee that Structured Alpha could be classified in the Trust's overall asset allocation according to the underlying beta component, that advice departed from the "planned asset allocation" and led the Trust to take on more risk than expected or desired.

212. As a direct and proximate result of Aon's breaches of the Aon Agreement, the Trust sustained actual damages, with the exact amount to be proven at trial.

PRAYER FOR RELIEF

The Committee requests that the Court enter judgment in its favor against all Defendants, jointly and severally, and an Order granting the following relief:

A. Restoration of all losses, in an amount to be proven at trial, resulting from the foregoing breaches and violations of ERISA, together with prejudgment interest running from the dates such losses occurred;

B. Accounting and disgorgement of fees and profits, in an amount to be proven at trial, together with prejudgment interest running from the dates such fees and profits were received;

C. Actual damages, in an amount to be proven at trial, resulting from the foregoing contractual breaches, together with prejudgment interest running from the dates such damages occurred;

D. Attorney's fees and costs under ERISA § 502(g) (29 U.S.C. § 1132(g)); and

E. Any such other legal and equitable relief as this Court may deem just and proper.

JURY DEMAND

The Committee demands a jury trial on all issues so triable. *See* Fed. R. Civ. P. 38(b).

Dated: September 16, 2020

Respectfully Submitted,

By: /s/ *Daniel Z. Goldman*

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Attorneys for Plaintiff Blue Cross and Blue Shield Association National Employee Benefits Committee

Attachment E

An Update on Federal Issues Related to Vermont Health Insurance

A presentation to the Green Mountain Care Board by:

Ena Backus, Director of Health Care Reform, Agency of Human Services
Emily Brown, Director of Rates and Forms, Department of Financial Regulation
Adaline Strumolo, Deputy Commissioner, Department of Vermont Health Access (DVHA)
Dana Houlihan, Plan Management Director, DVHA
Sean Sheehan, Policy and Implementation Analyst, DVHA

June 2, 2021

Agenda - Overview

I. Vermont Essential Health Benefits Benchmark Plan

II. Qualified Health Plan Benefit and Subsidy Changes

Agenda – Part I

I. Vermont Essential Health Benefits Benchmark Plan

A. Introduction/Context	Ena Backus, AHS
B. EHB Benchmark Plan Change Process	Emily Brown, DFR
C. VT Market Analysis, Federal Grant	Emily Brown, DFR
D. Benchmark Plan Change Timeline	Emily Brown, DFR

EHB Benchmark Plan Change Process Overview

Essential health benefits are defined through a state-selected, federally-approved benchmark plan.

The federal government allows States three options to update their benchmark plans :

- Select a benchmark plan used by another state during the 2017 plan year;
- Replace one or more categories of essential health benefits (EHBs) with the same category or categories of EHB used in another state's benchmark plan for the 2017 plan year; or
- Otherwise select a set of benefits to constitute the State's benchmark plan.

The Green Mountain Care Board (GMCB) has jurisdiction to review and approve, with recommendations from the Department of Vermont Health Access (DVHA), the benefit packages for qualified health plans. DFR has regulatory responsibility for the provision of the benefit packages. AHS Office of Health Reform coordinates the state agencies.

EHB Benchmark Plan Change Process Overview

Initiation of Benchmark Plan Review

- The process takes several years and requires significant planning and support, including actuarial services.

- A change to the EHB benchmark plan could be prompted through: (1) periodic review of the plan, (2) a legislative mandate to reevaluate EHB, or (3) state initiative to address an emerging health care reform priority.

Selection of EHB Benchmark Plan

- Proposals to change or to select a new EHB benchmark plan must be submitted to CMS for approval in spring of the second year prior to implementation of the new plan; for example, submitted in May 2022 for implementation January 1, 2024.

EHB Benchmark Plan Change Process Timeline

Timeframe	Process Step Description	Process Owner
Year 1	Market study/Analyze desired change to EHBbenchmark plan (e.g. adding a covered service)	AHS
Year 1	Secure budget funding for actuarial analysis and proposal submission to CMS	AHS
Fall Year 2	Conduct stakeholder meetings	AHS
Fall Year 2	Initiate actuarial analysis	AHS in consultation with DFR
Winter Year 2-3	Prepare EHB benchmark plan proposal	AHS/DVHA
March Year 3	Presentation of proposed EHB benchmarkplan change to GMCB	AHS/DVHA
March Year 3	Public comment period	GMCB
March - April Year 3	Revisions to proposal (if needed)	AHS
March – April	GMCB approval of Proposal	GMCB

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EHB Benchmark Plan Change Process Timeline

Timeframe	Process Step Description	Process Owner
April Year 3	Finalize proposal and all required reporting	AHS (supported by actuary)
April - May Year 3	Submission to CMS	AHS
~Fall Year 3	Approval from CMS	CMS
Fall - Winter Year 3-4	Internal/external communication	DVHA & Plan Design Stakeholder Group
Winter Year 4	Incorporate new EHB benchmark plan changes into plan designs	Issuers/DFR/DVHA
February Year 4	Present plan designs to GMCB for approval (incorporating new EHB benchmark plan components)	DVHA
January 1 Year 5	Revised EHB benchmark plan in effect	

VT Analysis and Federal Funding Opportunities

- State Flexibility to Stabilize the Market Cycle II Grant Program awarded by Centers for Medicare and Medicaid Services (CMS)
  - 24-month project and budget period from issuance
- Grant Projects Overview
  - EHB Benchmark Plan
    - Assessment of EHB Benchmark Plan
    - Research other State EHB Benchmark plans and perform analysis
    - Assess potential modifications to benefits currently included in the Benchmark Plan
  - Network Adequacy
    - Telehealth Impacts
    - Wait times and Access to Care
    - Mental Health Services
  - Enhanced Form Review
    - Prescription Drug Formularies
- Estimated Funding ~ $660,000

Agenda – Part II

II. Qualified Health Plan Benefit and Subsidy Changes

A. Introduction/Context	Adaline Strumolo, DVHA
B. Final 2022 NBPP and Benefit Changes	Dana Houlihan, DVHA
C. American Rescue Plan Act Impact	Sean Sheehan, DVHA

2022 Notice of Benefit and Payment Parameters (NBPP) Changes Impacting QHP Designs

1. The NBPP finalized a single annual limit, or maximum out-of-pocket (MOOP) of $8,700, $400 lower than the draft proposed amount of $9,100.

2. The individual minimum deductible for high-deductible health plans (HDHP) remained the same as the 2020 minimum at $1,400 (IRS Code § 223(c)(2)(A) 2).

3. The combined maximum out-of-pocket for bronze HDHPs will increase to $7,050 ($50 less than the anticipated amount) (IRS Code § 223(c)(2)(A) 2)

4. No changes to the 2022 Actuarial Value Calculator (AVC) from draft NBPP to final: 0% trend

2022 QHP Updated Summary of Plan Design Changes

	Deductible Plans	
Plan	Platinum	Gold
Changes	Increase medical deductible from $350 to $400	Increase medical deductible from $1,100 to $1,200
		Increase pharmacy deductible from $100 to $150
		Increase medical OOPM from $5,200 to $5,400
Require Approval?	NO	NO

	Deductible Plans	
Plan	Silver	Bronze w/ Rx Limit
Changes	Increase medical deductible from $3,200 to $3,400	Increase medical deductible from $6,250 to $6,450
	Increase pharmacy deductible from $350 to $400	Increase pharmacy deductible from $1,000 to $1,100
	Increase combined OOPM from $8,150 to $8,550	Increase combined OOPM from $8,400 to $8,700
Require Approval?	NO	NO

	Deductible Plans
Plan	Bronze w/o Rx Limit
Changes	Increase medical deductible from $8,400 to $8,700
	Increase combined OOPM from $8,400 to $8,700
Require Approval?	YES

	HDHPs	
Plan	Silver	Bronze
Changes	Increase medical deductible from $1,750 to $1,850	Increase medical deductible from $5,500 to $5,700
	Increase embedded single MOOP from $8,550 to ~~$9,100~~ $8,700	Increase combined MOOP from $6,900 to ~~$7,100~~ $7,050
		Increase embedded single MOOP from $8,550 to ~~$9,100~~ $8,700
Require Approval?	NO	NO

Changes from the previously approved plans to reflect the finalized NBPP and HDHP parameters are shaded in yellow.
All other changes from the 2021 plan designs shaded in orange as well as changes shaded in green received GMCB approval in January.

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Five Ways the American Rescue Plan (ARPA) Impacts Vermont Health Insurance

1) More Generous Premium Tax Credits – for 2021 and 2022

2) Tax Credit Eligibility for Vermonters with Much Higher Incomes – for 2021 and 2022

3) Opportunity for Zero-Premium Plans with Very Low Out-of-Pocket Costs for Households with 2021 Unemployment Compensation – for 2021

4) Holiday from Tax Credit Reconciliation – for 2020 only

5) Full COBRA reimbursement for six months (April 1 – Sept 30, 2021)

June System Updates

Impacts Current Exchange Members and Direct Enrollees

Key 2021 Milestones for Vermont's Health Insurance Marketplace

Special Enrollment Period for New Members

All winter, spring, and summer: Vermonters have been able to enroll in the marketplace through a COVID special enrollment period, extended until October 1 to allow:

- Vermonters without insurance to take advantage of the new American Rescue Plan Act (ARPA) subsidies
- Vermonters on COBRA to enroll in the marketplace after their temporary COBRA subsidy ends in September.

Plan Transfers from Direct-Enroll

April-Nov: Members who direct-enrolled with an issuer can transfer their plan into the marketplace.

Members will qualify for tax credits for every month enrolled in the marketplace – so it pays to act soon.

They will be able to take this tax credit as a tax refund next spring and/or as a discount on their monthly bill later this year.

Any payments already made toward the deductible and out-of-pocket limit will transfer with their plan.

Applying Subsidies for New and Current Members

June: System updates will be deployed.

Members will automatically be told of their new subsidy calculations. They will have the opportunity to apply some or all of their new tax credits as a discount on future bills.

Vermonters who hadn't wanted to enroll at previous levels of subsidies will be able to enroll and take advantage of new subsidies.

Opportunity to Change Plans Mid-year

Mid-June – Mid-Aug: All members will be given 60 days to change to a different metal level or plan design that best meets their needs and takes fullest advantage of their new subsidies.

An updated 2021 Plan Comparison Tool is online to help them with their summer decision.

2022 Open Enrollment

Nov-Dec: Most of ARPA's expanded subsidies continue into 2022.

Starting in 2022, all members will pay their monthly premium to their insurance company.

To qualify for subsidies, members still must apply and select a plan through the marketplace.

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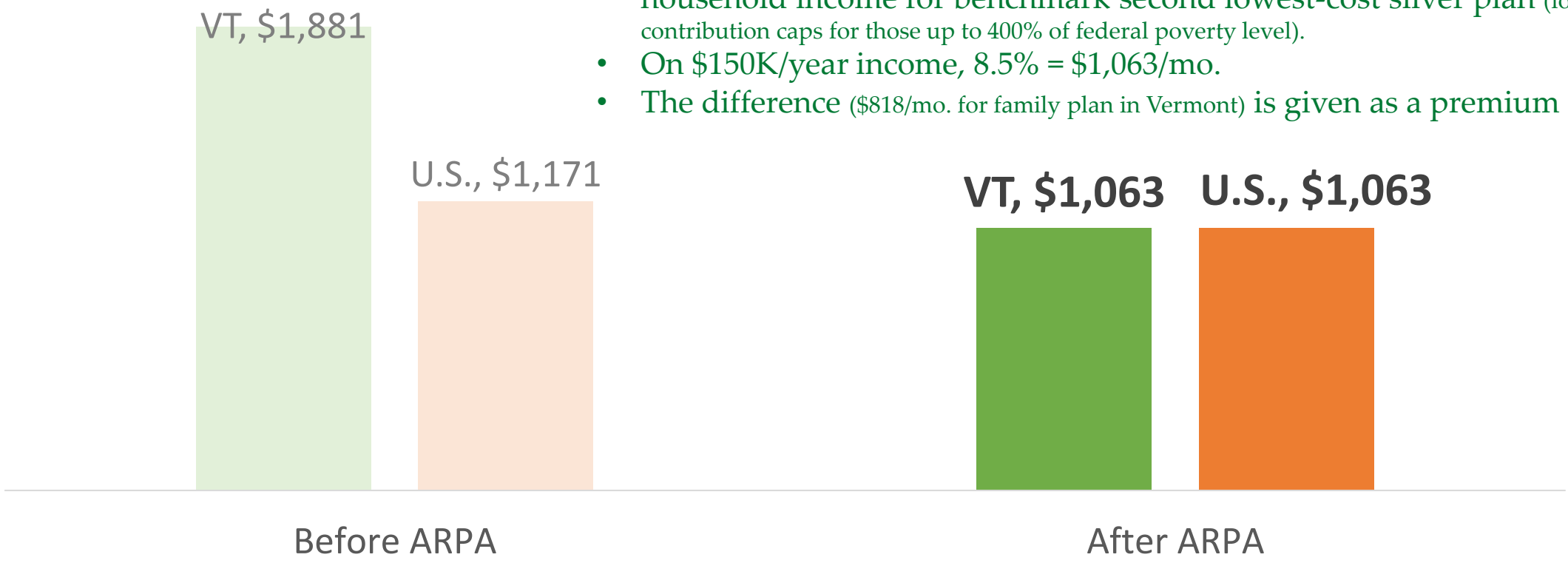
Net 2021 Silver Premium for Family of Three with $150,000 Income

- ARPA caps subsidy-eligible members' premium contributions to 8.5% of household income for benchmark second lowest-cost silver plan (lower contribution caps for those up to 400% of federal poverty level).
- On $150K/year income, 8.5% = $1,063/mo.
- The difference ($818/mo. for family plan in Vermont) is given as a premium tax credit.



National figures from KFF, assumes two 40-year-old non-smokers and one 10-year-old child

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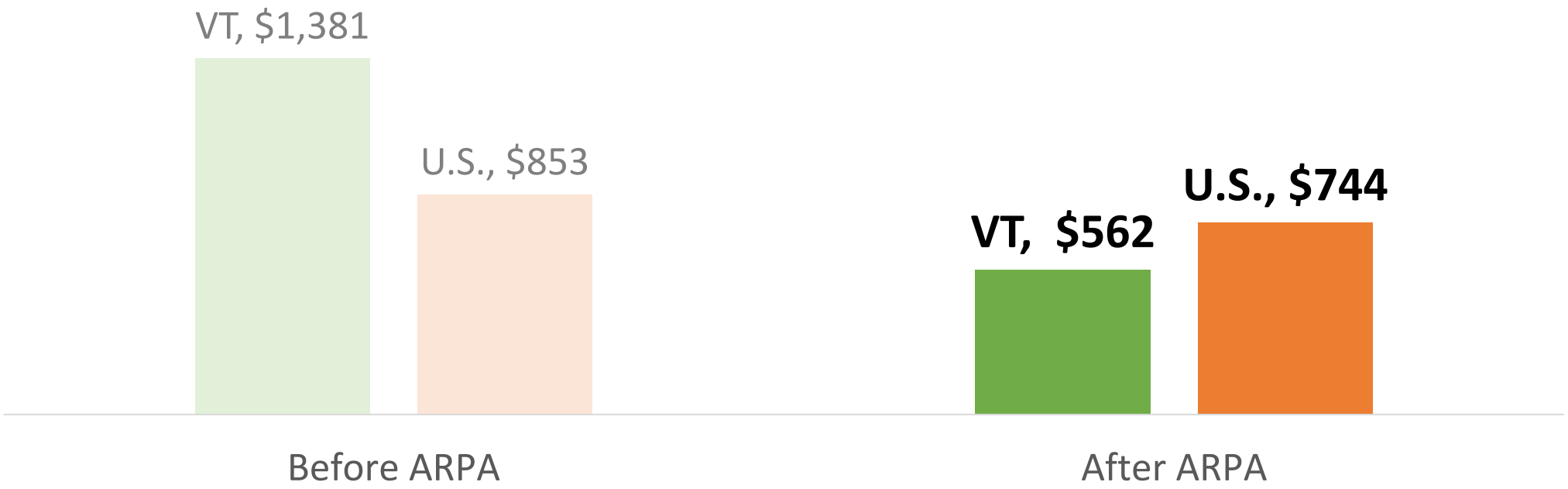
Net 2021 Bronze Premium for Family of Three with $150,000 Income

The premium tax credit ($818 for this Vermont family) can then be used on any metal level plan in the marketplace.



National figures from KFF, assumes two 40-year-old non-smokers and one 10-year-old child

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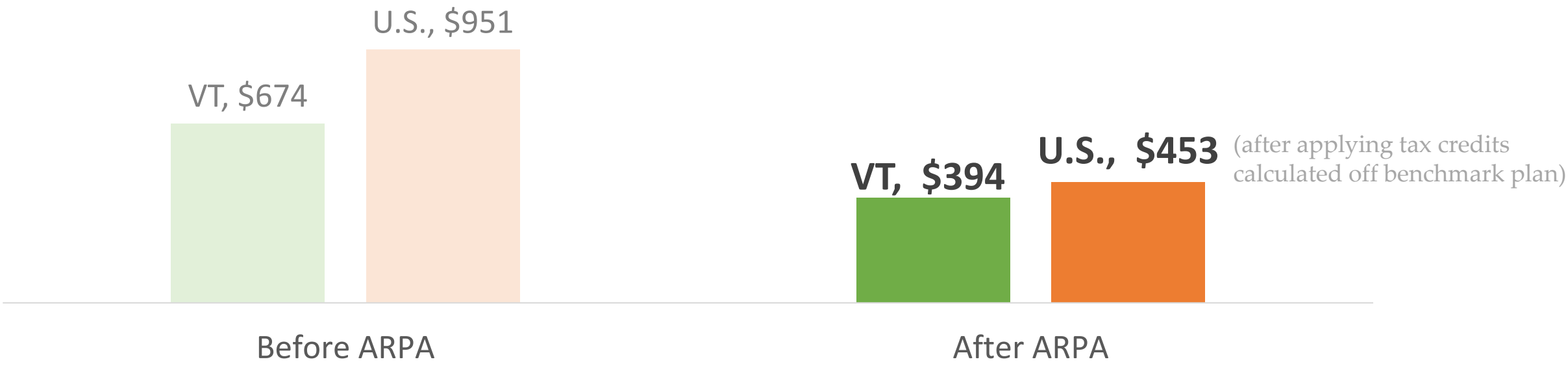
Net 2021 Gold Premium for 60-year-old individual with $55,000 Income

- In most states, age-rating means that ARPA's biggest winners are older marketplace members with incomes just over the former subsidy cliff.
- Nationally, the average 60-year-old member can buy a gold plan for less than half what it cost them before ARPA.
- Older Vermonters, who had been paying hundreds less than the U.S. average, also pay much less – but closer to the new national average.



National figures from KFF

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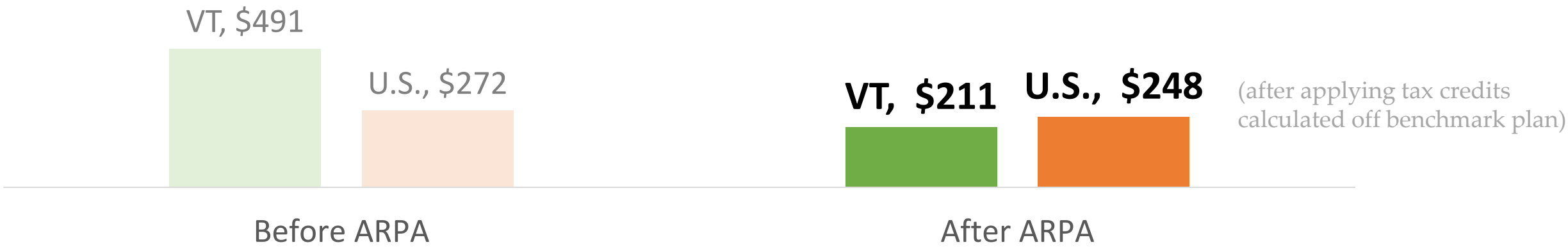
Net 2021 Bronze Premium for 27-year-old individual with $55,000 Income

- In Vermont, with no age-rating, ARPA's biggest winners are younger marketplace members with incomes just over the former subsidy cliff.
- Nationally, the average previously unsubsidized 27-year-old member barely gets any benefit; in Vermont, they can find a plan for less than half what it cost pre-ARPA – and they can now pay less than the national average!
- Of course, with no age-rating, an eligible Vermonter of any age earning $55K would have paid the unsubsidized $491 for this plan before ARPA and can now pay $211.



National figures from KFF

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Who Will Be Protected How Much in 2022

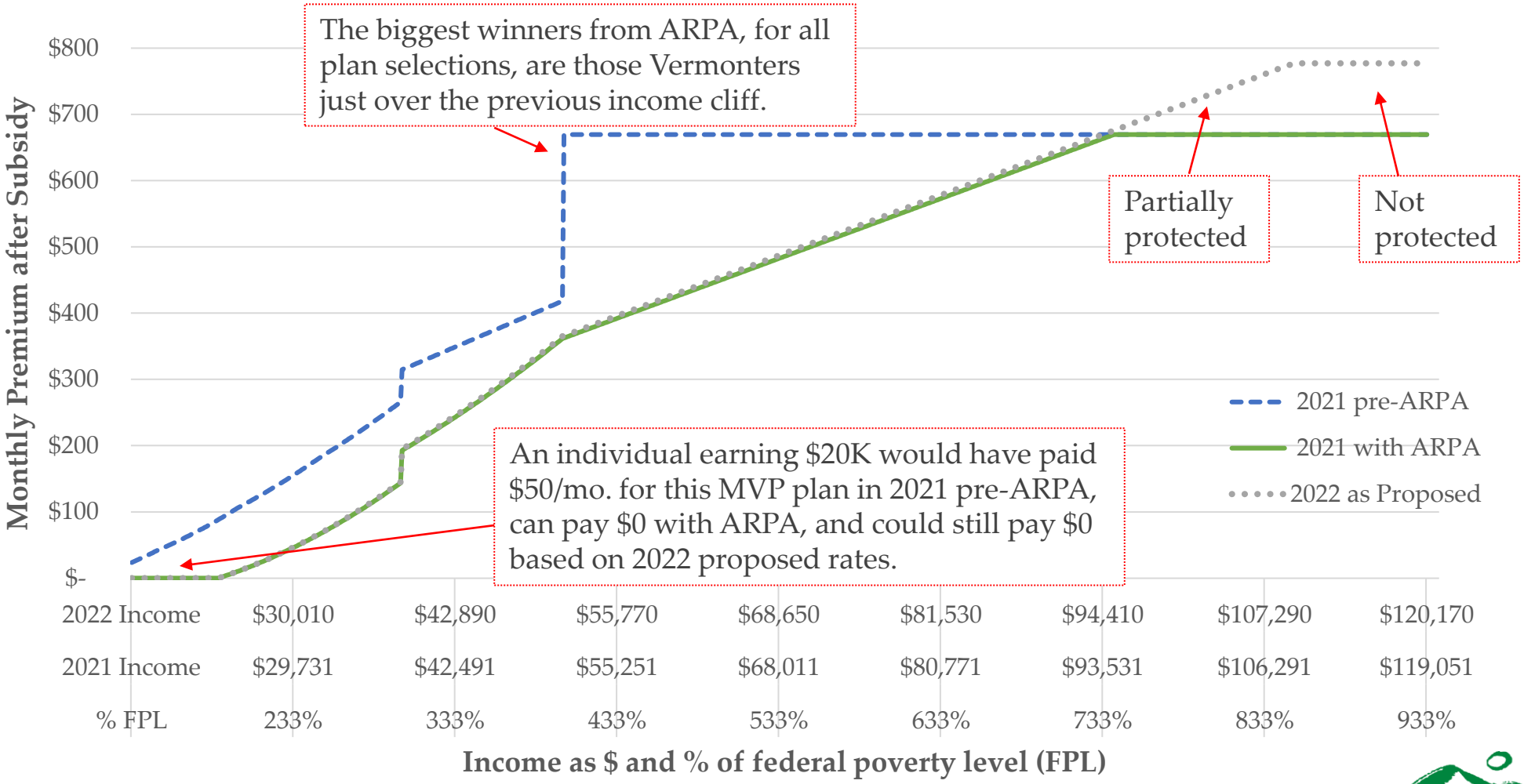
The data on the following slides are provided to show how financial help is calculated, using the hypothetical situation in which proposed rates were approved as is. DVHA provides this data for illustrative purposes only.

Because inflation was low and the required contribution levels (aka applicable percentage) are not changing in 2022, the question of which subsidized members would pay more with the same income and plan choice in 2022 is as simple as seeing how much more or less their particular plan's premium is increasing relative to the second lowest-cost silver plan (SLCSP).

Premium tax credit increase ($) = SLCSP increase ($)
If plan x increase ($) > SLCSP increase ($), then a subsidized member can expect to pay more in 2022 than 2021
If plan x increase ($) < SLCSP increase ($), then a subsidized member can expect to pay less in 2022 than 2021

MVP Silver HDHP Net Premium by Income

(1-person household, eligible for subsidies)



MVP's Standard Silver HDHP is the second lowest-cost silver plan (SLCSP) in 2021.

Under proposed rate increases, this plan's premium would go up ~$108 in 2022 but still be the SLCSP, the benchmark for calculating subsidies.

At each income level, subsidies would rise by a similar amount, leaving the subsidized member to pay about the same premium in 2022.

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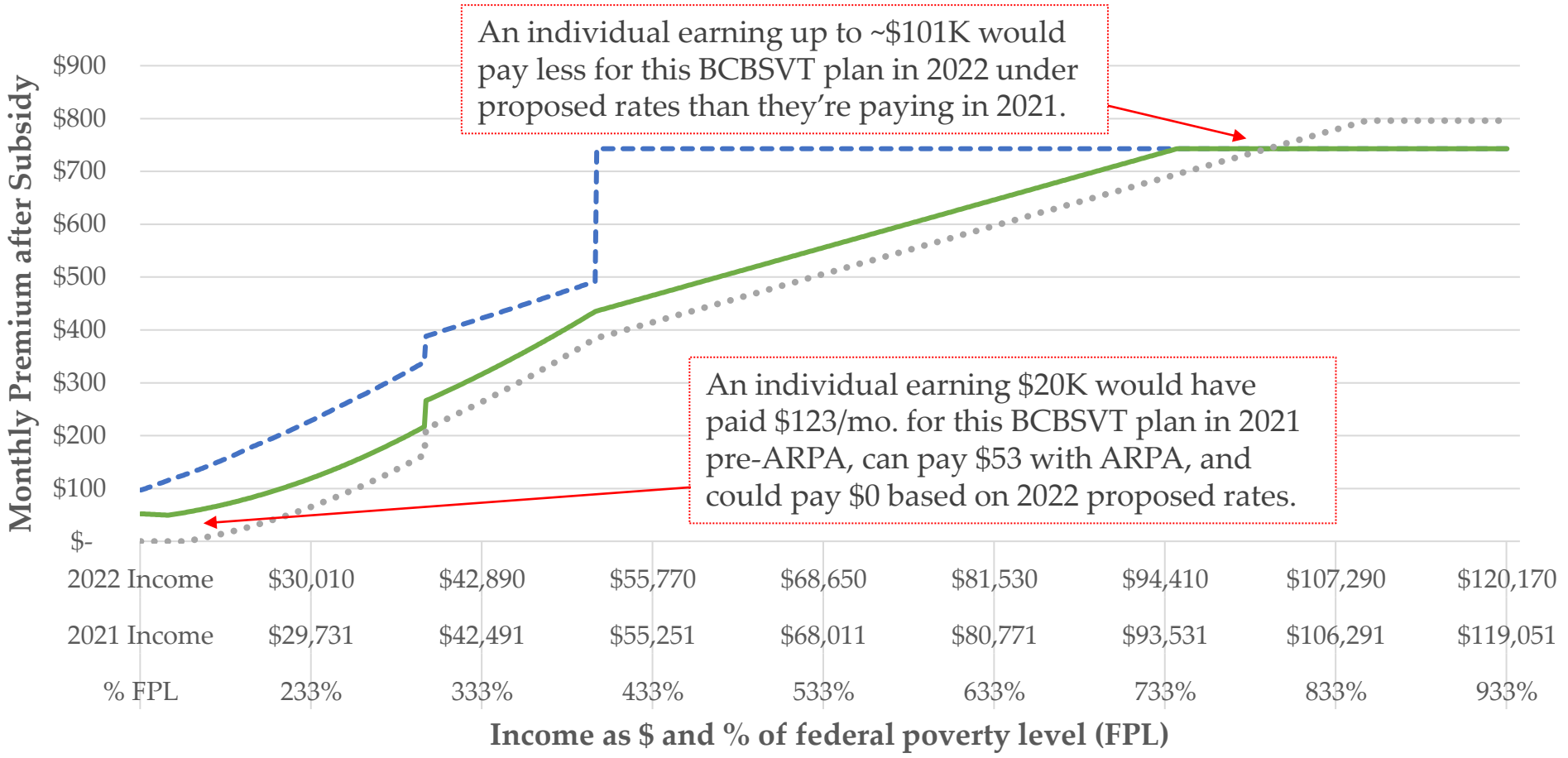
BCBSVT Standard Silver Net Premium by Income

(1-person household, eligible for subsidies)



MVP's proposed SLCSP increase = ~$108

BCBSVT's proposed standard silver increase=$53

$108 - $53 = $55

A subsidized member enrolled in BCBSVT's standard silver plan would pay ~$55 less in 2022.

For a single person with income up to ~$67K, that would be a double-digit % decrease.

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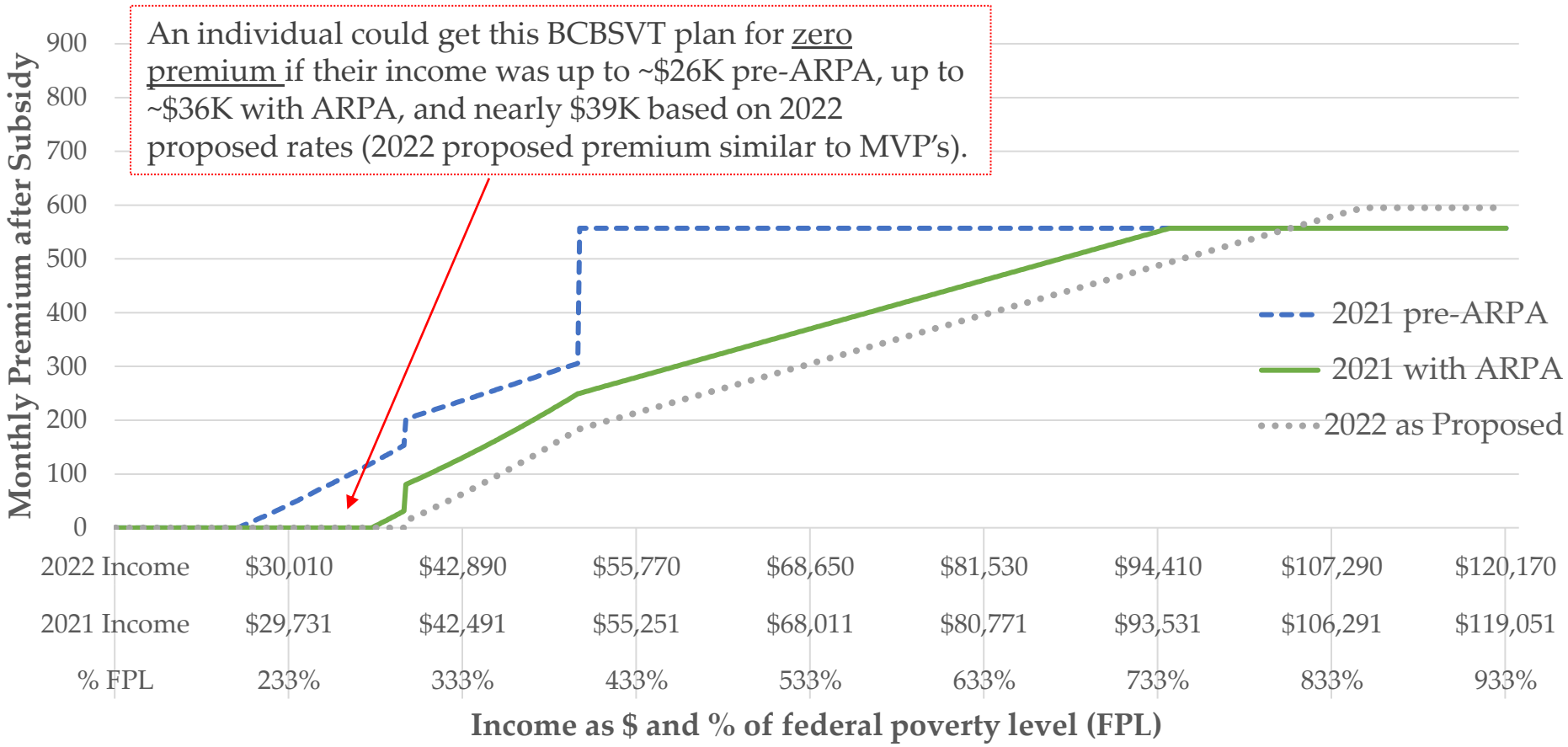
BCBSVT Lowest-cost Bronze Net Premium
(1-person household, eligible for subsidies)



MVP's proposed SLCSP increase = ~$108

BCBSVT's proposed lowest-cost bronze would cost $38 more than their 2021 lowest-cost bronze.

$108 - $38 = $70

A subsidized member who selects BCBSVT's lowest-bronze would pay ~$70 less in 2022 (a double-digit % decrease for all currently subsidized members).

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Summary:
Who Will Be Protected How Much in 2022

If rate increases were adopted as proposed…

Members who qualify for premium tax credits in 2021 would:

- Pay less in 20 plans (all 13 BCBSVT plans, all five MVP bronze plans, and two MVP silver plans)
- Pay the same in one plan (the second lowest-cost silver plan)
- Pay more in five plans (one silver, three gold, and the platinum from MVP)
  - MVP platinum members would pay $46 more (for single plan)
  - MVP gold members would pay $1-$16 more (for single plan, depending on which gold plan)

Some higher-income members who were unsubsidized in 2022 would hit the 8.5% cap and receive tax credits, thus mitigating some of the increase. At proposed rates, this would include:

- Members in individual plans with income ~$94K-~$110K.
- Members in couple plans with income ~$189K-~$219K.
- Members in family plans with income ~$265K-~$308K.

Unsubsidized members would bear the full cost.

Important Note: Who Will Not Be Protected from 2022 Premium Increases

1) Members with high incomes

- Members in single plans with household income <$94,500 and those in family plans <$265,000 will be fully protected as they are already capped at 8.5% of income for benchmark plan (second lowest-cost silver).
- Based on proposed premium increases, members in single plans earning $94,500-~$109,700 and those in family plans earning $265,500-~$308,200 would be partially protected, as the unsubsidized benchmark plan would cost more than 8.5% of their income and they would receive tax credits.

2) Members who do not qualify for premium tax credits

- Fortunately, one of the most common reasons – failure to reconcile the previous year's premium tax credits – will be mitigated by the fact that the American Rescue Plan Act granted a reprieve from tax credit repayment for tax year 2020.
- Another reason is having another offer of affordable minimum essential coverage, including members impacted by the "family glitch" – unless the federal government fixes the glitch before 2022.

3) Direct-enrollees who do not transfer to the marketplace

- Insurance issuers have noticed all members, supported by DVHA, and will continue to conduct outreach this summer and fall.
- Members are able to transfer their plan at anytime. Payments made toward deductible transfer as long as member stays with same issuer.

CERTIFICATE OF SERVICE

I certify that I have served the above Prefiled Testimony of Ruth Greene on Michael Barber, Laura Beliveau, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Jay Angoff, Kaili Kuiper and Eric Schultheis, counsel for the HCA, by electronic mail, on July 6, 2021.

/s/ Bridget Asay
Bridget Asay

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Montpelier, VT 05602
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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield Vermont 2022 Vermont ACA Market – Individual Market Rate Filing	))))	GMCB-005-21rr SERFF No. BCVT-132829271
In re: Blue Cross Blue Shield Vermont 2022 Vermont ACA Market – Small Group Market Rate Filing	)))	GMCB-006-21rr SERFF No. BCVT-132829562

PREFILED TESTIMONY OF DR. KATE MCINTOSH

Dated: July 6, 2021

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 and Utilization Management at Blue Cross and Blue Shield of Vermont (Blue Cross).

Please describe your primary job responsibilities.

I have a range of responsibilities in my roles as Senior Medical Director and Director of Quality and Utilization Management. My primary responsibilities include management and oversight of the following: medical policy; utilization management; quality of care issues; Blue Cross member safety; National Committee for Quality Assurance (NCQA) accreditation; HEDIS

measures; access and satisfaction surveys; credentialing of providers and Blue Cross network quality; physician advisory groups; Blue Cross's quality relationship with OneCare, and Blue Cross's COVID 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 A?

Yes.

As part of your employment responsibilities at Blue Cross, 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 vaccine uptake, new infections, hospitalizations, and deaths from COVID-19?

Yes, I regularly review current news and public health information about vaccine uptake, 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 vaccines?

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

Are you familiar with work that BCBSVT's chief actuary, Paul Schultz, has been conducting to model deferred care, returning care, deferred care morbidity, and vaccine development related to the pandemic?

Yes.

Are you also familiar with the impact of the cyberattack on the University of Vermont Medical Center, with respect to deferred and delayed care?

Yes.

Did you assist Mr. Schultz with certain aspects of his modeling work described above?

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 36 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 assessed our prior estimations in comparison to the changes that we were seeing at present. This data is presented in the actuarial COVID-19 modeling. 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 with regard to vaccinations, COVID variants, deferred care, and innovations in care delivery.

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

Yes.

In your opinion, is Blue Cross likely to experience ongoing claims in 2022 due to COVID-19? ? Please explain.

Yes. The general medical consensus at this time is that the US will have areas of surge in COVID-19 in areas where the vaccination rate has lagged or where individuals are highly susceptible. Although Vermont has a very high vaccination rate, we still have areas where the vaccination rate is lagging, such as Essex county and Orleans county. In addition, the medical community believes that we will have a surge in all infectious diseases this winter, since we have many children under age 2 who have not been exposed to daycare settings or to other children, and since many school-aged children and adults avoided being ill last year. We are already seeing a very unusual surge in Respiratory Syncytial Virus or RSV in the south of the United States, since this is a winter virus, and it's June. As respiratory infections rise, fears regarding COVID-19, and very probably active infections of COVID-19 will also rise. We believe that we will see a surge in testing for COVID-19, as well as for other respiratory viruses. The delta variant is affecting children and younger adults as well as older adults, and we expect that our spend on COVID-19 inpatient and outpatient treatment will also rise seasonally as well in 2022.

You indicated that you worked with Mr. Schultz on modeling relating to deferred care morbidity. Please explain what "deferred care morbidity" refers to.

Deferred care morbidity refers to the degree or burden of illness that is seen as a result of not receiving preventative care or early care for symptomatic conditions. Some people who deferred preventative or other care in 2020 and 2021 because of the pandemic and/or cyberattack will experience worse health outcomes as a result and will need more expensive care in 2022. As an example, anecdotal reports in the medical community speak of patients presenting with more advanced cancers or cardiac damage because of not seeing care earlier in the course of treatment.

Are you familiar with the approach used by Mr. Shultz in the COVID-19 modeling to account for deferred care morbidity?

Yes.

In your medical judgment, is that approach reasonable? Please explain.

Yes, the approach taken in the modeling is reasonable. As described by Mr. Schultz in the COVID-19 modeling, the health impacts created by limited access to care in the spring of 2020 are unknown. However, there is strong documentation in the medical literature of the impact of catastrophic events on long-term population morbidity. The National Academies of Sciences, Engineering, and Medicine (NASEM) have created a framework for assessing mortality and morbidity after large-scale disasters. They note that the "life cycle" of a disaster includes the "Response" period, the "Recovery" period, and the "Interdisaster" period, wherein mitigation and preparation can occur. We are still largely in the "Response" period for COVID. This pandemic is not controlled and can be expected to wax and wane for some time to come.

Against that background, Mr. Schultz decided to account for deferred care morbidity in the COVID-19 modeling by employing a stochastic model using a randomly generated morbidity factor between 1.000 and 1.005. That approach is reasonable given the many possible outcomes and data, the different types of morbidities, as well as the varying timelines for those morbidities which are noted by the NASEM Committee on Best Practices for Assessing Mortality and Significant Morbidity Following Large-Scale Disasters. This committee is working to establish standard practices for analyzing disaster-related causes of morbidity and mortality, which will augment these models going forward.

Is Blue Cross likely to experience claims costs in the individual and small group markets for COVID-19 vaccines in 2022? Please explain.

Yes. There are generally two costs associated with a vaccine, the vaccine itself and the cost of the administration. The federal government will cover the cost of the vaccines themselves through 2022. Plan sponsors are responsible for the costs of administration. To incentivize the administration of the vaccine, CMS has set the provider payment rates for the COVID-19 vaccines much higher than the rate for any other vaccine. Through May 2021, most vaccinations have been given in large health department or hospital-sponsored clinics. As a result, we have had variable billing of administration costs due to inconsistent billing. However, going forward, we expect that the vaccine administration will become more standardized and disseminated throughout the health care delivery system, and we expect a significant increase in routine billing of administration codes as a result. We have also included the costs of the administration of a booster in the modeling occurring a year after the initial round. Also, based on the recent studies of the Astra Zeneca Adenoviral vaccine combined with the Pfizer mRNA vaccine, there is a possibility that those individuals who have received the Johnson & Johnson vaccine will need to receive at least one additional dose of an mRNA vaccine due to the delta and other circulating variants.

Are you familiar with the trend assumptions in the individual and small group rate filings for 2022 that relate to mental health services?

Yes. The rate filings assume a 10.5% utilization trend for professional mental health services. This was based on historical, pre-COVID observations. Based on the data included in the COVID modeling, Blue Cross now expects the mental health services to increase by 20%. Although significant, these increases are likely significantly constrained by the supply of treatment providers. That means, we would likely be observing even higher increases if the supply of treatment providers were available.

Would you please describe from a clinical perspective what Blue Cross has observed and expects to see with respect to demand for mental health services in 2022 and beyond?

It is no secret that the pandemic has been very damaging to the mental health of the entire population. As an example, the Vermont Digger news service on June 25, 2021 reported that eating disorders are spiking and that demand for eating disorder treatment is being reported at two and three times higher than pre-pandemic levels. This particular trend is hitting adolescents especially hard, and our Utilization Management team has been overwhelmed with out-of-network requests for eating disorder treatment, as well as for other mental health treatment. Our claims data for the first quarter of 2021 is consistent with this significantly increased demand when compared to 2020, as our total medical claims cost for these services for the first quarter of 2021 more than doubled when compared with the first quarter of 2020.

Because of our rapid pivot to telehealth, we saw very little drop-off in the provision of mental health services during the pandemic. We expect this demand to continue, and to increase if capacity allows.

Further, I have reviewed data related to substance abuse and alcohol abuse that indicates we are likely to see increased claims for treatment in these areas. The CDC noted that overdose deaths accelerated during the pandemic, and this mirrors the trend that we have seen in Vermont as well, as fatal overdoses were up 38% as of April 2021. In addition, although opiates tend to grab the headlines, alcohol abuse is more common. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) says that one in eight Americans struggles with alcohol. Alcohol sales online were up 243% during the pandemic. A September 2020 study in Jama Network Open found alcohol consumption was up by 14% compared to 2019. A NIAAA surveillance report also in September 2020 showed that, for the 10 states monitored, sales of hard liquor, or spirits was up 26.5% over the prior three-year average, and sales of all alcohol was up 17.7%. Not every month was as dramatic as this, but there has clearly been a trend of significantly more alcohol sales during the pandemic, with only two months (May and November) showing lower

alcohol sales over the prior three year average, and all the other months from March to October showing an overall increase in per capita alcoholic beverage sales. The Vermont Department of Health in their last Data Brief on alcohol related mortality (Alcohol-attributable deaths in Vermont Data Brief. December 2017) also documented concerning levels of alcohol use and deaths from AUD in Vermont residents. Because of these underlying alcohol concerns for Vermont, and the compounding effects of the pandemic, we are anticipating an increase in demand for treatment services for substance use disorders and alcohol use disorders as the pandemic resolves.

The long-term morbidity impact of the pandemic on mental health and substance use disorders, as well as the long-term impacts of COVID infection specifically are unknown, but the transformation of digital healthcare services such as telehealth and audio-only telehealth, combined with the other pandemic related impacts on medical and mental health clearly indicate that the health care environment now and into the future is very different than what it was pre-pandemic.

Kate McIntosh, MD

State of Vermont, County of Addison.

Signed and sworn to (or affirmed) before me on July 2, 2021 by Kate McIntosh.

Signature of notary public: [signature]

Printed name of notary public: Lisa Ryan

Commission number: 157.0005298

Commission expiration date: 1/31/2023

Title of office is Notary Public.

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Attachment A

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 and Utilization Management

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

CERTIFICATE OF SERVICE

I certify that I have served the above Prefiled Testimony of Dr. Kate McIntosh on Michael Barber, Laura Beliveau, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Jay Angoff, Kaili Kuiper and Eric Schultheis, counsel for the HCA, by electronic mail, on July 6, 2021.

/s/ Bridget Asay
Bridget Asay

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STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield Vermont 2022 Vermont ACA Market – Individual Market Rate Filing	)))))	GMCB-005-21rr SERF No. BCVT-132829271
In re: Blue Cross and Blue Shield Vermont 2022 Vermont ACA Market – Small Group Market Rate Filing	)))	GMCB-006-21rr SERF No. BCVT-132829562

PREFILED TESTIMONY OF PAUL A. SCHULTZ

Dated: July 6, 2021

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 (Blue Cross). I have held that position since January 2015. I joined the Blue Cross actuarial team in 2013.

Please describe your primary job responsibilities.

As Chief Actuary, I oversee the actuarial services and underwriting departments at Blue Cross. 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 all Blue Cross 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, Enterprise Risk Management, 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 Blue Cross.

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 2020 regarding the actuarial analysis supporting the Blue Cross Vermont individual and small group rate filings for plan years 2015 through 2021.

As part of your employment responsibilities at Blue Cross, 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 the filings

under review and the actuarial report on COVID-19 modeling that we shared through the interrogatory process. 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 (ISG) 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.

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

I reviewed and relied on the following materials:

- Blue Cross and Blue Shield Vermont 2022 Vermont ACA Market – Individual Market Rate Filing, SERFF Tracking Number BCVT-132829271 (May 7, 2021)
- Blue Cross and Blue Shield Vermont 2022 Vermont ACA Market – Small Group Market Rate Filing, SERFF Tracking Number BCVT-132829562 (May 7, 2021)
- Blue Cross Responses to all Green Mountain Care Board questions, including the Board's June 7 Questions to Blue Cross and the Board's June 18 Non-Actuarial HCA Questions to Blue Cross
- Blue Cross Responses to all Lewis & Ellis Objection Letters in this matter

- The materials discussed in this Prefiled Testimony immediately preceding this question, beginning at page 2, line 25
- M. Rae et al., How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured (Kaiser Family Found. Mar. 25, 2021)
- An Update on Federal Issues Related to Vermont Health Insurance, Power Point Presentation to the Green Mountain Care Board by DVHA, DFR, and Vermont's Director of Health Care Reform (June 2, 2021)[1]
- Subscriber data provided by DVHA on June 10, 2021
- Blue Cross and TVHP Q3 2020 and 2021 Large Group Rating Program Filings (SERFF: BCVT-132350241, BCVT-132350492, BCVT-132713612, and BCVT-132713919)
- Claims, trend and paid claim projections from the 2021 Blue Cross Medicare Supplement and 2021 TVHP Medigap Blue filings (SERFF: BCVT-132570622 and BCVT-132559586)

PURPOSES AND OBJECTIVES OF THE RATE FILINGS

Were you responsible for preparing the Blue Cross 2022 Vermont Individual and Small Group Rate Filings (the Filings), which are the subject of this proceeding?

Yes. The Filings were prepared under my supervision, and, at the time of filing, I certified that they meet all relevant actuarial standards and that they comply with all applicable state and federal laws and regulations. That certification holds true today.

[1] https://gmcboard.vermont.gov/sites/gmcb/files/documents/DFR%20and%20DVHA%20Update%20to%20GMCB-6-2-21.pdf

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

Yes. The Filings and all other documents and information that Blue Cross 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 Filings?

The purpose of the Filings is to provide the rates and a description of the rate development for the ACA-compliant plans for the Vermont Individual and Small Group markets that Blue Cross proposes to offer for the 2022 benefit year. The Filings apply to plans both On-Exchange and Off-Exchange.

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

Our goal was to develop rates that will cover our policyholders' 2022 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 Blue Cross on a trajectory towards maintaining its policyholder reserves within the acceptable range ordered by the Department of Financial Regulation, while (3) presenting rates that are competitive in the market. 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 Blue Cross has experienced over time in this line of business due to underfunded rates. Because of Blue Cross's projected solvency position, we were able to incorporate two rate

reductions that will be funded through policyholder reserves: we continued our stance of paying for direct COVID costs out of reserves, and we changed our allocation of fixed administrative costs to reduce the allocation to ACA business. The latter will also be funded from reserves. In total, Blue Cross is absorbing approximately $11.9 million of costs through surplus, rather than filing premiums that would have been some 4.4 percent higher. Blue Cross has absorbed similar costs for its other insured lines as well, to a total of $15.4 million expected to be funded through surplus in 2022, which will directly reduce risk-based capital (RBC) by approximately 72 percentage points.

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 Filings 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 Blue Cross is requesting in the Filings.

Before the Vermont Legislature's decision to split the market into separate individual and small group markets , *see* 2021 Vt. Acts & Resolves 88, § 34, Blue Cross anticipated filing for an average decrease of 0.9 percent in the combined individual and small group market. Increases for specific plans range from -13.3 percent to 0.3 percent. The range of increases is due to changes to the actuarial values and plan designs. Apart from the Catastrophic plan, the increases range from -2.9 percent to 0.3 percent.

Upon the separation of the markets, Blue Cross ultimately submitted separate filings for small group and individual rates. Small group rate changes range from decreases of 7 percent to

19.8 percent (9.5 percent for plans other than On-Exchange Silver plans), with a weighted average decrease of 7.8 percent. Individual rate changes range from a decrease of 2.5 percent to an increase of 9.8 percent (increases of 6.2 percent to 9.8 percent for plans other than the Catastrophic), with a weighted average increase of 7.9 percent.

These figures can all be found on page 1 of Exhibits 9B.

IMPACT OF THE AMERICAN RESCUE PLAN ACT AND THE UNMERGING OF THE INDIVIDUAL AND SMALL GROUP MARKETS

Prior to this year, were the Vermont Individual and Small Group markets treated as a single market for rate review purposes?

Beginning with plan year 2014 (the first year of Vermont's ACA marketplace), Vermont law required that individuals and small groups be rated together in a combined, community-rated risk pool.

Did the Vermont Legislature change the law and unmerge the markets this year?

Yes.

Did Blue Cross take a position with respect to unmerging the markets?

Yes. We advocated strongly in favor of the change alongside many other stakeholders, including the Health Care Advocate.

Please explain why Blue Cross supported this change?

Blue Cross strongly supported this change because, with the passage of the American Rescue Plan Act of 2021 ("ARPA"), it is now possible to unmerge the markets in a manner that realizes significant savings for the small group market while shielding all but the highest-income individual-market participants from any corresponding premium increase.

The impact of ARPA's federal benefit expansion on the individual market is enormous: Individuals with income up to $94,500, couples with income up to $189,500, single-parent households with income up to $182,300, and families with income up to $265,500 all now qualify for federal premium assistance when purchasing insurance through Vermont Health Connect.[2] It is estimated that the expanded thresholds now cover 92 percent of families nationwide. *See* M. Rae et al., How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured (Kaiser Family Found. Mar. 25, 2021).[3] In other words, ARPA's expanded federal premium assistance means that the vast majority of individual market purchasers will not have to pay the premium increases that result from unmerging the market. Those amounts will be covered by federal premium assistance.

Therefore, thanks to ARPA, the premium relief that flows to the small group market with the split of the market—approximately 6.4 percent for the Blue Cross population—can now be realized while holding the vast majority of the individual market harmless.

Have you reviewed MVP's 2022 Vermont Individual and Small Group rate filings?

Yes.

Is there a relationship between MVP's approved rates and the premiums Blue Cross members will pay?

Yes. Although we have proposed significantly lower rate increases than MVP for the 2022 plan year, MVP still has the second-lowest filed silver premium in the Vermont ACA market. The second-lowest silver plan is the benchmark plan used for calculating federal premium assistance. Therefore, the amount of federal subsidy received by Blue Cross

[2] These thresholds are approximations based on 2021 approved rates. The final dollar amounts for the 2022 plan year depend on the approved premium of the second-lowest silver plan offered on Vermont Health Connect.
[3] https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/

policyholders in the individual market depends on the approved premiums of MVP individual market plans. Reductions to MVP's filed individual rates would result in lower federal subsidy amounts and therefore higher net premiums (i.e. billed premiums net of federal and Vermont subsidies) for the vast majority of Blue Cross individual market policyholders.

If the Board were to approve all rates as filed, approximately 90 percent[4] of families currently enrolled with Blue Cross through Vermont Health Connect (VHC) would experience a net premium decrease for the 2022 plan year. We do not have income information for members currently enrolled directly with Blue Cross, but any such members who are part of households earning less than 800 percent of Federal Poverty Level (FPL) would also see net reductions in premium.

On the other hand, if the Board were to reduce MVP's filed rates by 10 percent, only 12 percent of families currently enrolled with Blue Cross through VHC would experience a net premium decrease for the 2022 plan year.

Based on filed rates, what average net premium change will Blue Cross members experience in the individual market?

If the Board were to approve all rates as filed, even in the unlikely event that no members directly enrolled with Blue Cross are eligible for premium assistance, the average net premium change for Blue Cross members in the individual market would be a *decrease* of approximately 1.6 percent[5].

[4] All estimates of the APTC are based on data provided by DVHA on June 10, 2021. The data consisted of a de-identified list of all 7,760 Blue Cross subscribers enrolled with VHC. It included plan selection, tier level and income as a percentage of FPL. We made simplifying assumptions about the number of people in each household, and observed that changes in these assumptions were immaterial to the resulting change in net premium.

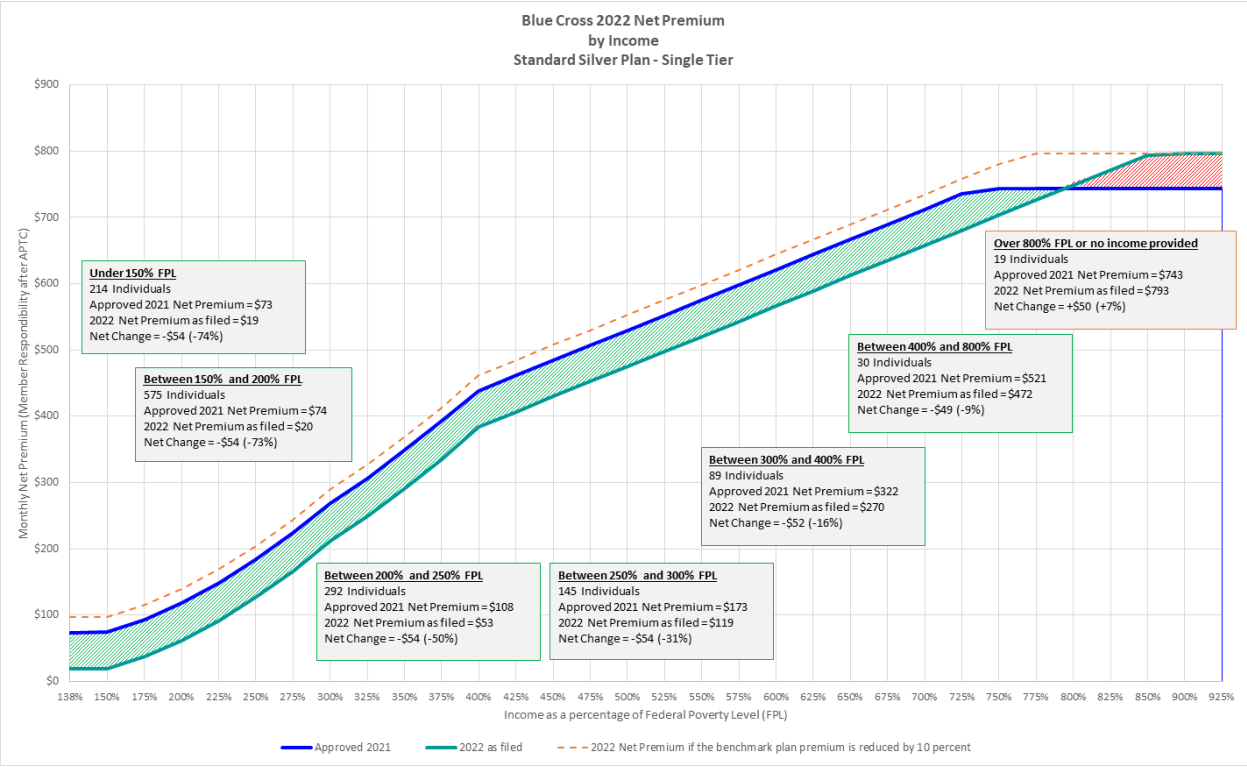
[5] Using the 7,760 subscribers included in the DVHA data and 2,707 subscribers directly enrolled with Blue Cross.

How did you calculate the average net premium increase?

We started with data from DVHA (described in Footnote 4). Using the tier information, we estimated the number of people in each household. Next, for each family, we calculated the maximum percentage of income that can be used for health care premiums, inclusive of the Vermont Premium Assistance. We then calculated the anticipated monthly tax credit using the percentage of income, the income as a percentage of FPL, and the premium of the second lowest silver plan. We performed that calculation for 2021 and 2022. For each family, we calculated the net premium—meaning the monthly premium after subsidies—and the net rate change.

Did you summarize the results of the calculations described above?

Yes. The graph below summarizes the results of those calculations for single tier for the Blue Cross Standard Silver plan.



Did you oversee the preparation of this graph?

Yes. I worked with other members of our actuarial team on this graph and I am fully familiar with the information it contains and the calculations it summarizes.

Please explain what the graph represents.

The graph shows the results of the above-described net premium calculations for a single subscriber on a Blue Cross Standard Silver plan at various levels of income. The blue line shows the net premium that results from the approved 2021 rates. The green line shows the net premium that results from the 2022 filed rates. The dotted red line shows the net premium that results if the 2022 filed rates for the second lowest silver plan (which, as noted above, is an MVP plan) are reduced by ten percent.

What are the statistics in the grey boxes?

They are the average net premium and net change by income range for individuals currently enrolled in the Blue Cross Standard Silver plan through VHC.

Can you explain the impact on MVP members if the rates for the individual market are decreased from their filed amounts?

With the exception of members very near or above the income limits described above, subsidized MVP members in the second-lowest Silver plan would see no change in their net premium. Members below the income limits described above who are enrolled in other MVP plans would see only very subtle differences in their net premiums.

What can you conclude from the graph?

The graph illustrates the unique opportunity—resulting from the confluence of the rates filed by both carriers and ARPA's substantial increase in available federal subsidies—to provide

tangible premium relief to most Vermonters in the individual market. Furthermore, it illustrates the complicated interplay among approved MVP rates, federal subsidies, and net premiums for Blue Cross members.

RATE DEVELOPMENT

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

Yes. The Actuarial Memorandum submitted as part of the Filings sets forth and explains the development of and rationale for the proposed rates, including: the facts, data, analysis, and methodology used to calculate the Metal Actuarial Value for each Qualified Health plan and Reflective plan offered by Blue Cross in 2022; 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 cost for providing Essential Health Benefits (EHBs) within the single risk pool of that market expressed on a per member per month basis.

Do the projected Index Rates reflected in the Filings comply with all applicable state and federal law?

Yes. The projected Index Rates reflected in the Filings comply with all applicable state and federal law, including 45 C.F.R. §§ 156.80 & 147.102. They were developed in compliance with the applicable Actuarial Standards of Practice; are reasonable in relation to the benefits provided and the population anticipated to be covered; and are neither excessive nor deficient.

The development of the Index Rate is explained in detail in the Actuarial Memorandum, at §§ 3.3, 3.4, 3.7, 3.8.

Please describe in general how the Filings were 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 Blue Cross individual and small group ACA market 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 Filings currently under review, we use actual 2020 experience as a basis upon which to project 2022 experience.

The COVID pandemic had an enormous impact on the utilization of health care services in 2020. A smaller impact resulted from a cyberattack on the University of Vermont Health Network (UVMHN) in late October 2020, leading to the deferral of many services that had been scheduled at UVMHN in late 2020. We adjusted the 2020 data to benchmark levels—that is, our

assessment of what 2020 utilization would have been in the absence of these one-time events—using the 2019 experience of members observed to continue Blue Cross coverage in 2020. The net impact was an increase to observed 2020 experience of just over six percent.

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 2020 claims experience even after adjusting for one-time events was significantly favorable compared to the expected experience built into the 2021 filing. The primary driver of the improved experience was a population shift that was observed to take place from 2019 to 2020—while the new population used more retail pharmaceuticals, they also used significantly less medical care. With the addition of a favorable risk adjustment transfer, "rebasing" to the actual 2020 population led to a net decrease to 2022 rates of 5.0 percent.

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 2020 allowed claims experience of members in Blue Cross ACA products. These members represented nearly a half million (exactly 452,386) member months of experience. We then need to anticipate how that claims experience might be different in 2022. 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 Blue Cross, 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 Blue Cross to providers as compensation for care provided to Vermonters—account for over 90 percent of premium dollars.

Blue Cross must comply with all regulatory requirements from both state and federal agencies. The Department of Financial Regulation (DFR) has ordered Blue Cross to be within a specific RBC range. *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).[6] In order to continue along the path of reaching the required range, Blue Cross must file a 1.5 percent contribution to policyholder reserves in these filings. Blue Cross is preparing to take over the billing for VHC enrolled members for plan year 2022. Other federal and state taxes and fees are remaining stable from 2021 to 2022. The combination of these regulatory requirements increases rates by 1.2 percent.

[6] 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).

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 Filings 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, Blue Cross projects a statutory MLR at the combined market level of 90.0 percent[7]. Therefore, the anticipated MLR significantly exceeds all applicable legal 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 a small 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 Filings.

First, we developed our projected administrative costs using an experience period of calendar year 2020. After adjusting actual administrative costs downward for the exclusion of non-recurring expenses and adjusting the allocation of overhead among lines of business to reflect a smaller allocation to ACA plans, we trended these costs forward for increases due to inflation and personnel cost increases. We assumed that administrative costs would not increase

[7] After the market split, the statutory MLR is projected to be 88.6 percent for the individual market and 91.3 percent for the small group market.

from 2020 to 2021 to reflect the Blue Cross decision to forgo cost of living wage increases in 2021. We reflect a rate of increase of 2.2 percent from 2021 to 2022. Finally, we added the cost of two new services: fees incurred by allowing policyholders to pay their premiums with debit or credit cards and additional costs involved with assuming billing responsibilities from Vermont Health Connect starting in 2022. Our analysis yields total administrative charges equating to 7.6 percent of premium. These figures are extremely low in comparison to other ACA market filings. Section 3.8.7.1 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 0.1 percent for the cost of bad debt. This small amount is based on the average uncollectible premiums due to mandated grace periods we have experienced over the last several years.

Our total cost of insurance—administrative costs plus contribution to policyholder reserves plus bad debt—represents 9.2 percent of premium. As previously recognized by the Department of Financial Regulation (our solvency regulator) and by Lewis & Ellis (the Board's actuary), our cost of insurance is very low compared to the industry. It is also less than half of the 20 percent cost of insurance allowed under federal and state law.

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

No. Blue Cross 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 2022 claims costs from your 2020 experience. First, please explain how you addressed trend in the Filings.

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 claims dollars incurred at facilities and providers falling under the jurisdiction of the GMCB hospital budget review process (comprising over half of total medical ACA claims dollars); (2) medical claims dollars incurred with providers outside the Board's hospital budget jurisdiction with whom Blue Cross contracts directly; and (3) medical 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 hospital budget cycle rather than repeating the higher increases that were approved during the 2020 budget cycle. We project a total annual cost trend for all provider categories of 4.4 percent.

Please describe how you calculated the medical utilization trend.

First, we created a "matched population" specific to each benefit year that resulted in an identical mix of age, gender, metal level, market, duration and health conditions for each of the four years of data. This new methodology completely removes any impact of population changes and durational antiselection from the trend calculation. Using our matched population, we estimate utilization trend by observing historical and emerging patterns of care. We assess each component of medical utilization (inpatient, outpatient, 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 1.9 percent. That total comprises 1.5 percent trend for inpatient facility care; 0.3 percent trend for outpatient facility care; 1.8 percent trend for professional services; and 6.7 percent trend 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 Filings.

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 11.1 percent.

Above, you testified that population morbidity is another key assumption driving your 2022 projected claims costs. Please explain how you addressed population morbidity in the Filings.

Population morbidity comprises a set of assumptions designed to quantify the expected differences between the experience period population (that is, 2020) and the projection period population, 2022. Those assumptions include:

- the differences between the experience period population and the projection period population due to individuals and small groups choosing to disenroll from Blue Cross 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 2022 risk adjustment transfer from MVP to Blue Cross 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 2022 as it is in 2021 for both carriers, with the exception of specific adjustments for population changes.

MODELING THE IMPACT OF THE COVID-19 PANDEMIC

Blue Cross prepared and submitted in this proceeding its current modeling of the impact of the COVID-19 pandemic. What is the purpose of Blue Cross's COVID-19 modeling?

We created and provided this year's COVID-19 modeling in order to model and depict the pandemic's ongoing impact on RBC as relevant to solvency. It is critical to bear in mind that, like last year, this year's COVID-19 modeling is not a direct component of our rate development. Its only connection to the filed rates is that it lends additional support to our request that the Board allow us to include a 1.5 percent CTR as part of our approved 2022 rates.

Please describe how Blue Cross modeled the impact of the COVID-19 pandemic.

The Blue Cross actuarial team, under my direct supervision, created a model that simulates paid claims under varying assumptions for the ACA markets, Blue Cross insured large groups, TVHP insured large groups, and Blue Cross and TVHP Medicare Supplement products, in order to examine the possible variance in paid claims in 2021 and 2022. The model and results are intended to quantify the impact the ongoing pandemic is likely to have on Blue Cross's solvency position. Blue Cross submitted this information, including a Supplemental Actuarial Memorandum describing the model in detail, in response to Question 1 of the June 21, 2021 Inquiry Letter 4 from Lewis & Ellis in this docket.

Please describe how Blue Cross developed the COVID-19 model.

Dr. Kate McIntosh, Blue Cross's Senior Medical Director and Director of Quality, the actuarial team, and I analyzed 36 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. We assessed our prior estimates relative to emerging data and made adjustments where necessary.

We also developed estimates related to ongoing direct COVID-related claim costs, including ongoing costs of testing and vaccine administration, The Methodology section of the COVID-19 Modeling 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 COVID-19 Modeling 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 medical claim costs 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. We use those output to estimate the change in RBC position for each scenario. The methodology we used to develop the model is explained in detail in the COVID-19 Modeling Actuarial Memorandum.

What data did you use to develop the model?

To generate baseline 2021 and 2022 claims, we used projected claims, trend, actuarial value (AV), and membership information from the Blue Cross 2022 ACA Market rate filings; claims, trend, and AV projections presented in or underlying the approved Blue Cross and TVHP Q3 2020 and 2021 Large Group Rating Program Filings (SERFF: BCVT-132350241, BCVT-132350492, BCVT-132713612, and BCVT-132713919); and claims, trend and paid claim projections from the 2021 Blue Cross Medicare Supplement and 2021 TVHP Medigap Blue filings (SERFF: BCVT-132570622 and BCVT-132559586). We used membership from internal reporting as of April 30, 2021 to approximate 2021 and 2022 membership. We included direct COVID-related costs incurred from February 2020 through March 2021 and paid through April

30, 2021. We included vaccine claims incurred through April 30, 2021 and paid through May 25, 2021.

To calculate the level of deferred care, we used claims incurred from January 2019 through March 2021 for all Blue Cross 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. Beginning in July 2020, utilization levels can be observed to have returned to levels that surpass trended pre-pandemic benchmarks across the Blue Cross book of business.

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

No. These costs are addressed separately in the RBC projection included in our July 1, 2021 Response to June 18, 2021 HCA Non-Actuarial Questions. At this time, we do not project material operational savings or costs apart from claims costs stemming from the pandemic.

Considering all 36 of the categories of health care services you modeled, what percentage of deferred care does Blue Cross estimate will eventually return?

Overall, our best estimate for commercial markets is that 48.1 percent of the services that were deferred during the slowdown period have been or will be made up. We expect that services will return at a lower rate of 42.8 percent for members in Medicare Supplement products. Support for these assumptions are in Appendix D of the COVID-19 Modeling Actuarial Memorandum. The commercial assumption is not materially different from the 51.7 percent assumption presented in the COVID-19 Modeling Addendum presented as part of the 2021 ACA filing.

We have observed that 43.6 percent of ACA market claims and 41.9 percent of large group insured market claims had already returned through March 2021. A lower figure of 25.4 percent of deferred Medicare Supplement services had returned by the same date.

Please describe the results the model generated.

There is far less variation in results now that we have been able to observe over a year of pandemic experience. We ran 10,000 simulations using the inputs described above and in the Methodology section of the COVID-19 Modeling Actuarial Memorandum and assessed the impact to RBC. The results show a median 2021 impact that offsets the observed 2020 gain. Further, we expect the pandemic to increase claims and thereby decrease RBC in 2022, driven by modest ongoing testing and treatment costs, costs for administering a vaccine booster, a small morbidity impact of the deferral of care during 2020, and accelerated demand for mental health services.

Across the three years studied (2020 through 2022), the median RBC impact of the influence of the pandemic on medical claims is a decrease of 24 percentage points. The 10,000 scenarios produced a range that varies by only about 10 percentage points to either side of the median.

The results are explained in more detail in the Analysis & Results section of the COVID-19 Modeling Actuarial Memorandum.

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

Blue Cross has clearly and consistently stated that any increase in claims costs directly caused by 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.

COMPLIANCE WITH LEGAL AND PROFESSIONAL REQUIREMENTS

Do the Filings 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.

Do the Filings comply with all relevant actuarial standards of practice?

Yes.

Do all of the steps Blue Cross took in preparing the Filings and developing the rates reflected in the Filings 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 Filings and other information submitted by Blue Cross during this proceeding, the rates proposed by Blue Cross 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 Filings?

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 Filings 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 Blue Cross has reasonably concluded is necessary to cover: (1) the projected claims costs of its members, taking into account the choices Blue Cross has made in order to promote robust access to high quality health care services for its members in the Vermont individual and small group markets; (2) Blue Cross'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 Filings, the Actuarial Memorandum, and the other information Blue Cross has provided

during this proceeding, Blue Cross 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 Blue Cross'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 6, 2021?

Yes.

Dated: July 6, 2021

Paul A. Schultz

State of Vermont, County of Washington.

Signed and sworn to (or affirmed) before me on July 6, 2021 by Paul A. Schultz.

Signature of notary public: Kathleen Yacavoni

Printed name of notary public: Kathleen Yacavoni

Commission number: 157.0007570

Commission expiration date: 1/31/2023

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, Laura Beliveau, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Jay Angoff, Kaili Kuiper, and Eric Schultheis, counsel for the HCA, by electronic mail, Delivery Receipt requested via Microsoft Outlook, on July 6, 2021.

/s/ Michael Donofrio
Michael Donofrio

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Attachment A
to the Prefiled Testimony of Paul A. Schultz:

Paul A. Schultz Curriculum Vitae

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 Blue Cross 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, Enterprise Risk Management, Regulatory, and Healthcare Reform Oversight committees; develop new product offerings and funding approaches; review large group rating process; direct team of six credentialed actuaries and three actuarial students; direct team of five underwriters. Participant in Vermont working groups, including Federal Issues Working Group, Vermont 1332 Waiver Working Group and AHS Fixed Prospective Payment Workgroup.

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

Responsible for oversight of the actuarial function: developed pricing and filings for all Blue Cross 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 2020 regarding actuarial analysis for Blue Cross Blue Shield of Vermont individual and small group rate filings.