STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD
GMCB-003-24RR, GMCB-004-24RR

BLUE CROSS BLUE SHIELD OF VERMONT
INDIVIDUAL AND SMALL GROUP RATE FILINGS HEARING
PUBLIC SESSION

July 22, 2024
8:07 a.m.

Hearing held Remotely before the Green Mountain Care Board via Microsoft Teams on July 22, 2024, beginning at 8:07 a.m.

P R E S E N T

BOARD MEMBERS:
Owen Foster, Chair
Robin Lunge, Board Member
David Murman, Board Member
Jessica Holmes, Board Member
Thom Walsh, Board Member

Michelle Sawyer, Staff Member
Mark Hengstler, Staff Attorney
Laura Beliveau, Staff Attorney
Michael Barber, Hearing Officer

A P P E A R A N C E S

Blue Cross Blue Shield of Vermont

Martine Brisson-Lemieux, Witness

Ruth Greene, Witness

Tom Weigel, Vice President and Chief Medical Officer

Lewis & Ellis (L & E)

Bridget Asay

Mike Donofrio

Kevin Ruggeberg, Witness

Department of Financial Regulation

Jesse Lussier, Witness

Kevin Gaffney, Witness

Office of the Health Care Advocate

Michael Fisher, Witness

Eric Schultheis, Staff Attorney

Charles Becker, Staff Attorney

Remote via Teams
July 22, 2024
8:07 a.m.

P R O C E E D I N G S

MR. BARBER: Good morning everyone. My name is Michael Barber, and I'm, as Chair Foster said, I'm the Board's General Counsel, and I'll be serving as a hearing officer for today's hearing. The hearing is being held remotely via Microsoft Teams.

The purpose of this hearing is to take evidence and argument on Blue Cross and Blue Shield of Vermont's 2025 individual and small group rate filings. The docket number for the individual rate filing is GMCB-003-24RR, and the docket number for the small group rate filing is GMCB-004-24RR.

The hearing is being held pursuant to 8 V.S.A. Section 4062, as well as Section 2.307 of the Green Mountain Care Board's Rate Review Rule, Rule 2.

It looks like we have all five Board members with us this morning. We also have Michael Donofrio and Bridget Asay from the law firm of Stris & Maher LLP, who are representing

Blue Cross today.

Representing the interests of health insurance consumers is Eric Schultheis from the Office of the Health Care Advocate. And Eric, is it just you or is Charles also here? I can't see him.

MR. SCHULTHEIS: Charles is also on, but I'll be primary. I'll be the only one on camera in most cases.

MR. BARBER: Okay. The Board's attorney, Laura Beliveau, is also here. She'll be leading the direct testimony of the Board's contract actuaries from Lewis and Ellis and may also have questions for other witnesses.

We are recording today's hearing. We also have a court reporter here to transcribe the proceedings. We will provide the parties with a copy of the transcripts when we receive them.

Because we are holding this hearing remotely, before we get any further, I just want to make sure that -- we did a little test of this, so I won't go through the whole list, but I just want to make sure the Board members in particular can hear, and we can hear

them. So if I call out your name, if you could just please take yourself off, off mute and confirm that you can hear and that we can hear you.

So Board member Holmes.

MS. HOLMES: Yes. Can you hear?

MR. BARBER: Yes.

And Board Member Lunge.

MS. LUNGE: Good morning.

MR. BARBER: Good morning.

Board Member Murman.

MR. MURMAN: Here that?

MR. BARBER: Yeah, I can hear you now -- could you --

MR. MURMAN: Just saying good morning.

MR. BARBER: Good morning.

And Board Member Walsh.

MR. WALSH: Good morning.

MR. BARBER: Hi. Good morning. So I -- does everyone have their cameras on? I'm going to need to take a second to just pin people, because I -- there's a lot folks on the call. Okay. I see you now. Okay. If anybody has any technical difficulties as we go forward

today, you can please just -- just text me and let me know, and I'll pause the hearing while we try to get that sorted out. So my cell phone number is (802) 585-4829.

For any members of the public who are present today, we will be taking public comment at the close of the proceedings. I can't exactly say when that will be. And if you don't want to kind of wait around and sit through a long day of witness testimony, we are having a meeting later this week on Thursday, July 25th, from 4 to 5 in the afternoon. And that will be dedicated exclusively to hearing from the public on both these rate filings and the individual and small group rate filings from MVP.

So information about that meeting can be found on the Board's website by clicking on the link for the 2024 Board Meeting information, or you could also go to the Department of Library's home page, and they have a calendar with all the upcoming meetings for all state agencies, and you can find information that way, too.

So I think we're ready to move on to the exhibit binders. So we received binders

from Blue Cross on July 18th. It looks like all the documents that contain confidential information have been identified in the exhibit list. The confidential information that is in these documents is, I believe, marked with blue highlighting.

Michael or Bridget, is there anything else you want to say about how confidential information is identified in the exhibits?

MR. DONOFRIO: No, I think that's exactly right.

MR. BARBER: Okay. Thanks. My understanding is that Exhibits 1 through 22 are documents that have been stipulated to by the parties, while Exhibits 23 and 24 are lists of documents that have been stipulated to by the parties with the actual documents themselves not being in the binders. Is that -- is that correct?

MR. DONOFRIO: Yes.

UNIDENTIFIED SPEAKER: Yes.

MR. BARBER: And then, the exhibit list shows an Exhibit 25, but I don't see a document at tab 25 of my binder. Is this a

placeholder for something?

MR. DONOFRIO: Yes. That -- that's a placeholder. I believe in the past, there have been occasions where the Board has asked for something to be placed into the binder, so we just left a placeholder just in case.

MR. BARBER: Okay. And then we received an Exhibit 26 via email on Friday, July 19th, which we did share with the Board members. Has the healthcare advocate stipulated to the admissibility of that document?

MR. DONOFRIO: Yes.

MR. BARBER: So does everybody have all of those documents? So it would be 1 through 24 and 26.

MR. DONOFRIO: Yes. Thank you.

MR. BARBER: Board members, any -- do you all have that in front of you? Anybody -- does anybody not have any of those documents? Okay.

MR. DONOFRIO: On Exhibit 26, I'd just like to thank Mr. Schultheis and Mr. Becker for working over the weekend and being in touch to secure that stipulation.

MR. BARBER: Okay. So does either

party have any objection to me admitting exhibits 1 through 26 into evidence at this time?

MR. DONOFRIO: No. Thank you.

(Exhibits marked 1-26 were admitted into the record.)

MR. BARBER: Okay. And please consider that done.

The last item I wanted to check off was, you know, I know Board members and the parties are kind of old hats at this by now, but please save any questions you may have about confidential information for an executive or nonpublic session. We have planned for at least one, possibly two of those today.

The schedule that we had discussed at the prehearing conference was that we would hear from Ruth Greene first and then Jesse Lussier and Commissioner Kevin Gaffney from the Department of Financial Regulation and then Dr. Tom Weigel. And then, we would have an executive session to allow for some direct and cross on confidential topics, particularly, I think, around prospective solvency assessments and provider contracting, other ones, potentially.

And then, we would hear from

Martine Lemieux and then Kevin Ruggeberg, and then Mike Fisher with a possible executive session prior to Mr. Fisher's testimony, if that's -- if that's needed.

So that's -- that's the schedule. That's obviously a lot to get through today. So I'm going to try to keep us on track and be mindful of that. And if you could be as well, I think that would be helpful. And if I -- if I end up making a suggestion to kind of speed things along, please don't take offense. There's just a lot to get through.

So does either party or any of the Board members, do you have anything that we need to discuss before we move to opening statements?

MR. MURMAN: Nothing from us.

MR. DONOFRIO: No, thank you.

MR. BARBER: Okay. Would Blue Cross like to make an opening statement?

MR. DONOFRIO: Yes. Thank you, Mr. Hearing Officer. Good morning, Chair Foster and Board members. Good morning, Mr. Barber, Mr. Schultheis, Mr. Fisher, and the HCA team. I'm Mike D'Onofrio. I'm here with my colleague, Bridget Asay, from the law firm of Stris & Maher,

representing Blue Cross Blue Shield of Vermont.

So like I said at this time last year, on behalf of the Blue Cross team, we all appreciate and take really seriously the inherent difficulty of the Board's job in doing rate review. You have to balance the interdependent statutory factors, including whether the proposed rates are affordable, whether they promote high quality care, and whether they support robust access to that care.

And as an aside, I just want to clarify that when I say proposed rates, I mean, not the originally filed rates, but the rates as shown in Ms. Lemieux's supplemental prefiled testimony. So kind of like our current, you know, most operative version of the rates. So at the same time, you have to consider that kind of three-legged stool. You also have to make sure the rates are adequate and not excessive, and that they protect the insurer's solvency.

I also said to you last year that I wished we could offer you an easy pathway through that thicket. And like last year, I'm sorry to say that we can't. In that vein, I think that this year presents perhaps the most

challenging set of circumstances that this group collectively has faced in the eleven years you've been reviewing Blue Cross's rates.

That follows from two hard realities. First, Vermont's healthcare costs continue to grow at an unsustainable rate. That's clear and undisputed from evidence in the record, including the filings themselves, the information that we've provided in response to questions from the Board and the HCA, the prefiled testimony we've submitted, the live testimony you'll hear today and L & E's, that's Lewis and Ellis' evaluations of Blue Cross's rate development.

Second, Blue Cross' solvency is in kind of an unprecedented and perilous state, as we come into the hearing. The 2023 year end RBC ratio of 337 percent, a historic low over the lifespan of this proceeding dating back to 2014, sounded initial alarm bells, and since then, the situation has gotten worse, thanks to significantly higher than projected 2024 claims.

This fact is also clear and undisputed in the record, based on Ms. Greene's prefiled testimony, again, our responses to Board

and HCA questions, and most importantly, the Department of Financial Regulations solvency analysis of the two filings.

In fact, DFR, who is Blue Cross' solvency regulator, has noted that Blue Cross' RBC has crossed the statutory threshold requiring Blue Cross to develop and provide a plan to DFR to improve its RBC level under V.S.A. 83.08. And DFR's recommendation, which you'll find in the binder at Exhibits 16 and 17, it's -- it amplifies the need this year to grow and not further deplete Blue Cross' reserves going forward, and I want to just read a bit of the recommendation. So beginning the quote here.

"DFR's overall solvency assessment of Blue Cross finds that the original proposed CTR, and therefore, the rate, is insufficient and must be significantly adjusted upward. Blue Cross has indicated to the Department the company will be adjusting the CTR factor from three percent to seven percent.

The Department supports this increased CTR and finds it necessary to increase and stabilize reserves of Blue Cross. Any downward adjustments to the filings of the rate

components that are not actuarially supported may prevent Blue Cross from meeting the necessary CTR and will further reduce Blue Cross' surplus and negatively impact its solvency". So in terms of roadmap of the hearing, Blue Cross will offer testimony from three witnesses today. First, you'll hear from Ruth Greene, Blue Cross' Chief Financial Officer. She'll detail the very serious dire solvency situation the company is facing and is prepared to testify generally about the company's finances.

After Ms. Greene, we'll hear from DFR and then Dr. Thomas Weigel, Blue Cross Chief Medical Officer, will take the stand. He's prepared to discuss Blue Cross' efforts to do what it can to keep the rates as affordable as possible, in spite of the gale force headwinds I discussed a moment ago.

And then finally, Martine Brisson-Lemieux, Blue Cross' Chief Actuary, will testify about the actuarial development of the rates, which, as I mentioned above, is not in dispute this year. Lewis and Ellis and Blue Cross essentially agree on the actuarial analysis and rate development.

So I want to sum up with two thoughts. First, Blue Cross' solvency situation is the result of many factors accumulating over time. Healthcare costs that grow faster than anyone anticipates, the behavior of financial markets, underfunding of the rates over time in these markets, as depicted on the table on page 6 of Exhibit 1, the actuarial memo, and then unforeseen strains on the system, like the COVID-19 pandemic.

The list reminds me that when I was working for the Board back in the early days of rate review. In one of the early rate hearings, Blue Cross explained that the reason why insurance companies have reserves is to make sure that the insurer can always fulfill its obligations to its members, whatever happens in the face of external events like financial upheaval or pandemics, or what have you. And that comment, that memory rings prophetic in kind of an eerie way today.

So in any event, this year, the Board, in an unprecedented way, must approve rates that it believes will add to and grow Blue Cross' reserves in light of the solvency

situation. Second, Blue Cross understands that many of our members are already struggling to pay the rates and that these proposed rates just intensify those struggles. We've read the public comments that the Board shared with us on Friday, and they -- they -- they speak a powerful message, and we -- we-understand that painful reality.

I think we've all asked ourselves throughout this whole process, how can we say these rates are affordable, one of the criteria that you have to evaluate in the face of -- of this reality and these -- these voices. And it's -- I'd offer up to you that it's -- the reason why we can is that in this context, in the context of reviewing health insurance rates, affordable has to mean something like as affordable as possible, given the unavoidable obligation to cover members' projected healthcare costs.

So as painful as we know it will be for many of our members, we have no choice but to propose rates that we believe will cover those projected healthcare costs, which are already high and which we know will continue to grow. In

light of our extremely challenging solvency situation, we have no choice but to propose rates that will also shore up our financial footing so that we can continue to serve Vermonters in these markets.

So last year at the end of my opening, I said something like this. If you reduce Blue Cross' proposed rates, but underlying costs and utilization grow as projected, and this year, as the evidence strongly supports, they likely will, Blue Cross will sustain another loss in this market at a time when its solvency position needs to be prospectively maintained and not taxed. And unfortunately, that's where we're at. Blue Cross did sustain further losses in these markets in calendar year 2023, and calendar year 2024 appears to be following suit.

So in light of the above, and in light of the testimony that you'll hear today, we respectfully request that you approve the proposed rates, which will allow Blue Cross to continue to work with you, the HCA, other shareholders, stakeholders across the system to make Vermont's healthcare system more sustainable over time.

Thank you for your team's energy and attention during today's hearing throughout this entire process, and we look forward to the conversation with you today. Thank you.

MR. BARBER: Thank you, Mr. D'Onofrio.

Mr. Schultheis, would you like to make an opening statement?

MR. SCHULTHEIS: I would.

So good morning all. Good morning. Board members, Chair Foster, Blue Cross Blue Shield. My name is Eric Schultheis, and I'm a staff attorney with the Office of the Health Care Advocate. I want to recognize, like Mr. Donofrio, that this year presents unique challenges. There is a real concern for Blue Cross' solvency. We are also staring down the impending expiration of enhanced premium tax credits, which means there will likely be a huge financial cliff for many Vermonters in 2026.

Amidst these unique challenges, a few things, unfortunately remain the same. The small group market is not supported by federal or state subsidies, meaning that the full burden of premiums and deductibles falls on small

businesses and their employees. In the individual market, even with enhanced subsidies, far too many Vermonters struggle to afford health insurance, let alone use it.

Our office has looked at the 2025 rates every possible way we can think of. It pains me to say that this year, we believe that Blue Cross will need a substantial rate increase to ensure it can continue to provide Vermonters with health insurance.

Make no mistake, our neighbors and local businesses cannot afford this large increase. More people will not be able to afford to use insurance even if they buy it. Many of our neighbors' lives will be ruined by incurring more medical debt. We believe we are choosing between two horrible things -- risk causing Blue Cross to become insolvent and force Vermonters to lose their coverage in the future or make Vermonters insurance costs even more affordable today. In other words, the Board is forced to choose not whether Vermonters will suffer, but when they will suffer.

The choice before you today makes one thing painfully clear. The system does not

work for Vermonters. There are three immediate steps the Board could take to make this system incrementally better for Vermonters. These steps will not solve our problems. These three steps will not change the horrible choice Blue Cross and the hospitals have forced upon you. These steps will, however, at least move us in the right direction.

First, Blue Cross needs to take more accountability for organizational reform to reduce costs and improve efficiencies. It is easy to diffuse responsibility and blame problems on the Board, or simply to say it is trying hard enough. It is harder to evaluate your own organization and recognize the need to improve. Vermonters deserve that Blue Cross. Stop finger pointing. Stop saying it is doing everything it can and look hard at what it can do better.

Second, the Board needs to finish its efforts to implement a definition of affordability that encompasses the dual burden of premiums and deductibles. Affordability is not mere cost reduction efforts by carriers. It must reflect affordability for Vermonters as mandated by rural and statute. The effort to define

affordability must be revisited, and this effort must lead to a definition.

Third, the Board needs to regulate the entire cost equation. We know that medical unit costs are a major driver of premium increases, yet the disparity in regulation between carriers and hospitals is glaring. While carrier rates are set in stone, hospitals often exceed approved budgets without repercussion.

Further, revenue overages are frequently just baked into the next budget submission, thus perpetuating cost overruns into the future. To make matters even worse, hospitals shirk their duty to look inwards when it comes to managing costs. Instead, we regularly hear from hospitals that Medicaid reimbursement rates are supposedly too low in Vermont, and thus the high commercial charges are justified.

However, Vermont has the highest Medicaid reimbursement rate in New England and one of the highest in the nation. Public payer reimbursement is not the reason for the high commercial charges of most Vermont hospitals.

It is not a debate, just like

climate change is not a debate. The evidence only supports one side. For the sake of Vermonters, this absurd excuse for high prices cannot continue, and hospitals must be held to account by the Board for its ordered charge increases. Before I summarize our position, I want to be completely clear. We are placed in today's position, not because of past Board actions or because of something Vermonters did. We are here because of the actions of regulated entities.

You will undoubtedly hear from the regulated entities why someone else is to blame for what is happening. Please remember that the only people who lose in the endless game of finger pointing between hospitals and insurers are Vermonters.

In summary, as we navigate Blue Cross' extreme 2025 rate proposal, a balanced approach is essential, one that addresses solvency, and it tends to mediate our neighbors suffering today. Blue Cross must stop finger pointing and look inward. The Board must renew its efforts to establish an affordability standard, ensuring that the lived experience of

Vermonters have a voice in our regulatory decisions. Lastly, the current system of regulation must be changed so that it effectively controls medical cost growth. Vermonters' health and pain are worth far more than these things. We can, including myself, must do better and must do better. Thank you.

MR. BARBER: Thank you. Mr. Schultheis. So Blue Cross can now call its first witness.

Ms. ASAY: Thank you. Good morning, Hearing Officer Barber, Chair Foster, Board members and HCA Counsel. I'm Bridget Asay, also here on behalf of Blue Cross, and we call Ruth Greene as our first witness.

MR. BARBER: Okay. Ms. Greene, are you ready to take the oath?

MS. GREENE: I am.

Whereupon,

RUTH GREENE,

a witness called for examination by counsel for the Petitioner, was duly sworn, and was examined and testified as follows:

MR. BARBER: Okay. Go ahead, Ms. Asay.

MS. ASAY: Would you please state your full name for the record?

MS. GREENE: Ruth Greene.

MS. ASAY: Ms. Greene, what is your position with Blue Cross Blue Shield of Vermont?

MS. GREENE: I am the Treasurer and Chief Financial Officer of Blue Cross Vermont.

MS. ASAY: Did you submit prefiled testimony in this matter?

MS. GREENE: Yes, I did.

MS. ASAY: And can you identify that, please, by exhibit number?

MS. GREENE: My prefiled testimony is Exhibit 19 in the binder.

MS. ASAY: Is the testimony contained in Exhibit 19 true and correct to the best of your knowledge?

MS. GREENE: It is.

MS. ASAY: Ms. Greene, you've testified at the Board's rate review hearings now every year for a decade, right?

MS. GREENE: I have.

MS. ASAY: How was this year

different?

MS. GREENE: I cannot overstate the seriousness of the financial challenges that Blue Cross is facing today. Our member reserves are at a historic low. RBC is far below the range required by the Department of Financial Regulation and trending downward. The critical need to protect our solvency is the main issue presented at the hearing. We understand that we're asking for a large increase on premiums that are already high.

The fact is, paying for the healthcare for our members is getting more and more expensive. The approved premiums in -- in these markets haven't kept pace with the cost of healthcare for our members, and the math is simple. Losses are paid out of reserves. Reserves are finite and shrinking. And we can barely manage the losses that we're experiencing in 2024, and this cannot be repeated in 2025. We don't make this request lightly. To continue serving these markets and avoid a full-blown solvency crisis, we have to have fully-funded rates with a seven percent contribution to reserve.

MS. ASAY: All right. You mentioned RBC, and let's start there. What is the RBC range that the Department of Financial Regulation requires for Blue Cross Vermont?

MS. GREENE: The RBC range required is 590 to 745.

MS. ASAY: And I just want to pause here, Hearing Officer Barber, and just preview for the Board and ACA counsel.

Ms. Greene will testify in the public session regarding reserves and RBC position for yearend 2023. Consistent with the Board's confidentiality rulings on our filings, we will reserve discussion of interim RBC and projections for an executive session. And I'll address that further at the end of the direct testimony.

Ms. Greene, what was Blue Cross Vermont's RBC position at the end of 2023?

MS. GREENE: At the end of 2023, it was 337.

MS. ASAY: How much did Blue Cross hold in reserves at the end of 2023?

MS. GREENE: Eighty-eight million dollars.

MS. ASAY: How would you describe Blue Cross's financial position and outlook at the end of 2023?

MS. GREENE: Our financial position at the end of 2023 was highly concerning.

MS. ASAY: How so?

MS. GREENE: Both our member reserves and RBC had dropped to 337, which is very, very low. In 2022, we had experienced significant losses that brought the RBC down to 434. Then, as we went into and completed 2023, the losses continued and were even higher due to higher claims than what we had predicted. And that was what pushed RBC down to 337.

We were talking with the Department of Financial Regulation ever since, really our RBC dropped below the bottom end of the target range. So we've been providing them with regular updates on the current situation.

MS. ASAY: As Blue Cross' treasurer and CFO, what kind of concerns were in your mind when you were assessing the company's financial position at the end of 2023?

MS. GREENE: I really had two

concerns. The first and foremost is focusing on a plan to make sure that we had fully-funded rates and able to bring our RBC towards the target range or at least make significant movement towards the target range. But also top of mind with an RBC of 337 is just the lack of flexibility and how we've talked before about the need for insurance companies to have adequate reserves to weather unexpected events and things that are out of the company's control and still being able to pay claims in the face of those unexpected events.

So starting the year with reserves at such a low point, really was very concerning. In addition to our focus on recovery of RBC, it was very clear that our capacity for growth was also very limited -- in fact, down to zero.

MS. ASAY: With that backdrop in mind, how has the first half of 2024 played out for Blue Cross?

MS. GREENE: The first half of 2024 got significantly worse. We have, as I included in my prefiled testimony, we had a claims surges in April and May that really tested our ability to keep paying those claims and also

caused concern given that it really is important for the premiums to cover the claims. So we are continuing to pay out of reserve.

MS. ASAY: Did you provide details about the claimed surge in your pre-filed testimony?

MS. GREENE: Yes, I did.

MS. ASAY: Is there anything you want to highlight for the Board from that testimony?

MS. GREENE: Yeah. There was two things that I'll note here in that. First, is the surge that we saw in April and May really was focused in the medical facility claims, not -- notably not the pharmacy or prescription drug claims. This means that the latest surge is coming from the providers that are regulated by the Board.

The second thing I'd like to point out, and if we could go to page 11 of Exhibit 19, there's a table on that page that shows the increase in per member per month medical claims from '22 to 2024. It's the second table at the top of that -- from the top of that page.

These increases are way higher and

faster than what we had included in claims. And if the contributions reserves had been fully funded over a number of years, we might be able to sustain such a significant increase, as shown there. But we really can't absorb this at this point given the low level of member reserves.

MS. ASAY: So just looking, staying on that chart, have Blue Cross rates been growing at the same pace as those claims expenses?

MS. GREENE: No, they have not.

MS. ASAY: Is it fair to, just in plain English, describe Blue Cross' reserves as a cushion?

MS. GREENE: Yeah. It's fair to describe that, although, with reserves at such a low level there is no cushion left. That has been clear since the end of last year.

MS. ASAY: Ms. Greene, you testified both here a few moments ago and in your prefiled testimony that Blue Cross Vermont is requesting a seven percent contribution to reserves for these markets. Is that a change from the request made in the original rate filings?

MS. GREENE: Yes, it is.

MS. ASAY: And what was the original request?

MS. GREENE: The original request in the rate filing was three percent CTR.

MS. ASAY: Can you please briefly explain the context for making that request in the original filing?

MS. GREENE: Sure. At the time of the filing, we had only preliminary 2024 results. As you know, the claims are not made and processed instantaneously, so it takes a little bit of time to understand how the early part of the year is developing. I can provide more details in executive session, but -- around RBC levels since the beginning of the year, but at the end of or at the time of the rate filing, the first quarter or the first three months of the year, we're a little bit high, but not significantly so in terms of claims. And we were still projecting RBC at the end of 2024 to be a modest increase over the end of 2023.

We also knew that the rate increase proposed for 2025 was very high. This is a result of the escalating and continuing

increases in the medical costs and the healthcare costs of our members. We knew that it would be very difficult to increase CTR on top of already high increases. We did discuss the idea of increasing CTR to five percent, and I feel we could have made a justification for that, but at the time we were very reluctant to add to the already high increases.

MS. ASAY: What changed after the rate filing in May?

MS. GREENE: Again, I can discuss projected RBC figures in executive session, but I can say that the April and May underwriting results were very, very unfavorable to our expectations, and our financial picture got significantly worse. As April claims came in, we started to become concerned. And then when May claims came in in June, we definitely felt that some action is required. Our RBC continued to trend downward.

MS. ASAY: Is Blue Cross now requesting a seven percent CTR in individual and small group markets.

MS. GREENE: Yes. We urgently need the Board to approve fully-funded rates,

including a seven percent CTR.

MS. ASAY: And is that request prompted by a -- by the reserve position?

MS. GREENE: Yes.

MS. ASAY: Ms. Greene, can you clarify what you mean when you say that the rate needs to be fully-funded?

MS. GREENE: Yes. I outlined this in my pretrial testimony on page 8 of Exhibit 19. That -- bottom of the page. "We can only achieve our target CTR if all components of the rates are adequately funded. If the Board reduces other components of the filed rate, those reductions are effectively reductions to CTR." So when I say fully-funded rates, I mean that the assumptions need to hold and also include an appropriate sufficient CTR.

MS. ASAY: Has Blue Cross been consulting with the Department of Financial Regulation as you've been assessing these developments?

MS. GREENE: Yes, we have. As soon as the April and May results began to emerge, we reached out, and I'm in touch with CTR on the most recent developments. We have been in

touch with them regularly, but this was unexpected. And we also shared with them our plans for bringing RBC back into the target range.

MS. ASAY: What is that plan?

MS. GREENE: The overriding priority for moving RBC for Blue Cross back towards and into the required range is to have fully-funded premiums, including a sufficient CTR. That has to be significant enough to move RBC to the minimal, minimally adequately-funded level.

MS. ASAY: Ms. Greene, have you read the solvency letter in this proceeding, which is at Exhibit 16 and 17 in the binder?

MS. GREENE: Yes, I have.

MS. ASAY: Do you have any reaction to the DFR letter to share with the Board?

MS. GREENE: Yeah. I'd like to point out several items. In fact, on the first page, they say that Blue Cross is facing extraordinary circumstances, and they explain that with the recent drop in RBC that has triggered a statutory action level. So we are

required by law to take steps to stabilize our situation. VFR on the next page also agrees that the 3 percent CTR is inadequate as filed. The Commissioner explains on page 2 "that an increase in the contribution to reserves is necessary to increase the company's surplus toward acceptable levels for the protection of policyholders."

They go on to show how the CTR for this book of business or that these markets have been underfunded in recent years, significantly underfunded. And in plain English, that means that those losses on page 3 have been paid out of reserves instead of premiums. And then the bottom line is the VFR letter also expresses that they agree with our request for 7 percent CTR.

On page 4, there's a quote that talks about our request for seven percent, and it says that the Department, "finds it necessary to increase and stabilize reserves of Blue Cross Blue Shield of Vermont."

So this is our solvency regulator, and they stated publicly in their letter that we have to take action to stabilize our situation. And as a result of our RBC filing in 2024, we do have statutory action event in place. And they

are saying that this is what we need to do, and I don't think it can be any clearer than that.

MS. ASAY: Ms. Greene, are you prepared to provide additional testimony and answer questions regarding Blue Cross's interim RBC calculations and RBC projections for 2024 and '25?

MS. GREENE: Yes.

MS. ASAY: Is it appropriate to provide that testimony at a public session?

MS. GREENE: No, it is not.

MS. ASAY: And why not?

MS. GREENE: Our financial projections are confidential, commercial -- commercially sensitive information that provide a business advantage to Blue Cross. We make reasonable efforts to maintain the confidentiality of our financial projections, and doing so is important in a competitive -- competitive environment.

Our financial projections also include items that relate to confidential contract negotiations, and the same is true for interim midyear RBC calculations. They are not final numbers, and they do not typically -- and

we do not typically share those calculations publicly. And they are confidential, commercially sensitive information.

MS. ASAY: In your pretrial testimony, you outlined some other actions in addition to the rate request here that Blue Cross is taking as part of its recovery plan. Do you recall that?

MS. GREENE: Yes.

MS. ASAY: And those are on pages 14 to 15 of Exhibit 19.

MS. GREENE: Yes.

MS. ASAY: Are some of those actions also confidential?

MS. GREENE: Yes. As we explained in our confidentiality request, some of those actions are not public and disclosing them now would disclose confidential, commercially sensitive information that provides a business advantage to Blue Cross. I can discuss further in executive session if the Board has questions.

MS. ASAY: So with respect to the actions that can be discussed publicly. Is there anything that you would like to highlight for the Board?

MS. GREENE: Yeah. I think the main point, and we'll keep coming back to this, is the main driver of adequate reserves is fully funded rates, including a sufficient contribution to reserve. There really are no levers as significant as that. There are other things we can do, and they all do contribute, but they really are not -- they pale in comparison to ensuring that premiums are adequate, including sufficient contribution to reserves.

MS. ASAY: Are you taking any steps regarding administrative costs?

MS. GREENE: Yes. And I take the comments by the HCA that we have Blue Cross Blue Shield of Vermont has been working to be more and more efficient and effective at what we do. L & E for years has pointed out that our administrative cost structure is very low by national standards, especially for Small Blue Plan. Beginning last year, in the middle of the year when our RBC dropped below 400 percent, we took further steps to limit any discretionary spend as you would expect we would do under the circumstances.

But we can't stop processing

claims or supporting our members or communicating with providers and implementing our, for example, fraud, waste and abuse programs, and meeting regulatory requirements. This is the core of what we have to continue to do.

So there's really no way to -- as an example, there's no way to sustainably reduce administrative costs that would be significant enough to, in the long run, repair -- repair the RBC. But it is important, and it does contribute. So we do remain focused on it. The cost of care for our members is the main driver of the reserve recovery, and we have to have premium rates, including a sufficient CTR that cover that cost.

MS. ASAY: So turning then to the rates in these markets, have those rates historically provided an adequate CTR?

MS. GREENE: No, they have not.

MS. ASAY: I'd like to direct you to Exhibit 1, page 6 -- page 6 of the actuarial memorandum.

MS. GREENE: I'm there.

MS. ASAY: Do the charts on page 6 of Exhibit 1 show the historical experience in

the QHP market?

MS. GREENE: Yes.

MS. ASAY: Is there a chart that's similar to the first chart on page 6 of Exhibit 1 that's found in Exhibit 13 on page 5?

MS. GREENE: Yes. The exhibit in Exhibit 13 corrects an error, but the bottom line on that table is the same.

MS. ASAY: And what is the bottom line?

MS. GREENE: The bottom line is dark. You can see that since the inception of these markets, we've had a cumulative loss, and that loss is noted in the paragraph below. The total loss in these markets cumulatively is $40.4 million. So that $40.4 million has come out of member reserves.

MS. ASAY: What were the losses in these markets in 2022 and 2023, and if you could point to the chart, the relevant chart?

MS. GREENE: Sure. The second chart on page 6 of Exhibit 1 on the far right, shows the gains and losses for each year, and the cumulative total is 40 million. In 2022, the loss was just over 50 million, and in 2023, the

loss was almost 33 million.

MS. ASAY: Has Blue Cross achieved an adequate CTR in these markets?

MS. GREENE: No. As you can see from this exhibit, we have not collected anything close to an adequate contribution to reserves in our premium to support these markets. Over the decade that we've been participating in the markets, you can see we've filed contributions to reserves in -- as low as one percent for many years. It was 1.5 percent until last year, not higher than 2 percent.

Our targets have been reasonable and low by national standards. That's the comparisons that L & E has done over the years. But in almost every year, the Board has either cut CTR explicitly or has made reductions to other assumptions within the rates that were not actually supported, so that amounts to the same thing in terms of a reduction to CTR.

And we show the comparison of those results in that same table. So as a result, over the last decade, instead of having these markets modestly add to reserves, these markets have actually lost significant -- we've

had significant losses that have drained reserves. So in plain English, it means that we've paid that out of -- out of reserves instead of out of premiums.

MS. ASAY: Is a cumulative historical CTR then negative new market?

MS. GREENE: Yes. The cumulative actual CTR is -1.7. And if you compare the -1.7 over 10 years, that means every year cumulatively had a -1.7. If you compare that to the filed contribution to reserve, that should have been supported at 1.6. That -- that gap is huge. If you run the calculations, it's about just under 300 points of RBC.

MS. ASAY: How -- you've spoken several times this morning about increasing claim costs. Yeah. How do increasing claims costs affect Blue Cross's RBC?

MS. GREENE: Increasing claims costs really is the main driver of the financial challenges that we've had because it directly reduces the reserves. It -- when we have a loss that's not supported by premiums, that comes out of reserves. And so the -- I'll describe it as in the numerator, if you will, of the RBC. It

just reduces the reserves.

MS. ASAY: Are there other ways that increasing claims costs affect the RBC level?

MS. GREENE: Yeah. The other significant impact for increasing claims is it -- when claims are increasing, it increases the authorized control level or the ACL. This is the denominator of the RBC calculation, and that authorized control level is a reflection of the risk that we have as an insurance company. And as claims go up, that calculation also increases. So the denominator grows, and even if reserves in the numerator stayed the same, RBC would go down. When claims go up at a significant pace, there's an inflationary effect, which just means that you need -- you need a higher CTR just merely because claims are increasing quickly.

MS. ASAY: Are there other factors that have contributed to the change in RBC?

MS. GREENE: Yes, there are.

MS. ASAY: I want to point you to what's been marked as Exhibit 26.

And Exhibit 26, just as a reminder for the Board was admitted this morning, but was

not in the binder. It's a one-page document.

MS. GREENE: Yeah. Yeah.

MS. ASAY: What is Exhibit 26?

MS. GREENE: Exhibit 26 is a chart that we provided to the Board after hearing last year that decomposes the historical changes in surplus over the years, and we updated that to include 2023.

MS. ASAY: Would you please summarize for the Board what Exhibit 26 shows?

MS. GREENE: Sure. There's a number of things I'd -- I'd like to point out on Exhibit 26. First, I would draw the Board's attention to the RBC history. You can see that it has been volatile in recent years due to both the factors impacting the surplus or members reserve member reserves and the numerator as well as the ACL. So that's both shown there. The most significant factor driving these changes in surplus is the -- coming back up to the top line of the exhibit, the underwriting gain or loss has to -- that's the line item where we have to see it supporting a modest contribution to reserve. And as you can see, the losses there have been significant, especially in '22 and '23.

The other factors impacting surplus, things that I would that we've talked about in past years. We had the COVID pandemic, which temporarily slowed claims payments in 2020. And then when the payments came back in 2021, '2 and '3, all of that was run through reserves. We did not put any of that in our premiums. That's what reserves are for, to cushion the impact of those unexpected items. And then there's a series of items on this exhibit. The equity gains and losses will go up and down from time to time, but overall they will cumulatively add to reserves.

We have the equity investment in our Vermont Blue Advantage Medicare Advantage business. We launched that business as COVID was getting underway. And that -- that business has also suffered in terms of high claims in the last two years as the medical cost trend has escalated. And then there's the tax law changes. And anyone who's been through these hearings for all of these years like I have, we had large changes in the tax code, and that came through beginning in 2017 and then also added to reserves in 2019 and 2021. And then of course, we've got

the pension losses and subsequent recovery of the -- the losses where we were defrauded by investment managers, and we recovered a majority of that through litigation and also with a catalyst for us freezing our pension.

So the last thing I'll point out on this exhibit is the ACL that I mentioned earlier. You can see that on the line second from the bottom. And that has grown in the last couple of years significantly. And that is both as a result of membership growth, but also the claims costs supported by that membership growth has grown tremendously, as I mentioned a moment ago.

MS. ASAY: In your opinion, Ms. Greene, does the fact that the other factors you've talked about impact RBC? Does that fact undermine Blue Cross' request for a seven percent CTR in 2025?

MS. GREENE: No, it doesn't.

MS. ASAY: Would you please explain why not?

MS. GREENE: The first thing I'd like to say is that I think we need to put the frame on this conversation. In past proceedings,

we've talked about the other factors impacting RBC and whether or not that should be attributed or not to the QHP market. But if we flip the frame and say that -- instead of thinking of contribution to reserves or CTR as a problematic add-on to rates, we really should be thinking about it as a critical part to any rate, and it really is not an optional item. And it's really required in order to sustain wages over time.

Because of that, I really don't think it's appropriate to look at the various things affecting reserves in total and attribute much of that to the QHP marketplace. But the QHP marketplace has to have premiums that sustain and cover the cost of healthcare, the cost of insurance, and include an appropriate CTR to sustain reserves. The reserves are needed to support the entire Blue Cross enterprise, and all of our -- serve a lot of different market segments, and all of those market segments will go through various stages.

And so reserves do have to sustain us through the natural ebb and flow of business results across the entire enterprise. In fact, if you silo reserves, if you think of number

reserves in a siloed fashion, you can make an argument that we wouldn't be in these markets at all because the reserves required to grow the business would have to be there in order for us to serve new members. So if we were attributing the reserves just to one market at a time, we would not -- we would not be able to grow the business at all.

MS. ASAY: Are there other reasons that justify a seven percent CTR in these markets specifically?

MS. GREENE: Yes, there are. I can elaborate a little bit more on this in executive session, but the QHP markets serve -- serve to require us to have a disproportionate share of the reserve requirements. So these markets have a relatively high-risk profile, and it really drives disproportionate share. And even if you were to focus solely on these markets, the seven percent is justified because we have such an overwhelming, obvious picture that these markets have contributed to the current financial problems.

The difference, as I said earlier, between the -7 percent cumulative CTR and the

fact that it should have been providing a modest cumulative 1.5 percent CTR really is significant.

MS. ASAY: I just want to clarify one thing. You just said that the cumulative negative CTR again was -- I didn't get the number. I think it's the way it came out.

MS. GREENE: Yes. The cumulative negative CTR of 1.7 that we saw on Exhibit 1.

MS. ASAY: In the Board's decision last year, the Board reduced Blue Cross' three percent CTR request to two percent, saying in part that the ratepayers in these markets, "should not bear a disproportionate burden." In your view, have the ratepayers in these markets formed a disproportionate burden in contributing to Blue Cross reserves?

MS. GREENE: No, to the contrary. As I explained, these markets have been draining our reserves rather than supporting them. We've explained for a number of years that (indiscernible) premium reductions that aren't justified actuarially don't save money, they just push costs onto future years. And we are at a place where we -- we cannot sustain that outcome anymore.

Even if you think about the last couple of years with the large losses and the increase in federal subsidies, the decisions made to reduce contribution to reserves or rate assumptions, thinking that that was going to save money, in fact, all that did was push losses onto Blue Cross Blue Shield of Vermont reserves and without even benefiting the individuals that have the subsidies.

So I'd like to just sum up the picture to say that we're just at a point where we can't sustain this anymore. To protect our solvency, we need fully funded rates in order to continue to serve Vermonters across all lines of business.

MS. ASAY: Thank you, Ms. Greene.

Hearing Officer Barber, that concludes the public session portion of Ruth Greene's testimony for today. We do have additional testimony that we would like to proffer in Executive Session. I believe that Ms. Greene gave a factual basis for doing so during her testimony. And if you'd like me to address that further now or later, I'm happy to do that. But otherwise, we have no further questions in

the public session at this time.

MR. BARBER: Okay. I think now would be a good time to take just a five-minute break, and then we'll come back at 9:20 and move on to HCA cross.

UNIDENTIFIED SPEAKER: Do you mind if we make it 10, actually?

MR. BARBER: Sure, yeah. We'll see everyone at 9:25 then.

UNIDENTIFIED SPEAKER: Thank you.

(Recess at 9:15 a.m., until 9:26 a.m.)

MR. BARBER: So we just finished the nonconfidential direct of Ruth Greene and turn it over to Mr. Schultheis for any questions he may have.

MR. SCHULTHEIS: Thank you. Hi, Ms. Greene.

MS. GREENE: Good morning.

MR. SCHULTHEIS: So just to kind of set the stage, I'm going to ask you first about a few questions about the dynamic between health insurance premiums and hospital-allowed charge increases. I want to try to avoid, if we can, eliciting confidential information. I trust you and/or your counsel will speak up if we

should be talking about anything in closed session.

I'm also going to ask you about File 2025 CTR and other BCBSBT books of business. Lastly, just to note, when I'm directing you to pages, I'm referring to the red pages, red page numbers printed on the bottom of the page. So could you turn to Exhibit 19, page 14? So Exhibit 19 is your prefile testimony. Let me know when you are there.

MS. GREENE: Page 14. I'm there.

MR. SCHULTHEIS: Okay. Do you see the question on line 5, which is about what Blue Cross is doing to improve its solvency position?

MS. GREENE: Yeah.

MR. SCHULTHEIS: Okay. And if you go over to page 15, which should just be across in the binder, do you see that list of bullets? And it's, I think the first or second -- the first, second -- the second bullet, which is about seeking relief from hospitals that exceeded their ordered commercial rate?

MS. GREENE: Yes, I see that.

MR. SCHULTHEIS: Okay. So my first few questions are aimed at putting an idea

to rest. So I apologize in advance to you and the Board if I'm treading over ground that is too worn. So do hospital -- do Board-ordered hospital commercial charge increases impact health insurance rates?

MS. GREENE: Yeas.

MR. BARBER: Okay. Do you remember that in previous years, we've heard that ordered hospital charge increases act -- should act as a ceiling?

MS. GREENE: Yes, I remember that.

MR. SCHULTHEIS: Yeah. So in reality, you ordered hospital charge amounts act as a ceiling?

MS. GREENE: I'm sorry. Could you repeat that again? Does it currently --

MR. SCHULTHEIS: Sure, Ms. Greene. So in reality, do Board-ordered hospital charge increases act as the ceiling?

MS. GREENE: Yes and no. They do act as a ceiling during negotiating and contracting as we go into a year. And I guess I would say no in the sense that we have to monitor after the fact if the mix of services and activities at the hospitals change significantly

from the assumptions going into the contract agreement, and sometimes they do change. So there is a -- there is just a natural part of the process of implementing rate increases that sometimes causes things to be higher or lower than what was expected going in.

MR. SCHULTHEIS: So the ordered rates, like, start as the ceiling, and you guys negotiate materially different rates, or is it just like a tenth of a percentage here or there?

MS. GREENE: Yeah. In reality, it's not a lot different than the ordered rates. The Dr. Weigel can testify some more about --

MR. SCHULTHEIS: Yeah.

MS. GREENE: -- the details here. But broadly speaking, for many years, the decisions made in the hospital budget arena are very difficult for us to negotiate anything below that.

MR. SCHULTHEIS: Okay. Thanks for clearing that up. So I'm going to shift to the mechanics of the regulatory processes for rate review and hospital budgets now. So in rate review, the outcome of rate review is that you get an ordered premium increase and then you

implement that ordered premium increase. Right?

MS. GREENE: Correct.

MR. SCHULTHEIS: Okay. So Blue Cross can't, for instance, because claims are coming in at a higher level than predicted, change the premium midyear. Is that correct?

MS. GREENE: That's correct.

MR. SCHULTHEIS: Okay. So whatever the ordered premium rate is, is what the premium rate for the year is, regardless of what happens.

MS. GREENE: That's correct for these markets, yes.

MR. SCHULTHEIS: So can hospitals go over the Board-ordered commercial charge rate or the NPR, I guess?

MS. GREENE: Yeah. The implementation of hospital charges, it's, you know, all of the charges for services are unique and different, and not all of those charges --and we've talked about this with the Board in the past, that not all of those charges have applied the same unit cost increases. But the collection of those services through the modeling of the contracting teams, they sort of design that

implementation in a way that, you know, both parties believe at that time that it will achieve the -- either the ordered rate or whatever small amount we've been able to negotiate under that rate.

MR. SCHULTHEIS: So I'm guessing from your prefile testimony that it actually did happen this year that a hospital went over or at least one or more hospitals went over. Is that correct?

MS. GREENE: Yeah. We monitor the hospitals and how it -- how the contracts unfold with actual results, and we do that every year. We've been doing that for a number of years. And sometimes they go higher or lower. Post-COVID, it's been difficult to understand how the mix of services is sort of unfolding relative to where our, you know, sort of typical history would tell us. But we have noticed that there's hospitals that, through the -- the mix of services after the fact, have indeed gone over the rate commitment that they had to us. So we'll be following up with those hospitals.

MR. SCHULTHEIS: So thinking back over the last, say, seven years, have overages

also happened in the past?

MS. GREENE: Overages and underages have happened in the past, and usually in a modest order of magnitude.

MR. SCHULTHEIS: So in the last five years, can you remember -- when that occurred and there was an overage, can you remember when a hospital had a substantial consequence or commercial charge overage that was Board-ordered?

MS. GREENE: I do not recall any.

MR. SCHULTHEIS: Okay. So we're going to switch topics again, and so my last set of questions for you are about contribution to reserves by block of fully-insured businesses business. Has BCBST amended its pending large group unit cost rate filing to change the contribution to reserves from three percent to seven percent?

MS. GREENE: Yes, we have.

MR. SCHULTHEIS: Okay. And have you done that, or has Blue Cross done that for association health plan filing?

MS. GREENE: Yes, we've updated both the large group and the association health

plan filings for both the seven percent CTR and the changes that have come through in the QHP rate review related to H.766 and the latest submitted hospital budget. So that -- those updates have been submitted.

MR. SCHULTHEIS: And I know it's not Board-regulated, but is -- is the VBA block of business has a contribution to reserve been increased in that?

MS. ASAY: So I'm just going to caution that that does go potentially into confidential territory. I think Ms. Greene can navigate what she can say here, but.

MS. GREENE: Yeah. So I guess I'll start and then we can go a little deeper in executive session if we need to. The Medicare Advantage business also historically has targeted a three percent CTR, but the reality in that business is that we only entered that market in 2021. So there was a five-year financial plan to get to a target CTR because of the cost of entering a new market and building to scale, we -- our business plan for entering that market planned for losses.

But in the ongoing sort of when we

get to run rate and break even, it will tend to target the same CTR as other lines of business. We -- there is a bid process with CMS at the federal level that supports the Medicare Advantage business. And we can talk more about actions we've taken in that bid process under our current circumstances that are probably better for executive session.

MR. SCHULTHEIS: So I'm not sure if this should be in executive session. I'm going to try it anyway, and you let me know if we should have it in executive session. So I think what you said, I think, was that you're going to target the same CTR, the seven percent, that you do in other books of business, but that's not going to be next year. That's going to be some time in the future. Correct?

MS. GREENE: Right. That is fair to say. CMS had implemented a number of revenue changes for all Medicare plans nationwide. And when we had to submit a bid, we were unable to achieve the target that we aspire to. But we are definitely working towards that.

MR. SCHULTHEIS: Great. Thank you for clearing that up. So those are all my

questions for Ms. Greene. And kind of just like Ms. Asay, did I reserve the right to do additional cross-examination of the witness, should we get-go into an executive session.

MR. BARBER: Okay. Ms. Beliveau, do you have any questions you'd like to ask Ms. Green?

MS. BELIVEAU: I do not. Thank you.

MR. BARBER: Okay. We'll move to Board members. The order will go to Board Member Walsh, Murman, Lunge, Holmes, and then Chair Foster. So Board Member Walsh, do you have questions?

MR. WALSH: Yes, I do.

Thank you, Ms. Greene and Mr. Schultheis. Let me just gather my thoughts from notes for a second, please. I think I'd like to start with questions regarding the uptick in April and May of this year. The first half of 2024, claimed surges in April and May. During your testimony, Ms. Greene, you mentioned that a big driver of that was medical facilities, and I was hoping you might explain that a little bit further.

MS. GREENE: Sure. I'll comment and also acknowledge that Martine Lemieux is also very familiar with the claims information that we've presented, so she could answer further detailed questions if necessary. But the uptick in April and May of course, when we experience a significant claim surge, especially this early in the year, we immediately -- our response was to immediately dive into that to see where the -- where the volumes and rates were coming from.

Some of the we -- oftentimes with a surge like that, we can see a pharmacy drug costs going up, but this wasn't the case. It was sort of in line with our expectations. And then it was on the medical side and concentrated in facilities, which means the hospitals and the -- including the drugs that are administered in the hospitals. So anecdotally, based on the data that we have been able to see so far, we've seen an uptick in some of the chemotherapies, which is, you know, important life-saving treatment for patients, and also in some of the other types of specialty drugs that are administered in the hospital.

So we're urgently following up on

that information to understand what might be happening. But yeah, that is again, kind of volume-driven, if you will. And a lot of times with the hospital estimates that we do, we're making estimates for both the unit cost increases as well as the utilization increases. So those facilities activity was a major driver of the April and May surge.

MR. WALSH: So thank you for that. It sounds -- if I'm hearing you correctly, it's both an increase in utilization and an increase in unit price.

MS. GREENE: Well, it's increase in the utilization of the things that are higher cost.

MR. WALSH: Okay.

MS. GREENE: Yeah.

MR. WALSH: Okay. Oftentimes, I'm used to thinking about this is a combination of utilization, price, and diagnostic intensity. And have you seen any change in diagnostic intensity in 2024?

MS. GREENE: Yeah, that is a really good question, if I may, to have you talk with Martine Lemieux about. We typically fold

utilization and intensity into the same assumption, and she can share what she has for information around 2024. We do know in the bigger picture, the health status of Vermonters has declined post-COVID, and we know that the more complex treatments and health conditions that members have, those are the high-cost treatments.

So we have broadly, over the last two years, seeing a shift towards those complex. But the April and May activity itself, you know, whether or not that bigger trend is also acutely evidenced in the April and May results, we're still looking at that.

MR. WALSH: So unclear at this point?

MS. GREENE: Yeah.

MS. WALSH: Okay. Thank you. I'd like to -- to talk a little bit more about medical trend more broadly. How many years make up the medical trend?

MS. GREENE: Can you say a little bit more about that?

MS. WALSH: Sure.

MS. GREENE: How many years in the

race or how many years --

MR. WALSH: In your calculations for setting this year's rate requests, how many prior years are reviewed to create the medical trend?

MS. GREENE: Yes. Again, Martine is -- is absolutely a good person to talk to about this, what we've included in the rate filing. We look at the 2023 base year of experience. So anything that has been updated from last year's rates that have to do with the base year experience. And then we look at 2023 and 2020 -- how 2024 is running through what the trend looks like and add that into rates. And then we make a projection of what 2025 would look like.

When Martine is selecting those rates of increases, medical trends for utilization, et cetera, she has a very disciplined and rigorous process for looking at a number of years. They might look at five years or three years, and they also incorporate anything that they have in their understanding of the experience that would help them understand if there was one-time effects that were affecting

those rates.

So a good example, a well-known example, is the COVID disruption was hard to understand what normal trends might look like with the disruptive disruption from COVID. We also had a major disruption in relatively recent history with the UVM Health Network cyber-attack. So there's a number of things that the actuarial team look at and review in order to determine what the appropriate trend is. And then that is all reviewed, as you know, by the actuary.

MR. WALSH: And so what I'm trying to understand thinking of a trend is, is the medical trend composed of a five-year period, a three-year period, a ten-year period?

MS. GREENE: The trend selection, as we call it, is informed by all of those views. And then the trend selection is determined based on the actuarial expertise of -- of the data and the statistics behind it. And I'm sorry if I sound like I'm avoiding questions, but I just want to make sure that there's a clear understanding that the medical trend is -- is clearly part of the actuarial science behind the rate setting.

MR. WALSH: Right. And I don't feel like you're trying to avoid anything. I feel like you're trying to clarify, and it's -- it's helpful. The medical trend, as I mentioned a moment ago, I tend to think of as consisting of many components but primarily utilization, price, and intensity.

And I'm wondering if you could provide us with a sense of, you know, in the opening statement was said repeatedly that unit cost or the price per unit is the largest driver, but I'm wondering if you could be a little bit more concrete. What proportion of the medical trend is driven by price, utilization, and intensity?

MS. GREENE: Okay. Well, if I go back to what I said at the beginning of my testimony, I think what I was intending to say was that the overall cost of paying for healthcare for our members is the overriding driver of premiums as well as in recent years' losses because our premiums have not coverage with the cost of paying for healthcare. And to connect back to your question, the -- that cost of healthcare, we make estimates for all of those

pieces, the unit cost, the utilization, the intensity, the drug components, new specialty drugs coming on.

So we make estimates around all of that, and they are just estimates. And I think the point I was making was that the overriding impact is when those estimates fall short, so our premiums, our approved premiums were not adequate to cover the overall cost of healthcare. So and all that includes all those pieces, the cost trends, utilization and intensity.

MR. WALSH: Okay. In a -- well, all three components are increasing the cost of healthcare, which you then payout, and the premiums have not kept pace with the ability to payout. That's the point that I hear you trying to make. Is that -- am I hearing that correctly?

MS. GREENE: Yes.

MR. WALSH: And what I'm trying to get a sense of, you know, we have in Vermont an access to healthcare problem. And so if we improved access, utilization may go up and it could be justified. Alternatively, prices may be rising, and that may be due to inflation or any number of factors that could drive price.

Intensity could be that indeed, Vermonters are sicker, or it could be using new software to find -- to make sure coding is -- accurately captures what's happening in hospitals. And what I'm trying to get a sense of, from Blue Cross' perspective, is one of those items driving healthcare costs any more than the other utilization, price, or intensity.

MS. GREENE: Yeah. I do think that it is all of the above. We have very high unit cost increases over the last couple of years. The budget guidance from the Board for this year was 3.4 percent, and that's what we built into our submitted rates and then we've updated that for what we submitted for that. That price has been a driver. We know that utilization trend has gone up because more people are getting care, and that's a good thing. And to your point, it does need to be paid for, so it's also a driver of the increase.

And then as I mentioned earlier, I do think intensity is also part of the equation. And it's logical to think with all of those things happening that there's no surprise in some ways that suddenly we're seeing all of these

factors come together with an acceleration of claims cost, and our approved premiums have to catch up with that.

MR. WALSH: Okay. Thank you. Switching topics a bit. What proportion of the claims paid out by Blue Cross are submitted by entities regulated by the Green Mountain Care Board?

MS. GREENE: That statistic I would defer to Martine so that she gives you the accurate statistic. It's a very large portion of that healthcare costs as part of our rates, but she can give you the number.

MR. WALSH: Is Martine due to present to us?

MS. GREENE: Yes. She'll testify later on the detailed components of the rate filing. So she -- she normally is up first, but this year we're doing something a little bit different. So she will be happy to answer those questions when she testifies a bit later.

MR. WALSH: Okay. Right. In the electronic binder that came on Friday using the page number that's -- the page numbering is difficult, but it's page 24, just the 24th page

in the electronic binder, 54 percent of claims were from GMCB regulated entities, leaving 46 percent from unregulated entities.

MS. GREENE: On that page, can you scroll to the page number to the lower right? That's in red and that would tell me what exhibit and page you're on.

MR. WALSH: I'll try. Exhibit 1, page 23.

MS. GREENE: Thank you so much.

MR. WALSH: Yeah, third paragraph.

MS. GREENE: Yes. Yes. Yeah. Sorry. This table, Ms. Lemieux includes this table regularly in the actuarial memorandum when we submit the rating. So yes, this is the Vermont facilities and providers impacted by the Green Mountain Care Board hospital budget review of 54 percent.

MR. WALSH: And in that same table at the bottom of that page, it appears that the cost trend is rising more rapidly among non-regulated entities. Am I reading that table correctly?

MS. GREENE: Yes.

MR. WALSH: Thank you.

MR. BARBER: Did you have other questions, Thom?

MR. WALSH: I'm -- I think I'm -- I think I'm looking at my notes, the rest of my questions are for L & E and DFR.

MR. BARBER: Okay.

MR. WALSH: Okay. Yeah.

MR. BARBER: And then Blue Cross' is actually will be testifying in the afternoon, so if you want to get some clarification on those questions you had, I think that'd be a good time to do that.

MR. WALSH: Right. Thank you for your time. Thanks for answering the questions.

MS. GREENE: Thank you.

MR. BARBER: Okay. Board Member Murman, do you have questions for Ms. Green?

MR. MURMAN: Yeah, and I -- and I'm sorry (indiscernible).

MR. BARBER: Dave, you're break -- we're having a --

MS. ASAY: I didn't hear you at all.

MR. MURMAN: Why don't you do someone else and come back to me?

MR. BARBER: Oh, you're good now.

MR. MURMAN: Weird. Okay.

MS. ASAY: Yeah. We couldn't hear you there for a second.

MR. BARBER: Okay.

MR. MURMAN: All right. Let's try this again.

MS. ASAY: Oh, we can hear you. Okay.

MR. MURMAN: All right. Great. So my questions are kind of jumbled together, so if you think they're more appropriate for someone else, would you please just direct me to that person, because that -- I don't know if I quite have these arranged, but I'll try to start with the ones that are specific to your written testimony, and I can work with those. Okay.

Just a second. Sorry. I need a different pair of reading glasses to read this. So -- okay. Actually, so a few that are in the L & E memo, but I think they're probably okay to discuss. The L & E memo, Exhibit 12, page 8, there's a bunch of confidential information. I'm not going to address that here. You -- sorry, this is not the L & E memo. This is your

response to the Green Mountain Care Board questions, Exhibit 12, page 8. There's this large chart of hospital relative cost. I'm just curious. It says Blue Cross Vermont internal monitoring. I was curious to know the year that that monitoring occurred? The RAND 5.0 data is from 2022.

MS. GREENE: Yeah, that is a question that I am unable to answer, but perhaps Dr. Weigel, who's testifying later, or Ms. Lemieux could possibly also?

MR. MURMAN: Okay. Okay. On the next page, there's a paragraph at the end there that discusses this sort of concept that hospitals can -- are allowed to increase their rates by the Green Mountain Care Board and then the hospital can then adjust the charge master as -- sort of as they want. And then the relationship with the insurer is to adjust sort of discounts off of those charges. Am I understanding that that process correctly there in the last paragraph?

MS. GREENE: Yes. The, you know, certain hospitals, you know, there are some hospitals that are different, but the ones that

do have the chargemaster, that is describing how that works.

MR. MURMAN: So the way I read that, to me that implies that if a hospital wants to increase their prices on one particular item when that charge master above the Board approved rate, they -- you think they can do that if they can offset that with a lower price increase in a different service; is that accurate?

MS. GREENE: That -- that's true. And as I mentioned earlier in response to the HCA question, the -- the contracting teams for both the hospital and Blue Cross look at the expectations for the mix of business. And to the best of everyone's ability, they -- they make estimates as to what that mix will look like and how the mix and the changes among those services will, in the aggregate, come back to the orders, cost increase, or the negotiated cost increase if it's slightly lower in a few rare cases.

MR. MURMAN: Okay. Let me back up. So from last year, (indiscernible) -- MS. GREENE: Your audio is breaking up now again.

MR. BARBER: Try turning off your video, Dr. Murman.

MR. MURMAN: Is there any difference there?

MR. BARBER: Yes.

MS. GREENE: Yes.

MR. MURMAN: All right. I changed -- I passed the mic to a different mic. Okay. So let me know if it stops and then I'll try my video if that doesn't work. Okay. So I was trying to say let's -- backing up a little bit, last year the Board was fairly specific in our orders that we were discussing a change in charge. In prior years, some hospitals used effective commercial rate. Does Blue Cross Blue Shield view those as different things, and if so, how?

MS. GREENE: Again, I think Dr. Weigel might be a good person to follow up with on this, but the -- we spent some time last year in hearing -- talking in great detail about how the ordered hospital budgets by the Board kind of flow into the rates, and so we are very much trying to go into each new year with an understanding of how the committed commercial rate will be implemented appropriately. It -- you know, consistent with our premium rate

assumption. Whether or not the terminology of effective rate or ordered rate, I don't know if that makes a difference.

I -- I personally don't have two different of those types of rates and so does the Green Mountain Care Board approved rate is -- was how we think about it. But then Dr. Weigel, who testifies later, is closer to it and might be able to further collaborate.

MR. MURMAN: Okay. I guess, so when you went -- from the Blue Cross Blue Shield standpoint, when you read a Green Mountain Care Board budget order, and you go into negotiations with the hospital, I guess what is the definition of rate? Is it -- yeah, I guess I'll leave it there.

MS. GREENE: Yeah. It's the published approved commercial rate increase that the Board publishes.

MR. MURMAN: And rate is defined by change in charge, change in reimbursement per unit, the amount paid by Blue Cross Blue Shield for the book of business for that specific health plan, what is -- what is the -- what do you mean by published rate?

MS. GREENE: So the commercial cost increase is what we're focused on --

MR. MURMAN: Okay.

MS. GREENE: -- and that is implemented in the way we were talking about. there's also -- well, yeah. It's the published commercial unit cost rate.

MR. MURMAN: Published commercial unit cost rate. And so -- and that -- and what is a unit in that?

MS. GREENE: Oh, unit costs as -- so the aggregate of all the services that that hospital is planning to provide in the coming contract year. The unit cost of all those aggregate services would be limited to that commercial unit cost rate increase.

MR. MURMAN: Okay. So would it be fair to say if you had the same number of enrollees in a plan, say 20,000 in '23 and 20,000 in '24, and 20,000 FY '25, that you would expect -- if the health of those people didn't change, so the services didn't change, would you expect if the unit cost, say if it went up by 10 percent, it would go from -- '22 to '23 would go from -- each year, that -- that group of people

would cost 10 percent more to pay for at that hospital?

MS. GREENE: True. That -- that -- in that example with all those assumptions, that's true.

MR. MURMAN: Okay. So if -- as -- as Thom Walsh was saying, if the intensity of the services were to increase, that -- to those patients, that would then not be reflect -- would that be reflected in the Board-ordered rate change?

MS. GREENE: The intensity and the utilization tend to happen according to the healthcare needs of the population in the year. So, you know, that's an assumption that the actuaries are, you know, looking at all of the historical information and the current information to see what they think that increase would look like. So it's the unit cost trend and then an additional trend for utilization and intensity.

MR. MURMAN: Okay. And my understanding, from what I've read and what you just said to -- to Thom Walsh, is that utilization includes intensity in a sense. Is

that -- so let me ask that -- go ahead. Yeah.

MS. GREENE: So just -- when I say that, I just mean to say in the way we develop rates, we're folding those two -- we look at them, but when they're expressed in the actuarial memorandum, and we put them together. They are different -- clearly different assumptions. You can use -- use more of the same, or you can use more intense services and both things would affect rate.

MR. MURMAN: Okay. So if a hospital or a group of hospitals, or providers were to work diligently to try to improve their documentation integrity is the term often used, which would then increase the intensity for the same services provided, but actually, you know, document it appropriately so that that reflects the services provided, can Blue Cross Blue Shield monitor if that's occurring, and if so, how?

MS. GREENE: We -- we don't have a lot of granularity to know what would have been coded previously, you know, if there's been an effort. There is a lot of literature written about coding growth, and it comes into play often with our risk adjustment work. So we do have

people who are studying the trends there. But we, you know, it could be a dynamic that the intensity has always been there, but the coding's now reflecting it appropriately. That's a possibility as well. But I think the claim has to be paid and the healthcare was provided, and the cost has to be covered by premiums.

MR. MURMAN: Yeah. I agree. What I'm trying to understand is say, for instance, within Medicare, which I know that's not what you do, but in Medicare fee for service, there's the case mix index. And so the case mix index is reflected by the documentation. And a higher case mix index basically reflects on a higher payment from Medicare. And there's efforts made to improve the case mix index documentation for a -- for groups of patients such that it reflects the care delivered.

In commercial, if the -- if there's a -- if there's the element of price that gets negotiated into this as well, because we're not fixed prices, like Medicare as case mix indexing increases, the equivalent of case mix index within commercial, higher amounts are paid for the same care, which is true with Medicare,

but prices have been established over time to support hospital budgets with less rigorous documentation.

So there is this nuanced thing that occurs that if no different services are being provided at these high prices, you end up generating more revenue -- hospitals would generate more revenue and thus, cost more than would be expected. And I'm trying to figure out if that could be related to this recent surge that you discussed in your testimony. So is there any sort of -- is that -- do you think that -- is there any indication that that's playing into this cost surge?

MS. GREENE: Yeah, we -- I have not done a deep dive to study if in fact that is the case. However, we do -- last year, during the budget -- hospital budget review process, we understood that there was going to be a focus at some of the -- the facilities on the Medicare coding documentation as a way to improve the -- the revenue coming through Medicare.

And we were concerned to a degree that that would have a sort of a ripple effect that as the process internally was improved to

more accurately -- more accurately reflect that diagnosis codes and intensity that it wouldn't be necessarily done for Medicare patients, that it probably would trickle over into commercials. So that -- that is a dynamic that we need to be watching.

And to the degree that that occurs, then the experience will become higher, and that does drive some of the trends. So that is part of the overall claims costs that we -- our premiums have struggled to keep pace with that increase.

MR. MURMAN: So I have a few questions. I'm trying to keep them in order in my head, but I think maybe we'll -- I'm going to sort of divert a little bit, because we got talking about this surge in costs through the spring here. And that -- you said it was -- you broke it out. You said it's most notably within hospitals, and one component of that was expensive therapeutics, expensive chemotherapy agents, for instance. Are there other components of the hospital increase that are outliers?

MS. GREENE: We -- based on the data that we have so far, that is the -- one of

the things that stuck out. Everything else seems to be with increasing generally, but we continue to look at that.

MR. MURMAN: Increasing generally over the forecasted?

MS. GREENE: Yeah, sort of the -- all aspects of the medical cost. The main take away for the April and May surge is that it was focused more on the medical side and more in the facilities, and not in prescription drug. I think we've had a lot of increases over the last few years, and they're often driven by just escalation in the prescription drugs trend. So my purpose in highlighting that was just to make sure that we -- we understood that it was in the medical category that we were seeing the surge --

MR. MURMAN: And do you --

MS. GREENE: -- we continue to look at it.

MR. MURMAN: Sorry. Go ahead.

MS. GREENE: No, that's all I needed to say.

MR. MURMAN: Okay. And do you know if that surge is occurring in the 46 percent of the non-Board-regulated entities as well as

the 54 percent of the Board-regulated entities?

MS. GREENE: I do not know the answer to that question off of the top of my head. I do know that it is happening in the hospitals that typically proportionately have a high share of our overall claims. But again, that is something that Ms. Lemieux could speak to more (indiscernible).

MR. MURMAN: Okay. So would she -- do you think she'd be able to give a distribution of that surge if it's happening in specific institutions or?

MS. GREENE: Probably not today. If there's something specific that you would find helpful, we can take it as a follow up.

MR. MURMAN: Okay. Thanks. Give me a second. I just need to look through my notes here for a moment. Mr. Donofrio said -- I don't know if he's still on or if he would be able to speak now, but the Vermont healthcare costs are rising at unsustainable rates. And I was curious if he has any information of comparison of that he looks at or that you look at compared to other states or regions of the country for comparison. Is -- do you -- does

it -- is it your position Blue Cross Blue Shield, and I'm not asking you to speak for him, but for you, Ms. Greene, is it your position that costs are rising in Vermont differently than others -- other regions of the country, or do you think this is similar or even trend?

MS. GREENE: Well, I will say that the Blue Cross Blue Shield of Vermont management leadership team has been very interested in the materials that the Green Mountain Care Board actually has been publishing around comparisons of Vermont cost to cost nationally, and it does seem based on that information that Vermont costs are higher than many other parts of the country.

MR. MURMAN: And does Blue Cross Blue Shield have any other information they use for those comparisons that you think would be helpful for the Board to -- to use or understand?

MS. GREENE: Other than the comparisons that we included in the responses to the questions, I would have to defer to the -- the team to answer that question.

MR. MURMAN: Okay. Thanks. I think I'm getting near the end here. Sorry. I got a little jumbled with different people's

questions.

Thom Walsh brought up Exhibit 19, page 15, sorry. It wasn't Thom, it was Eric Schultheis that -- we continue to closely monitor hospitals that exceed their commercial rate commitment, and plan to approach them for relief. Can you describe what that relief might look like?

MS. GREENE: So the conversation takes the form of us sharing with each of the hospitals that we're talking with, sort of our understanding of how the previous unfolded.

And then, you know, the hospital has to look at their own analysis, and our analysis. And so the -- the relief is, sort of, in the context of the committed rate in the contract, to say that there was a commitment made that was exceeded.

We calculate, you know, quantify the value of that and talk with the hospitals about either receiving some of that money back or some sort of future contract change, or -- or something along those lines.

MR. MURMAN: And is it a process that you've done in the recent years at all?

MS. GREENE:: As I mentioned, we've -- we -- the monitoring process we've done in the past, but it was only in recent years where we've been noticing that there was some things that we needed to more deliberately follow up on. Because, you know, an average hospital is -- you know, a typical contract might be over in some years and under in some years. And as long as it kind of evens out over time, and is a modest amount, , there -- there would be just a -- a mutual understanding of that information as it goes into whatever the next year's contract conversations are.

But we, you know, this is something that we do regularly, but it was worth mentioning because we have some items that we expect to be following up with.

MR. MURMAN: Are there specific hospitals that tend to be continuously under or continuously over -- or frequently under of frequently over the contract allowed amounts?

MS. GREENE:: They have a large --

MR. MURMAN: We can speak about that in executive session, if needed.

MS. GREENE:: Yeah. I think that

would -- that would be good. We can also talk with Dr. Weigel , who's testifying as well in the executive session.

But it tends to be the larger hospitals, because the larger hospitals -- if an assumption is off, it would throw off a larger variance.

MR. MURMAN: I'm actually -- I'm maybe more asking less about the variance from the -- but the trend of being on one side or the other.

MS. GREENE:: Yeah. I can say that the trend that you're seeing in a couple of hospitals is that it's been over. But again, the backdrop of post-Covid has made it very difficult to discern, you know, whether or not that is something that is -- I'm sure is an unusual one off because care (indiscernible), or if it's sort of a -- a more fundamental assumption in how the contracting is pulled together.

So I'm a little reluctant to call it a trend, because it's -- trends have been very up and down lately.

MR. MURMAN: Okay. I appreciate that. I know that you came up first largely to

talk about RBC and the -- the crises of the RBC situation at Blue Cross, Blue Shield, and I -- I only -- sorry, I have one question for you related to that, which is does -- Blue Cross, Blue Shield is part of a national Blues, and your -- all your peer Blues around the country.

What is the -- do you compare your RBC ranges, you know, barring the state-related goals. But what is the -- what is the peer group RBC range that's acceptable within the -- the national Blues, or is there one?

MS. GREENE:: Yeah that's a great question. So the collection of Blues plans in total tend to have a -- a weighted average RBC that is much higher than even our required range. When we spent our required range of 590 to 745, it was relatively low among peer group Blue plans.

That said, we also have a well-established monitoring level for blue plans that is 375 RBC. So any blue plan that drops to that level or -- or trends towards that level over a couple of years is often talking with the association.

But the vast majority of the blue

plans are at RBC levels much, much higher.

MR. MURMAN: And are there specific numbers that are used above that 375 that Blue Association recommends?

MS. GREENE:: In terms of above 375, do you mean?

MR. MURMAN: Yeah. Like, what's the -- is there a range that they -- that they feel is healthy?

MS. GREENE:: Yeah. The -- the Association, you know I won't speak to them -- speak for them, but my understanding is that they, like the NAIC, which is the National Association of Insurance Commissioners, recognize that the RBC is set for each entity, and it's unique for the risks taken on by that entity.

So I think they would struggle -- not the right word, but they would struggle to set one RBC for all Blue plans. So -- and I think L & E commented about that, and certainly the report that was issued when our target range was published. It -- it very much talks about that each company has a unique range that they need to manage within, based on the risk that they write.

MR. MURMAN: Okay. I have one more question. It's kind of like almost -- it's a fairly awkward question to ask, but I want to sort of just bring up a common critique of health insurers that I hear -- you know, I'm a physician, and there's, you know, we can -- I get -- here we go, I've got all these, you know, ASEP (phonetic) weekly, these come in my -- my mail on a daily basis.

The common critique of insurers is that one of the reasons for growth in healthcare cost in the United States is the profit-seeking behavior of insurance. Whether it's profit seeking in non-profits, or profiteering in for-profits, that's driving up the cost of care; high salaries, big bonuses. I was just wondering if you could discuss your thoughts and address that -- that critique.

MS. GREENE:: Sure -- I -- I appreciate the candor. Blue Cross is a not-for-profit company.

I think you can see from the information that we've provided in testimony that we are not making loads of money; we are in fact loosing lots of money. We are here to serve

Vermonters, and we're focused on serving as many markets in Vermont, full of Vermonters as we can.

In terms of large salary and executive pay, our -- our Board reviews that every year, and it's benchmarked against similar-sized companies, and that is shared every year in a report with the Department of Financial Regulations.

And I think operating in Vermont on behalf of Vermonters is, in my opinion, very different than what some other markets might be experiencing in terms of how insurance companies might be operating or behaving in their local markets.

MR. MURMAN: Great. Thanks for your -- thanks for your testimony this morning; thanks for taking my questions.

MS. GREENE:: Thanks.

MR. BARBER: Board Member Lunge, do you have questions?

MS. LUNGE: Thank you. I do.

Thank you, Ms. Greene. Is it okay if I call you Ruth?

MS. GREENE:: Yes, please.

MS. LUNGE: Thank you. And of

course, call me Robin if you like.

So I do have a couple of questions. I think, quite frankly, most of mine will be for executive session, because I wanted to ask about some of the redacted areas of your prefile testimony, and also for a little more information on the Medicare Advantage business that we've -- you've talked around a little bit.

So in your prefile testimony, which is in Tab 19, on page 5, you indicate that you have active plans to "improve revenue and margin across other lines of business."

Could you speak in a little more depth to those plans?

MS. GREENE:: Sure. That's page 5 of the testimony?

MS. LUNGE: Page -- yes. It's page 5, the red page 5.

MS. GREENE:: Okay. Thanks, nonetheless, thank you.

MS. LUNGE: It's line -- do you need the lines? It's lines 22 and 21.

MS. GREENE:: No I'm -- I'm sorry, I was just looking for the reference. The increased revenues and other lines of business,

the Board is aware that for many years, we served large clients that are often, due to the competitive market and the process of a request for proposal, or RFP, the rates that we're able to renew and win that business are below the cost of serving those businesses.

That said, we -- we have implemented -- because of the need to have all of our market segments pay their way, we have been implementing, and we've been successful, having new types of revenue for services that we do on behalf of the large clients, and they benefit. And then, we share in the savings in a way that adds to the bottom line, and reduces the losses on that book of business.

MS. LUNGE: Thank you. Would that -- would that -- and if, again, if this is executive session, please just let me know, and I'll save it. Would that include, for example, state employees, teachers, and -- as large clients that you bid for?

MS. GREENE:: It would be all of the large clients that we bid for, and each of those contracts is somewhat unique. And we can into more detail in executive session if

required. But each -- each client relationship has, you know, some of those relationship utilize our pharmacy, PBM; others do not. And so each circumstance leads us to a different set of levers to talk about with those clients.

MS. LUNGE: Thank you. So on page -- so if you could turn to pages 14 and 15 of your pre-file testimony in tab 19?

MS. GREENE:: Sure.

MS. LUNGE: So on the top of page 14, there's a chart that shows a comparison of member months to capital requirements. Do you see that?

MS. GREENE:: I do.

MS. LUNGE: Okay.

MR. BARBER: Robin?

MS. GREENE:: I believe that particular chart is redacted. It's hard to see, there's a blue --

MS. LUNGE: Oh, oh, oh; thank you.

MS. GREENE:: -- blue line under it.

MS. LUNGE: Okay.

MR. BARBER: Yeah.

MS. LUNGE: Got it, thank you.

I'll save it. I didn't notice the line around it, so I appreciate that -- pointing that out.

MS. GREENE:: No problem.

MS. LUNGE: Okay. So I'll come back to that. Lower down on that same page, there's a reference to Medicare supplement products and the premium increases in 2025.

We don't regulate, as you know, Medicare Supp, so I had a couple questions about the filings there. Do you have an RBC or a CTR contribution -- I'm sorry, a CTR contribution in -- in Med -- Med Supp plans?

MS. GREENE:: Yes we do, and it's -- historically, it's been the same as our other insured businesses and we will be seeking seven percent on that rate as well.

MS. LUNGE: Okay, thank you. That was my question.

And then on page 15, in the fourth bullet down, you indicate that you're seeking a number of formulary changes, or you're contemplating a number of formulary changes. How frequently do you form -- do you typically do formulary changes?

MS. GREENE:: Yeah. We have to

watch formularies constantly because of the -- the way the pharmaceutical industry shifts, and our PBM helps us keep up with that.

We make formulary changes typically twice a year, and they both -- both cycles require some very disciplined communication and advance communication to members impacted, et cetera. It's usually changes that come with the -- the turn of the calendar to January, and then there's usually a change -- well, there might be a change midyear. We don't have to do them twice a year, but if there's a need for a change, we can do them midyear with the appropriate notice.

MS. LUNGE: Okay, thank you. So what -- in terms of doing something differently from normal related to the RBC range have you been contemplating with formulary changes? Or is this just your normal review?

MS. GREENE:: Yes. Well I think normal -- it's hard to describe what normal would be, but because the pharmaceutical company -- or pharmaceutical companies have a lot of drugs that are moving through approval, and some of them are brand, and some of them are generic, et cetera, a

lot of times, the formulary changes are related to moving drugs between tiers because, for instance, maybe a biosimilar has -- has come out and been accepted by the medical community as a -- a replacement drug. And that might be significantly more cost-effective option. And so working with our PBM, we would -- we would be watching that, and making those types of changes.

I would say we would do that on a regular basis. And then, you know, depending on what's going on with FDA approvals, et cetera, there may be years where there's more changes, and there might be years where there's less changes.

MS. LUNGE: Okay. All right. So I'll just ask one more time, how is that connected to using towards the ordered range?

MS. GREENE:: Right. So if -- when we develop the rates for 2025, we have to make certain assumptions about the cost of medical care and the pharmaceutical care, and it assumes certain formulary. So what we're doing here is saying okay, we have to keep working that lever, and if we find an opportunity to make a change that find we can make, and can make it

midyear, that -- for the half year that that's implemented, that would fall -- because the rates have been set for that year, that would fall to RBC. But then, the cost improvement in those changes would fall into next year's rate -- premium rating because it comes in as part of experience.

So it's -- it kind of related to the timing, and we just know we have to not wait until the following year to make that happen. And especially under today's circumstances, we don't want to leave any money on the table, so to speak, to have those changes happen.

MS. LUNGE: Okay, thank you. On page 17 of your prefile testimony, you talk a little bit about this affiliation with Blue Cross Blue Shield of Michigan. And I'll give you a moment to get there.

MS. GREENE:: I -- on page 17 of Exhibit 19?

MS. LUNGE: Oh, I apologize, page 18. Sorry, I was looking at the -- the wrong page number.

MS. GREENE:: Yep.

MS. LUNGE: Okay. Thank you.

MS. GREENE:: No I -- I see the questions you're referring to now.

MS. LUNGE: Thank you. So I know that you have been speaking with them about transitioning your technology and systems and expect, as you note here, to forgo substantial expenditures on technology. Could you please -- do you have a quantification of that, and also could you give us an update on when you expect to transition your technology and systems?

MS. GREENE:: Sure. So the -- the way to think about the forgoing substantial expenditures is one of the challenges that we have operating as a small, locally-focused Vermont company, is that we lack the resources to invest in some of the newer technologies.

And examples might be the data technologies that are required to back some of the -- the member and provider-facing services -- portals and -- and apps, et cetera.

So we have not been able to keep pace with those technologies because it requires a -- a large investment. So that is, in fact, one of the large drivers behind our seeking an

affiliation. We wanted to affiliate with a company who has significant capabilities in that space. And they've already built them, so we don't have to start from scratch and build those.

The thing that is -- needs to be clear is that those costs are costs we're going to avoid. So they -- we could not put them in premiums because our marketplace really can't afford the large investments. So what we'll do is be able to access those capabilities, pay something, you know, reasonable to have access to those capabilities, and forgo coming to -- do the first-dollar investment is what we say.

In terms of timing, we are working through the planning for that because the affiliation was approved last fall. We have been taking inventory of the more, you know -- the more detailed technologies and figuring out what order, and where do you start, and how do you build on that. And that planning is continuing into this year. We do expect to understand what the -- the order intake will look like, and it will happen over a number of months or years as we work through that.

But it should begin soon, in terms

of the Vermont technology being able to take advantage of some of the -- the Michigan capabilities -- perhaps as soon as soon as next year.

MS. LUNGE: Would you expect that some of the technology would help with cost containment?

MS. GREENE:: I would expect that some could help with cost containment. More likely, and this is what we see all the time, is often when you want to implement a new program, whether it's a -- for example, say a pharmacy benefit management program or a medical management program, you would quite often -- working with tools and vendors that are cost prohibitive. And so we're looking for both some efficiencies as well as being able to input -- cost effectively implement programs that up to this point we haven't been able to do so in terms of technology and tools.

MS. LUNGE: Okay. Thank you.

I think everything else I have is for executive session.

MR. BARBER: Okay. Board Member Holmes?

MS. HOLMES: Great, thank you.

Thank you, Ms. Greene. I guess I just first want to acknowledge I recognize it's a tough year to come before the Board. It's also a tough year to sit on the Board.

MS. GREENE:: Yes.

MS. HOLMES: Yeah. It's just a tough year all around. So actually -- some of my questions have been asked and answered. That's helpful. A few I think I still have for executive session.

I think I'm just going to put in a request that -- for two follow-ups that -- because of questions that I've heard already, the questions that I had. So maybe just putting in a request for the two -- two things.

One is how the higher-than-projected medical facility utilization is distributed across both Vermont, and border New Hampshire hospitals. So expected utilization, you know, the excess utilization, basically by hospital, I think, would be -- probably answer a lot of our questions. And I would -- if it's possible, I'd like to include those New Hampshire border hospitals were a lot of Vermonters get

their care.

And then the second follow-up question is whether or not it would be possible to get that historical breakdown -- historical five to seven years, I don't know, something like that. of the overage or underage of commercial rate commitments again by hospital. And then whether relief for overages were granted, if you have that. I think that might be helpful to all of us.

MS. GREENE: Yep.

MS. LUNGE: Or at least I'll say to me, but I'm guessing from the questions of my prior Board members, it might help us. And if somebody wants to amend or add something to that, I -- we -- you know, we can get to -- but I think that would be helpful to us. I think we're really trying to understand what's been happening at the hospital level, since as you know, we regulate the hospital level. And so it's helpful for us to hear from your viewpoint what's happening with overages, and -- and how what we think we're doing in hospital budget decisions are translating into what actually happens on the ground. So those are my two requests.

And then I have just a couple questions at this point. One is I'm trying to understand a little bit better the relationship between membership size and RBC. So in particular, looking at the -- there's been, like, about a 40 percent growth in QHP members on the individual market between '22 and '24. So I'm wondering how has that impacted RBC.

MS. GREENE: Yes. The -- the growth in individual QHP has impacted RBC through that authorized control level calculations. So the additional membership and the claims that they -- the estimated claims that they bring inbound, serves to increase the authorized control level, which then means we need more surplus or member reserves in the numerators to sustain our weekly.

Some of that growth came from the Medicaid redetermination. So that was another thing that happened somewhat uniquely over the last couple of years. Because during COVID, the -- my understanding is that the State could not remove anyone from the Medicaid roll.

So after a certain period of time, I'm forgetting exactly when it started, but they

had to recertify all of those people, and renew it from some of the qualified health plan individuals who had come to us. And so that was the source of some of that growth. But yeah, hopefully that answers both questions.

MS. HOLMES: Yeah. Well, I guess I'm also then trying to think about the rates that you're requesting this year are -- are substantial, that's an understatement, or high. And I'm wondering if there's been an analysis of the impact of these particularly high written requests on expected membership, which would likely decline, or potentially could decline.

These are going to be -- I will use the term "unaffordable" for some people. I know there's lots of ways that we're trying to define affordability, but there are going to be able to absorb these rate increases. And so I'm wondering if you've done -- if Blue Cross Blue Shield has done an analysis on the expected reduction in membership as a result of the rate increases and then how that will impact RBC.

MS. GREENE: Yeah, that's a -- that's a great question. So first and foremost, we need to ensure that the premium rates for the

membership that we have and expect to renew are fully funded and include sufficient RBC -- or sufficient CTR to support our RBC recovery.

You're right, though. With such high increases, and not a lot of choices. People don't have a lot of choices on what to do if they can't afford Blue Cross' increase. We do expect that we might lose some membership.

And the impact of that loss of membership in the short run will -- will help relieve some pressure on RBC; you're absolutely right. But it is -- it is not the way that we would, sort of, sustainably repair the RBC levels, given that ultimately we need to have a -- an ongoing and continuing presence in the market to provide coverage to people who want Blue -- Blue network coverage.

So yes, it will -- we can estimate -- we know that some of the modeling, maybe a little some, is if you were to lose as much as 25,000 members as a result of this, that's a huge number, that would serve to increase RBC by 100 percentage points.

So it would take a lot of membership losses to, even in the short-term,

right the RBC ship. And certainly the sustainability has to be grounded first in the premiums to -- to cover the estimated -- the cost of healthcare, cost of insurance, and CTR. So that is a dynamic that, frankly, we might have masked some of the underfunded premium dynamic in past years, because when we lose membership, those RBC have a little bit of a benefit going on there. But overtime, we need to fully fund a CTR that sustains the RBC.

MS. HOLMES: Thank you. No, and I understand that. Is there an estimate of the expected membership levels for the independent and some -- individuals, sorry, and the small group market, as a result -- if the Board were to approve the rates in full?

MS. GREENE: Yes, so --

MS. HOLMES: Is there expected membership numbers?

MS. GREENE: Yeah the -- the rate filing itself, and I might Ms. Lemieux when she testifies. She can point you to where that is in the binder.

MS. HOLMES: Okay.

MS. GREENE: The rates by, like --

MS. HOLMES: That's -- so that's inclusive of that?

MS. GREENE: Right.

MS. HOLMES: Okay.

MS. GREENE: Well it's -- I would say with the additional seven percent CTR, those estimates are probably high.

MS. HOLMES: Okay.

MS. GREENE: Because we made those estimates with the original filing if that make sense.

MS. HOLMES: No that makes a lot of sense, I was wondering if there -- if there was going to be an adjustment based on the updated rate requests. So maybe when Ms. Lemieux can -- testifies this afternoon, maybe we'll hear more about that. That would be fantastic.

And my next question really, and I'm just going to make this my last question, is trying to understand -- with all of the hospital and insurance price transparency data that's readily available on the internet as a result of the federal changes over the past few years, I'm wondering if Blue Cross Blue Shield has done any analysis of how the negotiated rates at Vermont

and border New Hampshire hospitals compare to the negotiated rates of the larger out-of-state insurers like United Healthcares, the -- you know, the Aetnas the Cignas.

Whether you're looking at the hospital based websites, or the carriers' websites, I'm wondering if -- if you've all done an internal analysis to see if the negotiated rates at our hospitals and our border hospitals, how they compare.

MS. GREENE: Again, this would be a good topic for Dr. Weigel to comment on more -- in more detail. But I do know that we're looking at the same data that everyone else is looking at, especially as it relates to some of the bigger hospitals and what the -- what our most -- or close competitors are for the business in Vermont, and how our rates compare to their rates. I -- I've been involved with a few follow-up conversations around that dynamic, so I know it's occurring. But in terms of the extent of it and any conclusions from it broadly, I would have to defer that to my colleagues.

MS. HOLMES: Okay. Then a foreshadowing of my question to come. Okay. I

will leave it there. Thank you very much, I appreciate it.

MR. BARBER: Chair Foster?

CHAIR FOSTER: Just a couple of questions.

Ms. Greene, you spoke about hospitals exceeding the commercial rates approved by the Board, can you give us a sense of the magnitude of that for last year?

MS. GREENE: For 2023, we had at least one hospital that -- the calculation -- by our calculation, and this is yet to be reviewed by the hospital, but our calculation is as high as 10 million dollars that the -- that is somewhat of an outlier, hence, the reason why it's on my list of follow-ups, since that data is somewhat a new circumstance.

But -- but they are significant enough to (indiscernible) resources in pursuing.

CHAIR FOSTER: And in 2023, was it just one hospital, or were there others?

MS. GREENE: There were other hospitals. I don't recall exactly how many. Some hospitals were -- were over, but by much smaller amounts.

CHAIR FOSTER: And was 2023 an outlier in terms of the magnitude of overage?

MS. GREENE: As I mentioned earlier, 2023, from our perspective, was an outlier. 2022 also had variances to the contracted commitments. But again, it was difficult with all of the post-COVID claims processing to know how much of that was, sort of, just unique for that year, or if it was a trend that needed to be pursued. But that's part of what we're currently working through at the moment.

CHAIR FOSTER: Could you send us a chart of each hospital that had an overage in the last five years and by the amount of money please?

MS. GREENE: Yep. I believe that's similar to what Board Member Holmes, so five year overages and underages by hospital. Yep.

CHAIR FOSTER: Yes please.

MS. HOLMES: And also just -- sorry, just to add, and whether relief was awarded or not? Or given or not?

MS. GREENE: Right I have that on

there. If relief was granted, yep. Will do.

CHAIR FOSTER: Has Blue Cross ever notified the Board of these overages before -- before this year? I mean I know I had a discussion with somebody at Blue Cross at one point about this. But prior to this year, was the Board being notified in real time of overages?

MS. GREENE: I am not aware that we have been notifying on a regular basis. I know, through the rate review process last year, we provided a lot of information around -- I remember those very detailed charts that were hard to read, but we've provided a lot of information around what -- what the commercial rates were, and then what we actually saw by hospital by year for a number of years.

So we've provided various information through different parts of the dialogue, but I don't think we've provided that on a regular basis in a -- what you might describe as a real-time basis.

CHAIR FOSTER: How much RBC does $10 million translate to?

MS. GREENE: Ten million dollars,

our rule of thumb is .3 for a million. So that's 30 percentage points, but you might want to check my math. Sorry.

CHAIR FOSTER: Yeah, okay.

MS. GREENE: Thirty-three.

CHAIR FOSTER: I thought I recalled last year seeing -- there's a chart that you -- you all provided with the amount of rate increase that was negotiated with -- between Blue Cross and hospitals.

Has Blue Cross ever negotiated with a hospital for a rate increase that exceeds the Green Mountain Care Board's approved cap? I'm not talking about, like, through overages based on allocation of rate --

MS. GREENE: Yes.

CHAIR FOSTER: -- but an actual overall. Has Blue Cross ever negotiated a rate above what the Care Board capped it at?

MS. GREENE: If we have, it's very rare, and I will again defer to my colleagues to answer the question factually. I -- I do know that there's circumstance from time-to-time where -- and I hear from our contracting people that this particular hospital -- we were able to

achieve something better than what was in the order, but it -- it usually has some -- some circumstance related to it that's unique to that hospital. Not so much that -- I think we've shared with you over the last year, and maybe two years, what we've asked for in our negotiations, and what we would have gotten. And those results have been shared with you in a tabular form. So I don't have that knowledge here as I sit her today.

CHAIR FOSTER: I -- I recall that. What -- what would be the kinds of circumstances where Blue Cross would agree to give a hospital a rate increase that exceeds the Green Mountain Care Board's cap?

MS. GREENE: I'm sorry. I thought you were saying below the cap, but something that exceeds the cap?

CHAIR FOSTER: Sorry let -- let me back it up, yeah.

MS. GREENE: Yeah.

CHAIR FOSTER: By -- yeah. Has Blue Cross ever negotiated a rate with a hospital above the cap that the Care Board approved with the hospital?

MS. GREENE: I'll have to defer to the report that we sent you. And I will have to dig that out and look at it, and see if there were any.

(Court Reporter and parties confer on audio technical difficulties.)

MR. BARBER: So Chair Foster, if you want to pick things back up.

CHAIR FOSTER: Just a couple others.

Ms. Greene, the Green Mountain Care Board's hospital commercial rate approvals, can you explain how those are applied to hospital administered drugs?

MS. GREENE: Hospital-administered drugs are part of the medical services in the contract. So those would be part of the overall contracting agreement. Whether or not the drugs are part of the commercial rate increase itself or some other benchmark I -- I will have to take that back. That's a good question. I just can't speak to it directly.

CHAIR FOSTER: It sounded like -- I think it was from Dr. Weigel's testimony -- written testimony, that Vermont has the most

expensive hospital-administered drugs in the United States of America, and I was trying to get a sense of how and when that happened. If you can speak to that at all?

MS. GREENE: I -- I cannot speak to that. I think that would be appropriate for Dr. Weigel to speak to.

CHAIR FOSTER: Then the risk pool on the QHP market, could you speak generally to how the risk pool in the QHP market compares to the risk pool for the non-QHP market?

MS. GREENE: In a -- broad sense I think that they --

CHAIR FOSTER: That's --

MS. GREENE: I'm hearing an echo now, sorry.

CHAIR FOSTER: That's fine.

MS. GREENE: Okay. In a broad sense, because the QHP premiums, especially on the individual side, are -- you know, you know among some of the highest. I would say that the -- the risk pool in that (indiscernible) is higher than some of our others. We also know that small groups have a lot of choices in the marketplace. So oftentimes, if they have more

unhealthy people or higher claims, they will end up in the QHP risk pool. But I do think that the -- the large employers often will have a bigger population with a larger variety of age groups, et cetera, that changes the risk pool.

But I -- as I said here today, I couldn't give you a specific statistic between the risk pools. That is something that we certainly could follow up on.

CHAIR FOSTER: Yeah I'm trying to understand why the QHP markets go up so, so, so significantly, and painfully as you all have appropriately recognized. This is simply painful; it's just painful. And I don't really know what best to do about it. So I'm trying to understand as best I can what is going on. And I'm pinpointing that perhaps the risk pool is part of it, which would be a bit of an unintended consequence and that we have community rating, and it's actually driving people who have worse conditions to a QHP market that's far more expensive. That's a concern.

MS. GREENE: So we -- yeah no, I -- I absolutely agree this is painful for everybody. We've got to figure this out for

Vermonters. I think the -- the large group manual rate increase I think is in the high teens, we just have a percent of CTR, but they will also -- the large groups will -- insured large groups will also pay based on their experience. So if they have extremely high claims, they will have very high increases. Even the self-funded employers -- I can speak to Blue Cross as an employer, we've experienced significantly higher claims in the last couple of years, and I would expect to have equally higher claims experienced because of the utilization and that intensity, and the -- the declining health status of Vermonters.

So I -- I do think that (indiscernible) are high teens, 20 percent, even before the seven percent CTR. All of these are experiencing, in my view, pretty consistent high increases.

CHAIR FOSTER: You're anticipating my question. The self-funded plans, the rate increases on the self-funded plans, can you speak directionally to how they compare to what we're seeing in these QHP rate increases?

MS. GREENE: So the -- when we

talk about rate increases for self-funded plans, I speak about their, sort of, claims cost increases, which is something that they have to plan for, because they're covering the claims.

But the claims projections that we would be providing those plans are also very, very high. For example, all the teachers have had very high increases in the last few years in part for the claims trends that we've been speaking about today.

CHAIR FOSTER: Okay. And maybe this is for follow up, but in terms of the claims surge, I think you had said this to somebody else, but you're seeing it really isolated at hospitals, not at non-hospitals; is that right?

MS. GREENE: Right. For -- for those two months, which -- because claims are not, you know, they don't happen instantaneously and then we see them, we're still seeing some of the April and May claims come through. So as we learn more and more about that, we'll -- we'll be able to see what further trends there might be there.

CHAIR FOSTER: And do you have any ability when you review that information to

determine whether or not it's -- I don't know the right way to phrase it, but a desirable increase in excess. Are we talking -- is there a way to distinguish between inappropriate care or unnecessary care versus a surge that is something that is desirable and that the access gates have opened up somewhat.

MS. GREENE: Yeah the -- the number of moving parts makes it really difficult to really understand to a granular level the cause and effect. But we do -- you know, our -- our staff at Blue Cross who review the claims and look for the -- the waste and abuse from the things that might be, you know, habitual coding inaccuracy, or something like that. Those have a longer tail on them and a lot of times we don't see those patterns until that team had a chance to really look through things.

But certainly, the dynamic that Board Member Murman mentioned about the increasing the documentation at some of the hospitals, resulting in potentially additional claims for the additional intensity is something that again we -- we have a difficult time seeing what would have happened had they not been doing

that. So whether that's new intensity, or previously undocumented intensity, it's hard for us to tell the specifics in that area.

CHAIR FOSTER: All right, thank you.

I have no other questions. I appreciate it.

MR. BARBER: Bridget, do you have any redirect?

MS. ASAY: Yes very briefly, thank you.

Ms. Greene, there was some -- there was a question from a Board member earlier about the definitive costs, including salaries.

Are there any benchmarks that Blue Cross uses for executive salary?

MS. GREENE: The --

MR. BARBER: Can I just -- I'm sorry. Can I just interject and just ask folks to just speak up? I'm having a little trouble hearing.

MS. GREENE: Sure.

MS. ASAY: Absolutely. Should I repeat the question?

MR. BARBER: No I think I got it.

It's just -- it's just on the edge.

MS. ASAY: Okay.

MS. GREENE: Yeah. The executive committee of our Board does review the executive compensation against benchmarks, and they use an external consultant. I believe it's SullivanCotter that does the benchmarking for the Board.

MS. ASAY: I just want to point you to -- I'd like to point you to Exhibit 16, which is the DFR report. Page 1 on Exhibit 16.

MS. GREENE: I'm there on page one of Exhibit 16.

MS. ASAY: Right. So in the 3rd paragraph, I think we discussed this earlier, and you testified that this letter states that Blue Cross has triggered a company action level event. Do you see that?

MS. GREENE: Yes.

MS. ASAY: And do you see that in the next paragraph the reference to Blue Cross developing and providing DFR with a risk-based capital plan to identify corrective actions?

MS. GREENE: Yes.

MS. ASAY: Would you please summarize for the Board what the most important action of that plan is?

MS. GREENE: Yes. As part of the corrective action plan, the number one most important aspect is to achieve fully funded rates in all of our insured lines of business, including a seven percent contribution to reserve. That is the headline of that corrective action plan.

MS. ASAY: All right.

I have nothing further for the witness at this time, until the executive session.

Thank you, Ms. Greene.

MR. BARBER: Thank you.

Eric, any cross on that?

MR. MURMAN: No further questions, Chair Barber.

MR. BARBER: Then, I think we're ready to let Ms. Greene go for the moment and move onto the witnesses for Department of Financial Regulations.

So Jesse and Commissioner Gaffney, are you with us?

MR. GAFFNEY: Here, Mr. Chair.

MR. LUSSIER: And this is Jesse. I'm here. Can you hear me okay?

MR. BARBER: Yes. I can hear you just fine. Thanks.

Are you ready to take the oath?

MR. GAFFNEY: Yes.

MR. LUSSIER: Yes.

MR. BARBER: Okay.

Whereupon,

MULTIPLE PARTIES,

witnesses called for examination by counsel for the Board, were duly sworn, and was examined and testified as follows:

MR. BARBER: Okay. Then take it away, please.

MR. GAFFNEY: Thank you, Madam Chair, and thank you, Board. Kevin Gaffney, Commissioner to Vermont Department of Financial Regulation.

I guess I want to first outline kind of DFR's primary role as the solvency regulator, and kind of the special responsibility we have as it relates to Blue Cross Blue Shield of Vermont -- I'll probably refer to them as

either Blue Cross or the company in other references -- which was created in statute and subject to a comprehensive regulatory oversight.

And you know, our general authority and role here is about solvency. It -- and you know, our general mission as regulators in -- in all of our markets, is to protect consumers and make sure there's market availability.

And we -- we're coming to a point in time, and it's -- I'm not going to be redundant here, but just to say that we're not in a -- kind of a -- a regular condition here as we review these -- the solvency of this entity that we regulate. And really, it's -- it's about now, the ability of a company to kind of deliver on its financial obligations and its future solvency.

And when we look at the trends, we felt it necessary to engage with Blue Cross and -- and talk through and -- and start to begin the plan that's already been discussed a couple of different times. For reasons that we'll explain further in the executive session, we feel the three percent contribution to reserves

requested in Blue Cross' initial filing is inadequate to maintain solvency.

As you've already heard, at the end of '23, the RBC level was at 337 percent, and reserves continue to trend negatively, such that capital and surplus may be insufficient. Under the RBC order that the department issued about five years ago now, February of 2019, we required a -- an RBC level -- a target ratio between 590 percent and 740 percent.

When we developed that range, we worked with our actuaries and worked with -- with the cooperation of Blue Cross -- reviewed and approved that target range. And the auditors intended it as a guideline to support RBC request in future rate filings. As previously stated by the Department, the range of surplus target by Blue Cross is reasonable and necessary to protect policy holders.

And just to give a little backdrop, some of you may or may not know, but as the Commissioner -- Insurance Commissioner, we're part of the National Association of Insurance Commissioners. So I serve in that -- in that association with other state-based regulators.

And there were certainly instances in the 80s and 90s with both property and casualty and health insurers, failures that resulted in the development of model laws and the development of the risk-based capital model. Prior to that, there was just general capital standards, regardless of the size or mixed profile, risk profile of the entity.

So the RBC model now stands up a more specific reference point and guideline to account for individual differences among regulated entities. And these requirements are a minimum amount of capital required for an insurer to support its operations and rate coverage. The RBC model outlines a method for measuring this minimum amount of capital and authorizes regulators to take preventative actions.

And under these model laws, there are four levels of regulatory intervention, ranging from submission of action plans to a regulatory takeover of the company. These measures are designed to allow regulators to identify and correct solvency problems before insolvencies occur. And we're at that early stage now of the action plans.

And we do see that the current trends are causing us to focus on some key areas that the action plan should -- should encompass. The FR's goal to keep Blue Cross in the QHP market is to ensure that individuals have access to major medical coverage. As you may already know, Blue Cross has approximately two-thirds of the QHP market, and it has only one other competitor.

Maintaining its solvency is critical to ensuring access for individuals and small businesses. I'll have additional testimony that requires the discussion in confidential information and executive session.

And in conclusion, I just want to emphasize that I think we've heard -- I've heard a couple different times about developing an increased contribution to reserves. And this is, again, to stabilize the reserves. And it's going to directionally start to move in towards the range. But we are much closer to action levels and insolvency than we are the range. So this is more of a critical turning point that we see as the solvency regulators.

The primary factor in an insurer's

ability to maintain solvency is whether its rates are adequate. And this is just -- don't take this as my attempt to define affordability. Just through the lens of the solvency regulator, I would just say, you know, an affordable rate is the lowest adequate rate. Because we certainly have to first have adequacy and make sure we have markets protected and solvency of the payers and the insurers.

So availability of coverages, you know, are one of our key concerns and also just the fact that we are in a noncompetitive structure here with two primary providers of the QHP market. So those are my general comments. We'll have more to discuss in executive session, but I'm happy to take any questions.

MR. BARBER: Thank you. So does Blue Cross have any questions for this public session?

MS. ASAY: We do not. Thank you.

MR. BARBER: Does the ACA have any questions?

MR. SCHULTHEIS: Just a few questions.

All right. Commissioner Gaffney,

so I'm going to ask you a few questions. About the DFR solvency opinions. So I'm going to direct you to the exhibit and pages we were talking about. I said this before, but I think it bears repeating. Just for clarity, I'm referring to the red page numbers printed on the bottom pages of the binder pages. So first off, just for clarity, again, DFR issued two solvency opinions in these matters, right?

MR. GAFFNEY: Yes.

MR. SCHULTHEIS: And these two solvency opinions are essentially the same, correct?

MR. GAFFNEY: Essentially, yes.

MR. SCHULTHEIS: Essentially, yeah. So would you turn to Exhibit 16, which is DFR's solvency opinion for the individual rate filing? Let me know when you get there.

MR. GAFFNEY: I'm here.

MR. SCHULTHEIS: Great. So if we're talking about reserves, which are measured at the enterprise level, it makes sense for me to just ask you questions about one opinion, since each opinion contains essentially the same information about reserves that we just stated?

Sorry. Do you want me to repeat that?

MR. GAFFNEY: Did you ask me a question? I'm sorry.

MR. SCHULTHEIS: I did. No. No problem. So since we're talking about reserve levels and reserves are measured at the enterprise level, I can just ask you questions about DFR's opinion in the small group memo, and it's essentially the same.

MR. GAFFNEY: Okay.

MR. SCHULTHEIS: Okay. So could you turn to page 4 of Exhibit 16? Exhibit 16 is the solvency opinion. And do you see that little line graph on the top of the page?

MR. GAFFNEY: Now, you're referring, just to be clear, Mr. Schultheis, you're talking about the small group now?

MR. SCHULTHEIS: Yeah. So Exhibit 16, page 4.

MR. GAFFNEY: Okay. Because you had me -- I was in the individual.

MR. SCHULTHEIS: Yep. Sorry.

MR. GAFFNEY: I was in the individual. I'm on the small group now. Go ahead.

MR. SCHULTHEIS: So I just want to be clear for the record, in Exhibit 16 is solvency impact 2025 for Mont QHP market, individual rate filing of Blue Cross Blue Shield of Vermont. Is that where you are, Commissioner Gaffney?

MR. GAFFNEY: Are you using -- you used the small group reference, and you used individual, so just let me know --

MR. SCHULTHEIS: Oh. Yeah, yeah, yeah. I'm sorry.

MR. GAFFNEY: -- which solvency opinion do you want me to be looking at?

MR. SCHULTHEIS: Yeah. I just -- I just wanted to clear things up. We're on Exhibit 16, page 4. Do you see the graph, the line chart on the top of page 4?

MR. GAFFNEY: The RBC ratio over time?

MR. SCHULTHEIS: Yep. The historical contribution to reserves.

MR. GAFFNEY: Yes. Okay.

MR. SCHULTHEIS: Okay. So I just want to make sure we all understand this graph. So on the Y axis is contribution to reserves as a

percentage of premium.

MR. GAFFNEY: Okay.

MR. SCHULTHEIS: Correct? And then on the X axis is years 2019 through 2023, correct?

MR. GAFFNEY: Yes.

MR. SCHULTHEIS: And the Blue line is what Blue Cross filed for percent contribution to reserve, right?

MR. GAFFNEY: Yes.

MR. SCHULTHEIS: And the yellow line is what the Board approved, right?

MR. GAFFNEY: Yes.

MR. SCHULTHEIS: And the red line is the actual contribution to reserves, right?

MR. GAFFNEY: Yes.

MR. SCHULTHEIS: Okay. So I know this is going to be partially a function of the scale of the Y axis, but the blue line and the yellow line are pretty close together; is that correct?

MR. GAFFNEY: Well, they look close together, but they are different.

MR. SCHULTHEIS: I know they're different. And I know if we change the scale of

the Y axis, that difference could be made bigger or less, right?

MR. GAFFNEY: I mean, just to be clear, rather than -- rather than talking about what they look like, I would say that the blue line, and Jesse can keep me straight, is closer to that one and a half percent level --

MR. SCHULTHEIS: Okay.

MR. GAFFNEY: -- I believe.

MR. LUSSIER: That's correct.

MR. SCHULTHEIS: So I'm just asking --

MR. GAFFNEY: And the yellow line -- and the yellow line is as low as negative, I think, in the most recent year.

MR. SCHULTHEIS: Okay. But I asked you if the lines look like or are relatively close, at least compared to the space between the red line and both the yellow and blue line; is that correct?

MR. GAFFNEY: Well, I like to deal with numbers, so I'll just say that the filed CTR of one percent was as much as I think almost two points lower in the most recent year.

MR. SCHULTHEIS: Okay. So just to

be clear, I want to -- and you like to talk about numbers, the observation in 2023 of the blue line and the yellow line is much higher than the observation on the red line; is that correct?

MR. GAFFNEY: Absolutely. Well, except for -- except for, obviously, COVID in 2020, where COVID --

MR. SCHULTHEIS: No. I'm asking about 2023, Commissioner Gaffney.

MR. GAFFNEY: Okay.

MR. SCHULTHEIS: Okay.

MR. GAFFNEY: Just '23 is what you're asking for -- well, you've been talking about the trends. I just want to -- you're talking about '23?

MR. SCHULTHEIS: Yep. That was my question, sir.

MR. GAFFNEY: Okay.

MR. SCHULTHEIS: Okay. And then I want you to look at the first paragraph of page 4 in the exhibit we're on. So Exhibit 16 and DFR states that the inadequate premium rates, Blue Cross's contribution, actual contribution to reserves has been negative, correct?

MR. GAFFNEY: Yes.

MR. SCHULTHEIS: Okay.

MR. GAFFNEY: Over time.

MR. SCHULTHEIS: And I'm looking at the graph right now. Would it be fair to say that Blue Cross's predictions of premium were off? Because that red line looks a whole lot lower in 2023 than either the blue or the yellow line.

MR. GAFFNEY: Yeah. No, that's a fair observation of what you're saying. I would say that there's a lot of different components that go into that -- probably some that we need to discuss in the executive session. But what I'll say is that it's not just a product of anticipated claims, it's a product of the approved rate -- rate increase.

MR. SCHULTHEIS: So I want you to -- can you turn to page 3 in Exhibit 16, and look at the third full paragraph, the third and the fourth sentences?

MR. GAFFNEY: Jesse --

MR. SCHULTHEIS: So that starts --

MR. GAFFNEY: Jesse, I'm going to ask you to help me where I'm at because I'm just looking at the solvency opinions.

MR. LUSSIER: This is Jesse. Are we talking about the sentence that starts, "Rates are developed"?

MR. SCHULTHEIS: Yep. Jesse, that's correct. So in that sentence, DFR acknowledges the truism that because rates are prediction, there's not a big C correct rate, just probabilities, right?

MR. GAFFNEY: Correct.

MR. SCHULTHEIS: Okay. And I just want to ask you two questions about what you talked about just now. So you said that solvency is needed to ensure at access, correct?

MR. GAFFNEY: Yeah. Solvency is necessary at a minimum to make sure you have a marketplace. Yes.

MR. SCHULTHEIS: So I wonder if it's actually quite that simple. So it seems like solvency is sufficient or is necessary to ensure access, like you just said. But also if people can't pay for services, then they don't have access. So they're both -- they're both necessary facts, but neither one is sufficient; is that correct?

MR. GAFFNEY: I think what you're

asking is outlining the challenge of this year. The challenge that, you know, is ultimately in the hands of the Board, in that -- that access is -- is about having payers in the market, one, right? You need -- you need insurers to have a marketplace, and we have -- we have two. And the one we're talking about has two-thirds of the marketplace. And it's on a negative trend that's well below the recommended range.

And the reason you have the recommended range is exactly what you were saying when you said big C correct rate. There isn't -- there isn't that, right? You're going to predict you're going to try to predict and anticipate future losses and then you're going to have your experience. And those are going to vary. Hopefully, the -- the variance is modest, but it can be, you know, in certain years increasing.

And I think we've seen in recent years an increasing deterioration in outcomes and morbidity in Vermont. And -- and that's why we got much more involved. This was on our radar based on the year-end RBC. But when we saw the results in early part of this year, in April and May, we really felt that we needed to engage more

actively and start those action plans.

MR. SCHULTHEIS: So I think we all understand the solvency position. I just want to direct us back to what you said about access. So access is a complex idea, correct, in that it involves both solvency and whether people can actually afford to go see a doctor, correct? Is that what you're saying?

MR. GAFFNEY: Well, I'm just saying that at the outset, access is about having a marketplace, and then access is also about the affordability of the marketplace. But you don't start with what do you want the price to be. You start with what do you need the premium to be to pay future obligations. So that's the solvency calculus.

It's how do you -- how do you meet the future obligations and how do you insure -- because it's not just about like company action levels, but it's about whether -- whether companies stay in a particular market. And so we just we are -- we are in this position where we are far outside the range and really feel that it's reasonable what's being filed here, because, you know, a seven percent CTR is still not going

to -- it's going to start to shift in the right direction if it's actually realized.

MR. SCHULTHEIS: Commissioner Gaffney, I'm sorry. I'm going to stop you. I was asking about access and not the overall solvency position. I don't think anyone is disputing what Blue Cross's solvency position is now. I'm just asking, like, think about this kind of scenario, right?

You have adequate rates. They're hugely expensive, right? Only Elon Musk can afford to pay for that insurance. And what I'm saying to you -- what I'm asking you is, like, that's great. Elon has a lot of access, but all the people who are priced out don't have access; is that correct?

MR. GAFFNEY: Well, I don't think that's the situation we're in, but --

MR. SCHULTHEIS: Well, sure. We're not in it. I was trying to be extreme.

MR. GAFFNEY: So that's not the situation we're in. So I just have to deal with the situation we're in. And the situation we're in is that there's increasing costs. So even the base rate increase is double-digit. And there's

also a need, a need to bolster reserves of one of our payers that, that that serves two-thirds of the marketplace.

So my focus in terms of access is making sure there's a payer in the future because if we do nothing, and we have no payer in the future, then I haven't done anything to help access for anyone.

MR. SCHULTHEIS: Okay. So then it's -- I think what I'm hearing is, like, I mean, and I understand it, I think. It's that it's your job working for Department of Financial Regulation to focus on solvency and not these other aspects of access, correct?

MR. GAFFNEY: I think the Department -- so I'm just staying in the lane here. But I will say that the Department is always open to collaborating with our sister agencies, with the Green Mountain Care Board, on ways to affect other cost drivers of health insurance. So we're always willing to be at the table and assist in those areas. But when we're staying in the kind of the area of the rate regulator, the Green Mountain Care Board and the solvency regulator, DFR, that's what I'm trying

to articulate. We understand there's other factors that --

MR. SCHULTHEIS: Okay.

MR. GAFFNEY: -- underpin this, but there's some basic financial actions that we see are necessary.

MR. SCHULTHEIS: Fair. I want to ask you just really one question about -- well, I hope it's one question -- about affordability, which I know you said you didn't want to get into. And then you said that it's that there's an adequate rate. Did you say that? Did I hear that right?

MR. GAFFNEY: Yeah. I think I qualified it as I'm not attempting to define affordability. All I'm saying is through the lens of where we are and as the solvency regulator, it seems like, you know, from a solvency perspective that, you know, adequacy is that lowest possible adequate rate.

MR. SCHULTHEIS: So I'm just wondering is -- are you are you familiar with GMCB Rule 2, which says, you know, about the rates adequacy and that it's not excessive. And then there's another word that's about

affordable. It sounds like you're saying that word shouldn't be there. It should just be an inadequate.

MR. GAFFNEY: No. I think that actually also includes insurance solvency in that.

MR. SCHULTHEIS: Oh, it does include that, too. So all three things let's say.

MR. GAFFNEY: Yeah. So it's all -- it's all part of it. It's all part of it. All I'm saying is as a solvency regulator, we have to make sure we have payers in the future that can meet their obligations.

MR. SCHULTHEIS: Okay. Thank you, Commissioner Gaffney. That's all my questions. And I reserve the right to do additional cross if the witness speaks in executive session.

MR. BARBER: Board Member Walsh, do you have any questions for the DFR?

MR. WALSH: Yes. Thank you. Good morning, Mr. Gaffney. Thanks for being with us.

MR. GAFFNEY: Good morning.

MR. WALSH: My question also was regarding Exhibit -- the graph at Exhibit 16 on

page, I think it was 4. And I wanted your help understanding the historical contribution to reserves. What leads to the difference, the actual contribution compared to the filed contribution?

MR. GAFFNEY: Well there's three components. There's the file contribution, there's the approved contribution, and then there's the actual. So the actual is once you actually have your experience and your claims, and you know, and I think there's a graph above here, which, you know, you can just see the surplus over time, going from a high of 130 -- in the last five years, 135 million to 87, just almost 88 million in the most recent year.

MR. WALSH: So the --

MR. GAFFNEY: There's losses. The last two years, I think there's 45 million in losses the last two years. And that's kind of consistent with that red line.

MR. WALSH: So those -- those losses have been paid out of the -- out of the reserve?

MR. GAFFNEY: Yeah. That's where you see the reduction in the reserves, right.

You see that same trend line where the reserves are dropping and the contribution to reserves are negative.

MR. WALSH: Okay.

MR. GAFFNEY: Yeah. I mean, the basic kind of the basic -- oh, yeah. Go ahead, Jesse.

MR. LUSSIER: I was going to say, if you go to page 3 of the exhibit, and you see the dollar amounts of the gains/losses for the QHP, that's essentially what the red line is reflecting.

MR. GAFFNEY: Thank you, Jesse.

MR. LUSSIER: Yeah.

MR. WALSH: Got it. Okay.

MR. GAFFNEY: That's the -- that's the 15 and 32 million the last two years that I was referencing there, you know, around 47 million.

MR. WALSH: Okay. Thank you. That was my only question.

MR. GAFFNEY: Thank you. Thank you, Jesse.

MR. BARBER: Board Member Murman, do you have any questions?

MR. MURMAN: I don't right now. Thanks.

THE COURT: Board Member Lunge?

MS. LUNGE: Hi, Commissioner.

Hi, Jesse. Thanks for joining us.

MR. GAFFNEY: Thank you.

MS. LUNGE: I had a couple questions about what materials you used in preparing your solvency opinion. Did you review the Blue Cross Blue Shield's annual statement?

MR. LUSSIER: Yeah. Do you want me to --

MR. GAFFNEY: I think there were a number of things. I'll let Jesse kind of run through all the things that we looked at.

MR. LUSSIER: Yeah, just in the normal course of solvency, we'll review the annual statements and all of the related information that comes in through the annual statements and through the iSite database. And we can talk more about that in the executive session. So we reviewed their -- their 12/31/2023 data. And in addition to that, Blue Cross has been updating us with the 2024 information as it becomes ready.

So I think the -- the-- the most recent information is --is probably through May, as we've been discussing. At a high level, that's what we've been reviewing. Let me know if you want any more specific information.

MS. LUNGE: Thank you. All right. Could I ask you to turn to Exhibit 26, which was not in the printed binder, but was distributed.

MR. GAFFNEY: I'm not sure I have a copy of that.

MR. BARBER: I was worried about that. Let me take a minute to email that to you.

MS. LUNGE: Okay. So we -- while you're doing that I'll come back to it. And certainly, I can -- I only have a couple more questions. So if you need a moment to review it, we can have others go and then come back to it.

So on page 2 of Exhibit 16, which is -- it looks like the language is also identical in Exhibit 17, page 2. In the second to last paragraph, you indicate that you are monitoring solvency, quote, using all available tools. What tools are those?

MR. LUSSIER: So the -- generally speaking, solvency analysis includes reviewing

the reports that we talked about before. iSite, which is NEIC's database has -- yeah, the Board's familiar with the annual report, correct?

MS. LUNGE: I can only speak for myself. So I'm familiar with the annual report. I can't speak for anyone else.

MR. LUSSIER: You've seen those. The -- every single data point that's captured in the annual report is -- is within iSite. and I think our analysis is confidential, so I can speak more about this in the executive session, but there are a series of just practices and procedures that are kind of standardized that come down from the NEIC.

Those include the annual reports and the information that comes along with the annual reports. And again, I can talk more about that in the executive session, if that's okay.

MS. LUNGE: That sounds great. Thank you. It sounds like I should probably just reserve the rest of my questions for the executive session. And maybe in order to give you time to look at exhibits.

I don't know how you want to handle Exhibit 26, Mike, do you want me to ask

Jesse or give him some time to be able to look at it?

MR. BARBER: Exhibit 26 is not confidential, to my knowledge. So I'd prefer to get that out of the way now.

MS. LUNGE: Okay. Have you received Exhibit 26, Jesse --

MR. LUSSIER: Yes.

MS. LUNGE: -- Commissioner?

MR. GAFFNEY: We have it. We just got it.

MS. LUNGE: Okay. Great. So is it fair to say that this exhibit is a summary of information included, for the most part, in the annual statements as demonstrated by the references in the far left column?

MR. LUSSIER: It appears so yes.

MS. LUNGE: Okay. So could you tell me which of these items you considered in writing your solvency report?

MR. LUSSIER: We consider the -- which of these items specifically? I mean, of course --

MS. LUNGE: Yes.

MR. LUSSIER: -- I think you would

normally look at the underwriting gain and loss. The -- that's one of our main focuses, as in specifically the QHP lines. But we'll also look at I'm looking at -- find out what else is here. Obviously, we'll look at the reserves, the ACL and the RBC, which are on the bottom. And -- and generally, we focus on the underwriting gain or losses of -- of the QHP business.

MS. LUNGE: Okay. This however, because it is based on the annual statement, would be all underwriting gains or losses, not just the QHP business; is that correct?

MR. LUSSIER: Correct.

MS. LUNGE: Would you have considered, or did you consider one, two, three four -- the fourth line down, equity gains and losses for the Medicare Advantage business?

MR. LUSSIER: As it applies to the overall reserves of -- of the entity, yes. But I don't think we specifically reviewed it.

MS. LUNGE: Okay. And in your solvency opinion, however, the only items that you referred to were the underwriting gains and losses; is that right?

MR. LUSSIER: I'm sorry. Could

you repeat that?

MS. LUNGE: In your solvency opinion, you only refer to the underwriting gains and losses; is that right?

MR. LUSSIER: We refer to -- well, we refer to the RBC.

MR. GAFFNEY: RBC.

MR. LUSSIER: And we also --

MS. LUNGE: But in terms of the factors that contribute to the RBC level.

MR. LUSSIER: Oh. I think we might have to reread the letter.

MS. LUNGE: Okay. Thank you.

MR. GAFFNEY: Yeah.

MS. LUNGE: I have no further questions.

MR. BARBER: Okay. Chair Foster, do you have any questions?

CHAIR FOSTER: Just sort of one conceptually, if that's okay.

Thanks for being here, Commissioner Gaffney. It's nice to see you.

MR. GAFFNEY: Our pleasure. Same here. Our pleasure. Wish it was under better circumstances.

CHAIR FOSTER: Yeah. I share that feeling. So these -- these rates, I understand the financial situation and the solvency concerns. They're acute. And if you look at this insurer, they do a pretty good job on admin costs, and they're very leanly run. But I worry that there might be people buying down insurance or leaving the insurance market all together because of the cost increase, right? So a 24 percent or a 20 percent rate increase, several hundred dollars per month more for -- for folks. Do you have any concerns about the level of rate increases causing the market to shrink, thus putting greater long-term pressure on the insurer?

MR. GAFFNEY: I mean, there's a lot of considerations, Mr. Chair, and certainly, you know, we want to make sure, you know, getting back to the access discussion, that we can afford access to as many as want this valuable coverage. So it's always, right, it's always a concern. Even as the solvency regulator, obviously, I'm the regulator of rates and solvency and many other markets.

So all of these dynamics are front

of mind when we're dealing with this. It's -- is there a functional availability issue once the price hits a certain level, right, where it doesn't become available? But you know, the critical issue here, though, is we are on the verge of something more substantive than -- and I'm not saying it's not substantive. I'm not discounting because I can answer your question more specifically and acutely, in that, I've already talked with my staff about, well, what is one point of CTR per member per month. And that's between 10 and $11. So we understand the impact here. We're trying to be mindful of that impact.

We also recognize, at least in today's structure, that at least in the individual market, there are almost 30,000, you know, individuals receiving subsidies. So that impact at least will be moderated for those that can least afford it. But that doesn't -- that doesn't, you know, that doesn't solve all the considerations or issues, but it's all part of what we're -- we -- we think about as solvency regulators.

CHAIR FOSTER: Are you on your end

in your office, seeing any signs of potential deterioration of the market because of the costs? And what I mean by that really is either a shrinking pool or people buying lower levels of coverage?

MR. GAFFNEY: Yeah. Not in the solvency work, and I'll say that that's certainly something that I think we all should be trying to assess. What is the -- what is the -- what are the dynamics, the market response to these -- these things? I've seen it. And I can tell you just more broadly, I've seen it in the -- in the property and casualty market, and all of you are familiar with Florida and Texas and California, and all the other challenges we're having.

And what we're seeing over time in these markets is that costs are going up, and cost sharing sometimes has to go up so that that can mitigate the overall cost, whether that's higher deductibles and the like. So -- so all of those dynamics are in play in a marketplace, right? And we just -- our primary focus here is we'd be -- we'd be not -- we'd be asleep at the wheel if we weren't addressing the critical issue of having a payer in the marketplace.

CHAIR FOSTER: Okay. I have no other questions. Thank you, sir. Nice to see you.

MR. GAFFNEY: Yeah. Same here.

MR. BARBER: And Board Member Holmes, did you have any questions?

MS. HOLMES: No, I did not. Thank you.

MR. BARBER: Thanks. So it sounds like, Commissioner and Jesse, that you have some additional testimony you'd like to give in the executive session, and the Board members have some additional questions for you for that confidential session as well. So I'm not exactly sure when that will be, but the order of things is now we're going to hear, I think, from one more witness, probably need to break briefly for lunch and then come back to an executive session likely in the early afternoon. Are you able to be with us for that?

MR. GAFFNEY: I've cleared my schedule. Yes.

MR. BARBER: Okay. Thank you.

So Mr. Chair, do you have any preference of whether we move on to. Dr.

Weigel's testimony now or take -- take, like, a 30-minute lunch break now?

CHAIR FOSTER: Why don't we try and get through Dr. Weigel's direct at least and maybe just a two-minute break for folks. I think we've been going an hour and a half or so. Maybe just two minutes, and then we'll do Dr. Weigel? Five? Five minutes.

MR. BARBER: Okay. Okay. Let's go off record and we'll see everyone back here at two till noon.

(Recess at 11:53 a.m., until 12:01 p.m.)

MR. BARBER: All right. And Blue Cross, if you'd like to call your next witness, please?

MR. DONOFRIO: Yes. Thank you, Mr. Barber. We call Dr. Thomas Weigel. Thank you.

MR. BARBER: Okay. Doctor. Dr. Weigel, I'd like to administer the oath now if that's all right?

DR. WEIGEL: Yes.

MR. BARBER: Okay.

Whereupon,

THOMAS WEIGEL,

a witness called for examination by counsel for Blue Cross, was duly sworn, and was examined and testified as follows:

MR. BARBER: Go ahead, Mr. Donofrio.

MR. DONOFRIO: Thank you.

Dr. Weigel, please state your name and current position for the record.

DR. WEIGEL: Sure. My name is Tom Weigel. I'm the Chief Medical Officer at Blue Cross Blue Shield of Vermont. I'd also like to add that I'm in the same small office as Mike, but I am not changing my background due to the prior warning that I might be cut off.

MR. DONOFRIO: Good. Thank you for that clarification. Your background is nicer than mine. How long have you held that position?

DR. WEIGEL: Since September of 2022.

MR. DONOFRIO: And when did you start at Blue Cross?

DR. WEIGEL: December of 2021.

MR. DONOFRIO: If you would, please briefly describe your job

responsibilities.

DR. WEIGEL: Sure. As Chief Medical Officer, I serve as the principal clinical spokesperson and executive responsible for the program's budget and resources; the pharmacy quality utilization management; case management; and medical director departments. I recommend and monitor clinical aspects of benefit administration, monitor the quality of healthcare services, conduct quality improvement programs, and participate in provider reimbursement, development, and value-based care initiatives.

MR. DONOFRIO: Did you prepare pre-filed testimony for this proceeding?

DR. WEIGEL: Yes.

MR. DONOFRIO: Would you please turn to Exhibit 20 in the binder that's on the desk in front of you?

DR. WEIGEL: Yes.

MR. DONOFRIO: Are you there?

DR. WEIGEL: Yes.

MR. DONOFRIO: And is that the pre-filed testimony that you prepared?

DR. WEIGEL: Actually, let me turn -- yes. That is.

MR. DONOFRIO: And was all of that testimony true and correct to the best of your knowledge, at the time we submitted it?

DR. WEIGEL: Yes.

MR. DONOFRIO: And does that remain the case today?

DR. WEIGEL: Yes.

MR. DONOFRIO: Are you aware that as part of the Board's review of the proposed rates before them, the Board has to consider whether the proposed rates are affordable, promote quality care, promote access to healthcare, protect insurer solvency and are not unjust, unfair, inequitable, misleading, contrary to the laws of the state and that they are adequate and not excessive?

DR. WEIGEL: Yes.

MR. DONOFRIO: So one of the many criteria that I just listed is that the proposed rates are affordable. Do you believe the proposed rates satisfy this criterion, and could you please explain?

DR. WEIGEL: Sure. I -- I believe the proposed rates satisfy the affordability criterion, providing our members with access to

high-quality healthcare they need at the lowest possible cost to them is our core mission and the overarching goal of everything we do.

We do understand that many of our members struggle to pay the premiums we have to charge in individual and small group markets. We understand that the proposed rates currently under review are no exception.

That's why we undertake a host of programs aimed at reducing the cost of healthcare, thus enhancing affordability, while also promoting quality and access to necessary care. Those programs are detailed in the May 13th, 2024 memo I prepared along with our CFO, Ruth Greene, which was submitted as Attachment D to the rate filings. And it's also attached to my pre-filed testimony.

MR. DONOFRIO: Would you please turn to page 2 of Exhibit 5 in the binder?

DR. WEIGEL: Yeah.

MR. DONOFRIO: Is that the first page of the document you just described?

DR. WEIGEL: Yes.

MR. DONOFRIO: What is the purpose of that document?

DR. WEIGEL: In past rate review proceedings, the Board has voiced an expectation that Blue Cross to provide more information related to affordability. So this document is our response to that expectation.

MR. DONOFRIO: How does the document fulfill that expectation?

DR. WEIGEL: It describes the programmatic efforts we're engaged in as we try to control healthcare costs, using the relative -- - relatively limited levers that we have.

MR. DONOFRIO: Now, before we turn briefly to those programs, I want to ask you, Dr. Weigel, did you have a chance before the hearing to review the public comments about the proposed rates that the Board provided the parties on Friday afternoon?

DR. WEIGEL: Yes, I did. And they're powerful and it really a painful illustration of the burden we know that many of our members and Vermont neighbors face. This is exactly where we're trying to do everything we can to slow the growth of our members' healthcare costs, because slowing that growth system wide is the only way we can reverse the trend of ever-

growing premiums and make healthcare affordable and sustainable for Vermonters.

MR. DONOFRIO: So is -- is Blue Cross aware that its current proposed rates outstrip economic indicators that reflect people's ability to pay things like household income or wage growth?

DR. WEIGEL: We're aware of general economic indicators regarding wage growth, inflation, and household income. We also, of course closely track increases in the price and utilization of the healthcare costs that we pay for. We're keenly aware that the growth of those healthcare costs outpaces increase in wages and household income. Compounding that challenge, Vermont's healthcare spending is a high outlier compared to the rest of the country.

MR. DONOFRIO: Can Blue Cross adapt its rates to line up with economic indicators like household income or wages?

DR. WEIGEL: Unfortunately, no. Blue Cross cannot develop rates based on individual member and small group employee income or business finances. Even if we had perfect

information about our members' incomes and small business finances, we would have no choice but to propose rates that are adequate to cover our projected claim costs, regardless of how those rates compare to the economic indicators because we're legally obligated to cover our members' costs.

MR. DONOFRIO: So again, how -- how -- in the face of that, how are you able to conclude that the proposed rates are affordable?

DR. WEIGEL: The facts I just discussed leave us with only two levers that we can control to propose rates that are as affordable as possible. The programs I mentioned earlier, which are described in Exhibit 5 that aim to reduce underlying healthcare costs and the tight control we exert over our own administrative costs. Because I believe we are doing everything we can on those two fronts, I conclude that the proposed rates are affordable in the context of this proceeding.

MR. DONOFRIO: So do you track and review information about how healthcare costs in Vermont stack up to costs around the country?

DR. WEIGEL: I do.

MR. DONOFRIO: And how do Vermont's costs currently compare?

DR. WEIGEL: Sure. Looking at data from the Kaiser Family Foundation healthcare expenditures, at least in 2020, were 20 percent higher than the national average. I'm seeing that these costs are getting higher and higher each year. To begin with, according to the 2024 RAND 5.0 report cited in my pre-filed testimony University of Vermont Medical Center operates at 317 percent of Medicare rates, far exceeding the national norm for hospitals.

So again, they're at 317 percent. As a reference, Dartmouth-Hitchcock operates at 191 percent of Medicare rates and the most expensive hospital in Massachusetts, Mass General Brigham, operates at 231 percent of Medicare.

The impact of those high UVM Medical Center rates ripples across Vermont's entire healthcare system because UVM Medical Center absorbs about half or 52 percent of our total hospital spend, according to the Board's most recent Vermont hospital reporting on year-end actuals.

That financial strain is exacerbated

because here in Vermont, about 47 percent of our total healthcare expenditure flows into hospitals, according to the 2020 Vermont Healthcare Expenditure Analysis. That amount is far above the national average -- that 47 percent is far above the national average of 30 percent as reported in Peterson Kaiser Health System Tracker.

MR. DONOFRIO: So referring back to Exhibit 5 in the binder, the memo that you described earlier, would you please briefly describe the programs discussed in that document?

DR. WEIGEL: Sure. Programs that enhance access, quality and affordability span the following three categories -- value based payment models; payment integrity; integrated health management, which includes both case management and utilization management. Beyond those programs, we achieved additional savings for our members by managing our administrative costs aggressively and keeping them low, especially for a plan of our size. Our comprehensive network and world class members support further promote ready access to high quality care for our customers.

MR. DONOFRIO: And are you prepared to answer specific questions today from Mr. Schultheis for the HCA and the Board members regarding the contents of this document?

DR. WEIGEL: Yes.

MR. DONOFRIO: Okay. Before I wrap up, I'd like to ask you a few questions about hospital budgets. So first off, how do the rates -- hospital rates set by the Board impact Blue Cross' premium and reserves?

DR. WEIGEL: Sure. Blue Cross is unable to negotiate with hospitals effectively after they have undergone the Green Mountain Care Board review process. In our experience, hospitals view the Board's order as the definitive amount owed to them, which hinders traditional payer provider negotiations.

Instead of discussing the specifics of each Blue Cross provider contract, hospitals now focus solely on implementing the Board-ordered commercial cap, which was clarified last year that it was a cap. The hospital's interpretation of the Board's hospital review process has, therefore, eliminated our ability to engage in the sorts of meaningful negotiations that used to

occur.

MR. DONOFRIO: How does the manner in which hospitals implement the Board's hospital budget orders affect your negotiations with the hospitals, bearing in mind -- you know, please restrict your testimony to kind of more general statements and not granular numerical statements about specific negotiations. That can be covered in executive session if necessary.

DR. WEIGEL: Sure. The virtual monopoly of Vermont hospitals has historically made negotiations difficult. And since the Green Mountain Care Board process was implemented, negotiations have become essentially impossible. For example, UVMHN has developed expertise in modeling reimbursement terms that appear to align with the Green Mountain Care Board cap, but results in aggregate unit cost increases exceeding the cap.

Attempts to address high payment areas are met with the health network's insistence on offsetting any sort of savings or reductions for our members, with increases elsewhere to maintain revenue right up to the Green Mountain Care Board approved cap.

MR. DONOFRIO: Dr. Weigel, can you comment on the effectiveness or ineffectiveness of the current revenue-focused hospital budget model?

DR. WEIGEL: Sure. I think a big part of it has to do with the starting point and the idea that --that we're making increases from a starting point. A revenue-focused model does not work effectively, especially with the current baseline revenue at 317 percent of Medicare being exorbitant. In fact, looking at the RAND data, the outpatient charges at UVM Medical Center are actually 427 percent of Medicare.

So looking at that as a starting point and saying that we should make a 3.4 percent increase doesn't make sense, and we should instead be working backwards toward something that should be appropriate for, you know, hospitals in the United States or hospitals with that profile. The goal should really be to ensure that hospitals don't take in more money than necessary. Blue Cross Vermont historically cannot negotiate lower -- lower overall payments once the Board approves a commercial rate increase, except for some minimal discounts.

UVM Health Network has taken the negotiating position that total revenue can now be reduced by payment reform efforts, payments integrity programs, reduced payment for any specific service, or any other mechanism. Excluding UVM Health Network from our provider network is not realistic due to the negative impact on patients and the existing consumer protections, which would actually force us to pay a higher out-of-network rates if we were not contracted with them. These facts leave us with virtually no leverage in those negotiations.

MR. DONOFRIO: What is the consequence if a hospital ends up taking in more revenue than its Board-ordered budget level?

DR. WEIGEL: To the best of my knowledge, there's no -- almost no repercussion from going over the Green Mountain Care Board-ordered budget level. From my understanding the hospitals have been consistently allowed to retain excess revenues.

MR. DONOFRIO: Does Blue Cross plan to take any action in this regard?

DR. WEIGEL: Sure. As Ms. Greene testified and has stated in her pre-filed

testimony, we plan to approach hospitals that exceed the Green Mountain Care Board-ordered commercial rate cap for release.

MR. DONOFRIO: One moment, please. I have no further questions at this time.

MR. BARBER: Okay. That didn't take long, but I feel like there's a lot there that Board members and HCA will have questions on that will take us pretty far. So why don't -- Chair Foster, if it's all right with you, can we take a quick lunch break and then come back to this?

CHAIR FOSTER: Sounds great.

MR. DONOFRIO: Mr. Barber, can I -- can I just ask one question of Mr. Schultheis? Do you have a sense of how long your cross is?

MR. SCHULTHEIS: Ten minutes, I would say on the outside.

MR. DONOFRIO: The -- the litigator in me would ask, with the hearing officer's and the Board's indulgence, could we move through the cross since it's not that long and pause at that point?

MR. BARBER: That's fine with me, so --

MR. DONOFRIO: Thank you.

MR. BARBER: Eric?

MR. SCHULTHEIS: It's a lot of pressure to speak quickly.

So hi, Dr. Weigel.

MR. DONOFRIO: Eric, I don't want to strong arm you into anything so.

MR. SCHULTHEIS: No. You're not. I'm just --

MR. DONOFRIO: If you want the break, please take the break.

MR. SCHULTHEIS: No. Absolutely not. I just was making a joke.

MR. DONOFRIO: Okay. Thank you.

MR. SCHULTHEIS: Dr. Weigel, I'm going to ask you a few questions about the affordability standard in rate review and then talk with you about hospital prices and its impact on health insurance premiums.

DR. WEIGEL: Okay.

MR. SCHULTHEIS: I'm going to be referring to some of your pre-filed testimony, but I'm not going to ask you to read things out loud. I will, however, direct your attention to a page and line so that you can remember what you

said, okay?

DR. WEIGEL: Okay.

MR. SCHULTHEIS: Okay. Please turn to Exhibit 20, page 4. Exhibit 20 is your pre-filed testimony and various attachments. Let me know when you get there. Maybe you're already there.

DR. WEIGEL: Yes, I am there.

MR. SCHULTHEIS: Okay. So just to know, like, I'm not going to be asking you about what Blue Cross does to reduce rates, but what the affordability standard is. So on page 4, lines 1 through 5, you're asked a question whether you are familiar with the standard the Board uses to evaluate rate filings, and you state that you are, correct?

DR. WEIGEL: Correct.

MR. SCHULTHEIS: And then in lines 9 through 19 on that page, you explain why you believe the proposed rates meet the affordability criterion, correct?

DR. WEIGEL: Right.

MR. SCHULTHEIS: Yeah. And then, well, you don't even have to turn to it. It's the other page that you're open to page 5, and

look at lines 4 through 6. You are asked a question about why the rates are affordable. Specifically, the question you are asked is how the rates can be affordable, quote, even though they outstrip economic indicators that reflect Vermonters' ability to pay like household income and wage growth, right?

DR. WEIGEL: Yes.

MR. SCHULTHEIS: Okay. So -- so I want you to think back to the standard, which you know. The rate review standard doesn't say affordable but not considering whether Vermonters can pay, correct?

DR. WEIGEL: It doesn't say anything about pay.

MR. SCHULTHEIS: Okay. So it just says affordable?

DR. WEIGEL: Right.

MR. SCHULTHEIS: Okay. And then I want to direct your attention to page 6, lines 10 through 14. Let me know when you're there.

DR. WEIGEL: Yep.

MR. SCHULTHEIS: Okay. You say there are two levers that Blue Cross can control to propose the lowest rate possible, right?

DR. WEIGEL: Right.

MR. SCHULTHEIS: And those two levels, you say, are administrative costs and healthcare costs generally, correct?

DR. WEIGEL: Correct.

MR. SCHULTHEIS: Okay. And you conclude on lines 13 and 14 that because Blue Cross controls those two levers, that the proposed rates are affordable, right?

DR. WEIGEL: Right.

MR. SCHULTHEIS: But the rate review standard doesn't say affordable insofar as administrative costs are kept low, right? Like, there's no modifier to the word affordable.

DR. WEIGEL: I don't think it has that language in it either. No.

MR. SCHULTHEIS: Okay. And the rate review standard also doesn't say affordable if the carrier tries to contain healthcare costs, right?

DR. WEIGEL: Does not have that language in, correct.

MR. SCHULTHEIS: All right. So I'm going to switch topics now to hospital prices. And like I said to Ms. Greene, my

preference is that we speak in generalities and have as much of our discussion in the public session as possible. So as always, as I said to Ms. Greene, just let me know or your counsel will let me know if we are kind of moving in the direction of confidential information, and you can answer the question in closed session, okay?

DR. WEIGEL: Okay.

MR. SCHULTHEIS: All right. So turn back to page 5 of Exhibit 20. So as you just said in your pre-filed testimony, you list some shocking facts about UVMMC prices. UVMMC has a relative price of 317 to Medicare, compared to Dartmouth at 191, and Mass General Brigham at 231, right?

DR. WEIGEL: Yes.

MR. SCHULTHEIS: How did you feel when you saw those relative price numbers?

DR. WEIGEL: I was surprised, and I did my training at Mass General. And I know the comprehensive care that they provide there, you know, every level of care and every specialty and subspecialty service. So I was again surprised at that difference.

I guess the other thing that jumped out

at me is, this is 2022 data. And I believe the medical center got a 14 percent bump in 2023. So rough math would move 317 percent above 350 percent.

MR. SCHULTHEIS: And so looking nationally or thinking about prices nationally, if you know, how does UVMMC's prices compare to other academic medical centers?

DR. WEIGEL: I don't have that data in front of me. I do know that the average U.S. hospital is 250 percent of Medicare, and that the RAND rated hospitals on a scale of 1 to 10, with 5being average, and that, at least, with the 2022 data, UVM was a 9out of 10.

MR. SCHULTHEIS: So if you could follow up, maybe with kind of relative prices of other academic medical centers that are kind of the same size, right? We don't talk about, like, huge Cedar Sinai or something like that included. That would be great.

DR. WEIGEL: Okay.

MR. SCHULTHEIS: So you know, I guess, well, you know this better than me, but so if my memory serves me, this is pre the merger of MGH and Brigham Women. But I was just trying to

think doesn't -- isn't the -- doesn't MGH have a pretty high percentage of Medicaid patients?

DR. WEIGEL: That's my recollection. I don't have that in front of me, but they certainly serve an urban community.

MR. SCHULTHEIS: Okay. So I'm just reading through your testimony, and you state that UVMMC accounts for 52 percent of Blue Cross's hospital spend in Vermont; is that right?

DR. WEIGEL: Right.

MR. SCHULTHEIS: Right. So in your opinion, is that other 48 percent big enough that it is material to the rate? So what -- the other -- looking at the other 13 hospitals in Vermont?

DR. WEIGEL: You know, the other 13 hospitals would, you know, add up and aggregate for something material. And yeah.

MR. SCHULTHEIS: All right. So I want to switch topics again and briefly get your opinion on this rate review process and how it compares to the hospital budget process. And some of this covers things that Mr. Donofrio already spoke with you about, and some of it is taking things from a slightly different angle

than he spoke about. So you spoke that the two regulatory processes. Are they -- do they seem substantially different to you?

DR. WEIGEL: Sorry. Which two regulatory processes?

MR. SCHULTHEIS: Sorry. Rate review. So what we're currently in and how hospital budgets work.

DR. WEIGEL: All right, yeah, but -- well, they're definitely different and connected.

MR. SCHULTHEIS: So how are they different, Dr. Weigel?

DR. WEIGEL: Well, you know, it's more of the focus of the review. I think we're in this unique situation in Vermont where a lot of what we do as a payer is transparent. And so if we're making changes to the way things happen and the way we do things or cost that, that ends up going into the Green Mountain Care Board, you know, rate review.

Whereas in other states you could make a change that might be pretty impactful financially and not, you know, lower your rates because of that. So given that they are tied

together because, you know, we have to work the hospital rates into what we're doing.

MR. SCHULTHEIS: Yeah. So you talked a little bit with Mr. Donofrio about, you know, how regulating revenue ignores the starting point of prices, right? I want --

DR. WEIGEL: Right.

MR. SCHULTHEIS: -- talk to you about NPR in a slightly different way. And I'm doing this not to discount your previous observations, but to highlight another issue with regulating NPR, okay?

DR. WEIGEL: Yes.

MR. SCHULTHEIS: So this is an oversimplification, but at a really high level, commercial charge multiplied by utilization equals net patient revenue?

DR. WEIGEL: Right. And it's not by payer, but in aggregate, I believe.

MR. SCHULTHEIS: Yeah. So I'm trying to understand what this means. So one hospital has high prices, say four, and low utilization, say two. And then we have another hospital with low prices, say two, but high utilization, say four. Both of those hospitals

have a net patient revenue of eight; is that right, kind of roughly?

DR. WEIGEL: I think I'm following what you're saying. It sounds correct.

MR. SCHULTHEIS: So like, that to me is odd. I mean, so two very different things could look the same when measured by net patient revenue, right?

DR. WEIGEL: Yeah. For example, Northeastern Vermont Regional Hospital has about 187 percent of Medicare. And so they could see, let's say, one and a half people for the same codes as the medical center.

MR. SCHULTHEIS: So when we talk about access or expanding access, we're not really talking about revenue. We're talking about prices times utilization, right?

DR. WEIGEL: Correct. Yes.

MR. SCHULTHEIS: All right. So thank you so much, Dr. Weigel. Those are all of my questions for the nonexecutive session.

DR. WEIGEL: Thank you.

MR. BARBER: Okay. I think a quick lunch break and return at 1, unless anyone has any objections to that. Proceed with Board

questions for Dr. Weigel on these topics. Plan for an executive session after that to hear from Ruth Greene, DFR and Dr. Weigel and then finish up with the actuaries and Mr. Fisher. So anyone have any objections to that plan?

MR. DONOFRIO: Mr. Barber, we're back on the record at 1:00; is that right?

MR. BARBER: Yes.

MR. DONOFRIO: Okay. Thank you.

MR. BARBER: Okay. Let's go off record and I'll see everyone back here at 1. Thanks.

(Recess at 12:29 p.m., until 1:04 p.m.)

THE CLERK: Okay. We're going back on the record. The time is 1:04 p.m.

MR. BARBER: Okay. And Dr. Weigel, just to remind you, you're still under oath and I'll turn it over to Board Member Walsh for questions.

MR. WALSH: Thank you and good afternoon, Dr. Weigel. I appreciate your testimony earlier, diving a little bit deeper into pricing. During the break, I was trying to get a better sense of some of the percentages that were being shared in written testimony and

while you were talking.

In earlier testimony, it was discussed that fifty-four percent of Blue Cross business is due to GMCB regulated entities and 46 percent to nonregulated entities. And I was wondering if you or anyone on the staff has examined pricing trends, utilization trends or coding, diagnostic coding changes among nonregulated entities, where the growth in claims seems to be rising faster than among regulated entities?

DR. WEIGEL: So we'll get you more data on this. And our team may be able to answer some of these questions.

MR. WALSH: Yeah.

DR. WEIGEL: You know, let's say the unregulated providers in Vermont would be our community providers. We typically have them on a community fee schedule, which, you know, would go up. I think we had proposed for this coming year that that community fee schedule would go up by 4.5 percent. And there's been similar increases in prior years, let's say, plus or minus a couple percent, whereas the hospitals have gone up, you know, double digits a number of years.

MR. WALSH: Um-hum. Yeah. Yeah. That's very clear from the data that you've shared with us and data we've seen elsewhere. I'm just trying to get a clear sense of everything that's going on. Forty-seven percent of Blue Cross business among regulated entities is to hospitals. I think that number was mentioned earlier. And 52 percent of that 47 is UVM.

DR. WEIGEL: Medical center.

MR. WALSH: Medical Center. And if it is the health network, what percentage would that jump to; do you know?

DR. WEIGEL: I don't have that in front of me.

MR. WALSH: Okay. I'd like to know that. And I'm also interested to know -- we think of the medical trend -- I think of the medical trend, as I said earlier this morning, as a function of the utilization of care and the price of that care and the diagnostic intensity associated with the patient using that care. And all three of those can drive the medical trend.

And what I've heard consistently from testimony so far today is that the prices, rising

prices, seem to be the biggest driver. And that's consistent with the literature that I've seen from across the country.

Our prices in Vermont are rising faster -- among the fastest in the nation I've also heard you say. It'd be helpful to me thinking about this to try to understand what proportion of the rise in premiums is due to prices versus utilization versus diagnostic intensity.

Because we have a challenge of trying to encourage greater access, which should drive up utilization, which will drive up the medical trend, which would raise premiums. So trying to understand what is a reasonable reason for rising premiums would -- would be helpful to us. Member Holmes talked earlier about follow-up questions, and I think understanding utilization price and diagnostic intensity by hospital is something that if you're able to help us with, I'd greatly appreciate that.

DR. WEIGEL: Sure. I think it would be best if we gave you a breakdown of the exact data. And I have 2022 to 2023 data for, you know, major facility. And of that 5.4

percent was an -- there's a 5.4 percent increase in number of members served. There was a 12.5 percent increase in number of services, an 11.5 percent increase in allowed dollars per service and a 6.7 percent increase in services per member.

I don't expect you to remember that, but those are the types of numbers it sounds like you're looking for. You know, what's the service going up by; how many more members; you know, what's the coding impact. So we'll get you that data for the different hospitals.

MR. SCHULTHEIS: That'd be very helpful. Thank you very much. That's all I had.

MR. BARBER: Dr. Murman?

MR. MURMAN: Hey. Yeah, thanks. Thanks, Dr. Weigel. I just have a few questions. So one is something I asked Ms. Greene, and maybe I'll sort of try to ask you as well and see if I can get more insight into this, which really speaks to Exhibit 12, page 9, the last paragraph on that page. There is a description of how when a hospital is given a rate increase from the Green Mountain Care Board, that they have flexibility to adjust their charge master in a

way that they think is probably best for their -- their -- their business. And that when -- then when you go negotiate with them, you're negotiating discounts off that charge master. I guess one, one -- the first question I have is, does that sound like a reasonable summary of that paragraph?

DR. WEIGEL: It does. So for example, if a hospital is getting a five percent increase and let's say this past year, they have the same utilization for a head MRI with contrast and a head MRI without contrast, for this following year, if they got a five percent bump, they might say we're going to increase the with contrast by seven percent and the without contrast by three percent.

MR. MURMAN: And that is something they do on their own, and -- and you don't have any negotiation with, or do you have some ability to augment their prices?

DR. WEIGEL: So we do the math on our end, and as long as it looks like it will be cost neutral based on utilization, we work with them around that.

MR. MURMAN: And is that

neutrality across the whole line of business from that hospital, or would that be just within imaging, say, for instance?

DR. WEIGEL: That would be across the whole hospital. So they could propose a reduction in inpatient, an increase in outpatient. They could propose a reduction for cardiology and an increase for ENT. You know, an example that might make sense of how this could be impactful over time.

MR. MURMAN: That'd be great.

DR. WEIGEL: Sure. So for example you know, the UVM Medical Center, as you said, doesn't or all the hospitals don't necessarily increase their charges for each thing equally. There's something, as you know, called conscious sedation, so --

MR. DONOFRIO: So Dr. Weigel and Board Member Murman, I apologize for stepping in.

DR. WEIGEL: Sure.

MR. DONOFRIO: I just want to caution you that if we're getting into specific facts and figures --

DR. WEIGEL: Yeah.

MR. DONOFRIO: -- probably best

left for executive session.

DR. WEIGEL: Okay. Yeah. This is an example for executive session then.

MR. MURMAN: Okay. That'd be that'd be great. So but I think with looking at public data in say for instance, the RAND data, you can see when you look at our Vermont hospitals, some of them have say, astronomically, there's a there's a table there in the RAND data table 4, which has breaks out the outpatient services.

And you can see that some of our hospitals have incredibly high prices for things like you mentioned, MRIs, CT scans. And so what I'm trying to understand is that from what you're saying is that is the hospital's choice of where to put that rate increase. They want to put that in advanced imaging. They could put that in advanced imaging, but they might take a reduction somewhere else say an obstetric care, hypothetically?

DR. WEIGEL: Correct.

MR. MURMAN: Okay. And so -- and when we look at the RAND data, what's sort of a common trend across all the Vermont hospitals is

no matter where they sit in their pricing, their outpatient pricing is several deciles above their inpatient pricing. I don't know if you noticed that trend, but I see that there. Do you see that, too?

DR. WEIGEL: Yes. I looked at the RAND data. Yeah.

MR. MURMAN: There may be one or two outliers. I'm not 100 percent sure, but that that looks pretty -- so and one thing that we do hear from time to time is that hospitals lose money on these inpatient medical admissions or other inpatient admissions. But it sounds from what I'm understanding now, and just -- if you think this is correct, that they actually have the ability to choose where that rate goes.

They could choose to increase the reimbursement for inpatient medical admissions. But it appears that the choice compared to national peers has gone towards the outpatient services category. Does that seem reasonable interpretation of that from what you can tell?

DR. WEIGEL: Looking at the data, that sounds reasonable.

MR. MURMAN: Okay. And so --

okay. And so when the -- I'm still trying to understand the details of this and I'm sorry if this is redundant for other people, but so when the Board orders this -- so one thing that we see in the hospital budget process is sometimes a hospital, and there's a few hospitals that budget with this methodology.

They'll say they could add up everything they got last year. And they look at their revenue coming in this year. And they look at what their increased utilization they predict, and they say, oh wow, we're going to be short $10 million. So what we need is more commercial rate increases to make up that $10 million.

And what I'm trying to understand is -- we've also heard testimony to certain hospitals, if they -- if they can't get that -- if there's a sort of, say, an initiative from an insurer to reduce the payments in an area because of a quality issue or whatnot, that that the hospital then say, well, you need to increase the payments to offset those reduced payments, is that that's something that I think we've spoken about before.

DR. WEIGEL: Right.

MR. MURMAN: Does that -- does

that sound accurate?

DR. WEIGEL: Correct. Yeah.

MR. MURMAN: Okay. So then if a hospital is --comes over that, say, $10 million that was needed through commercial rate increase -- so I guess, is that $10 million increase the rate that we're talking about. So let's say they get 100 million in commercial revenue, and they need 110, and they're going to get that through increased commercial rate, is the rate that we talk about the price, or is it that -- that -- that total revenue generated from, say, one commercial insurer, as far as you know?

DR. WEIGEL: The extra -- so that's the breakdown that I think was being asked for for hospitals. So some of it is the rate per service which is where we try to match up that Green Mountain Care Board rate. Some of it is increased utilization, and some of it is you could either say increased complexity or increased coding. You know, so you can -- you can code things to get paid more, you could say. So those would be three categories. And hopefully that will bear out in some of that data that we send you on the hospitals.

MR. MURMAN: Okay.

DR. WEIGEL: So that extra $10 million could be more patients through the door. It could be more complex patients according to coding, or it could be that the rate increase was five percent, but on average, the charges came in at eight percent.

MR. MURMAN: Okay. Can I draw your attention to Exhibit 26? Total different topic. And this may have been more appropriate for Ms. Greene, but -- and if so we can talk about it, I guess, at a different time. But in line one, two, three, four there's equity and gains losses VBA. What is VBA?

DR. WEIGEL: So that's Vermont Blue Advantage. That's our Medicare Advantage product, which did not exist until 2020.

MR. MURMAN: Okay. And then in 2020, if I'm reading this right, it lost $3.4 million?

DR. WEIGEL: That's how I'm reading it.

MR. MURMAN: Okay. And then '21 would be $6 million, '22, $11.5 million and then '23 $22.5 million loss there?

DR. WEIGEL: So I'm going to defer to either Ms. Greene or to Martine on that because it's quite possible that the business didn't even start until 2021, so I don't have the answers for you on -- on that.

MR. MURMAN: Okay. I'm just trying to -- this is something I maybe I didn't pick up until I read this chart again today. That looks maybe like 40 --

DR. WEIGEL: Yeah. I think what Ms. Greene testified was that that's a new line of business for us. And so we actually budgeted, you know, a loss for a number of years because it's starting up in a Medicare line of business that we were not in before. And so because of that, there's no contributions to our reserves that are coming from that because there was a built-in loss to get into that line of business.

MR. MURMAN: Okay. I think that this chart though, and maybe we could defer this to talk with Ms. Greene about it again. But this chart doesn't -- okay. So this is all contribution to reserves and those. So this is drawing from reserves essentially to run this program?

DR. WEIGEL: That's my impression. But why don't we leave that for Ms. Greene?

MR. MURMAN: Okay. That is all I have right now, so thank you.

MR. BARBER: Board Member Lunge?

MS. LUNGE: I think all of my questions are related to executive session, so I will pass it on to the next.

MR. BARBER: And the next is Board Member Holmes.

MS. HOLMES: Great. Thank you. And good afternoon, Dr. Weigel.

DR. WEIGEL: Good afternoon.

MS. HOLMES: I wanted to talk to you about -- I think it's on Exhibit 5, page 4, the enhanced community primary care program.

DR. WEIGEL: Okay.

MS. HOLMES: Are you the right person to ask this question about this program?

DR. WEIGEL: Yes.

MS. HOLMES: Okay. In the description there, it described a $6.30 per member per month maximum for delivering, you know, high-quality, low-cost care. But the expected payout would be about $2.54 per member

per month. So I'm wondering if you could just describe a bit the expected shortfall there from the primary care provider's perspective, why they're falling short of achieving the maximum payout.

DR. WEIGEL: Sure. So this is a program that was new in 2024. And what we did was we took the dollars that were previously being paid to OneCare for their programs. And we're taking that money and putting it into these two value-based care programs, Vermont Blue Integrated Care, or VBC, and the ECPC program that you referenced.

And so for the program that you referenced, we actually focused this program on community primary care providers. And so and we also had heard feedback from our other program, VBC, that the providers didn't want to have to submit information to us about things that they were doing, but that they just wanted us to recognize the good work that they were doing and incentivize that. So we looked at claims metrics, which are easy for us to measure and to look at.

And so we're looking at quality of

care metrics around high blood pressure and diabetes direction of services, whether they're referring their patients more expensive sites for laboratory care or imaging. There was an incentive to install an electronic medical record overlay called Innovaccer. This is an overlay that helps providers close gaps in care and avoid duplicative care. And so they could earn a certain amount PMPM for each criteria that they met. And so it's possible that if you didn't meet all the criteria, that you wouldn't get that whole $6.30.

Most of the shortfall was actually for not installing the Innovaccer program EMR overlay. And so we're reexamining that for the 2025 year to see whether we want to incorporate that.

MS. HOLMES: Got it. Is there a calculation that you've done about the expected, say, return on that investment, PMPM, in terms of the cost savings that you're expecting? I mean, will it exceed, for example, $2.54 per member per month?

DR. WEIGEL: Yeah. We don't have the data --

MS. HOLMES: Or $6.30?

DR. WEIGEL: Yeah. We don't have the data yet for that.

MS. HOLMES: Is there a plan to do that calculation?

DR. WEIGEL: Definitely, yes.

MS. HOLMES: Okay. I'm curious about these GLP-1 drugs, the Wegovys and the Mounjaros. It is listed as one of the drivers explaining some of the pharmaceutical trend. And I'm wondering if you, when you're doing the calculations, thinking about the increased pharmaceutical expense associated with these drugs, do you also factor in any potential cost savings associated with better diabetes management or you know, better cardiovascular disease outcomes through weight loss, anything like that?

We've got the pharmaceutical trend uptick. Is there any compensating reduction in cost associated with the use of these drugs in in the calculations?

DR. WEIGEL: Yeah. So most of these medications are pretty new. And so we don't have the long-term data. The weight loss-

specific medications, the pharmaceutical companies are actually pursuing FDA approvals for non-weight loss medications. .

So for example, cardiovascular disease and things like that. So but we don't have long-term data to really see what the cost savings might be. We do have data to suggest there's a very high discontinuation rate for these medications over the course of a year. And we can provide that data if that's of interest.

MS. HOLMES: No. I'm just curious if there's an associated benefit to usage of these drugs in terms of cost savings that's also included in the analysis.

DR. WEIGEL: Yeah. So I -- I -- I can try to dig up a paper. I'm doing this from memory, but there was an analysis around the cost of the medications and the savings, and I believe the analysis was that I think medications would have to cost about seventeen times less to actually -- with the gains and benefits for heart disease, and you know, all these other things that the medications are so expensive, you know, 1,000-plus a month that they don't -- at that price, they don't offset, but I -- I'll dig up

that article for that.

MS. HOLMES: Okay.

DR. WEIGEL: My number might be wrong.

MS. HOLMES: That's okay. I'm asking you on the fly. And I'm also curious about in 2024, Blue Cross Blue Shield waived prior approval for the open MRI machine, using the open MRI versus another alternative. My assumption is that there's expected cost savings associated with waiving that prior approval process. Is that something that you all have analyzed?

DR. WEIGEL: We don't have numbers from that, and we actually did not plan for specific cost savings. The hope is that providers generally will refer their patients to open MRI, which is a lower cost facility, but you know, we have no way to really predict how much of that would happen.

MS. HOLMES: Okay. And do you waive any other prior auths for other lower cost providers? That's the one that's noted, and I believe there was even a news article about it, but I'm wondering if there's other opportunities

for waiving of prior authorizations for other low-cost providers.

DR. WEIGEL: I'll have to talk with my contracting person and get back to you on that. You know, we certainly made a big effort in 2023 to remove prior authorizations for all in-state in-network mental health services, whether it's inpatient, residential, partial hospital, IOP, outpatient therapy, outpatient psychiatry visits. We don't have any prior authorizations on those, and were able to remove those hopefully to, you know, increase access -- and in that realm.

MS. HOLMES: Okay. That'd be helpful to understand how you're able to direct patients to -- to more lower cost providers, particularly since the providers themselves are the ones often directing that care, as you well know, but they might have an incentive if they don't have to fill out a prior auth, right, to -- to direct their patients to more lower cost services.

I'm also curious about your -- the description of the lab benefit management and sounds like you're working with a third-party

vendor -- vendor to provide more oversight of the genetic tests that are being done and also hospital lab work. And I'm wondering how much you're expecting to save from this particular program, and if any -- if your third-party vendor has identified any outlying providers that are ordering a high number of potentially unnecessary labs or tests yet in your analysis.

DR. WEIGEL: So on the latter one, they -- you know, they have you know, payment integrity and you know, fraud, waste, and abuse built into how they -- how they pay the claims. The most common thing that they would see would be an unbundling, meaning, you know, you can order like a chem 7, which includes seven different tests and that's billed as a bundle or you can bill all seven separately, which is a lot more expensive. So most of what they catch is the bundling or unbundling for that. And Martine would have information about the savings on that.

MS. HOLMES: Okay. I will hold that thought then. And then this is the question that I had actually asked Ms. Greene this morning with regard to all of the hospital and insurance price transparency data that's now available,

wondering if Blue Cross Blue Shield had done any analysis comparing the negotiated rates at Vermont hospitals, New Hampshire border hospitals with the larger out-of-state insurers, you know, the Aetnas, the Cignas, United Healthcare, all of those larger insurance carriers, wondering if how Blue Cross Blue Shield stacks up in the negotiated rates with our hospitals on an absolute level, and then, frankly, on an annual growth level.

I know that data hasn't been out that long, but what kind of analysis has Blue Cross Blue Shield done to see that?

DR. WEIGEL: Yeah, I think we'll have to send that to you separately, but I'm happy --

MS. HOLMES: Okay.

DR. WEIGEL: -- to get that for you.

MS. HOLMES: That's fantastic. Thank you. And I recognize there are a lot of codes to analyze. So if it's -- you know, if you want to pick the most frequent codes or something like that, that you have -- whatever analysis you've done that would give us a sense of -- of

relative negotiated rates.

And then I just have one other question, but frankly, it's a big one, so it's like a 40,000-foot question. And you know, this relates to the work that we're doing as a state right now. You know, this premium growth that we're seeing, I think we can all recognize it's unsustainable, and as I'm sure you're aware, Act 167 requires the Green Mountain Care Board to work in collaboration with AHS to try and figure out more cost-effective ways to deliver healthcare in the state.

And I think what we're seeing and learning is a bit about, you know, how affordable are we -- is our current healthcare system and the financial projections of hospitals are troubling. Blue Cross Blue Shield solvency is troubling. If you look at hospitals -- if you look at households and businesses, they're struggling to pay taxes and premiums.

So my question to you is you have a very unique perspective over the entire system, and I'm wondering what you -- specifically what you might see as a path forward for hospital system transformation that's going to bend

premium growth in the future and whether Blue Cross Blue Shield has any data or analysis that would help us inform our hospital transformation process along the dimensions of quality.

For example, are there certain hospitals where revision surgeries are really high or surgical site infections are really high because maybe volumes are low? Or are there any -- is there any data around costs? You know, you've talked a little bit about prices already. You've talked a little bit about potentially unnecessary labs and images, but I'm wondering what -- what you see as a path forward to -- to try and provide some premium relief to consumers in the future and what data you could add to the conversation to help us move there.

DR. WEIGEL: Sure. You know, first looking at quality, what we see in our quality data and when the Blue Cross Association looks at our data compared to, you know, other Blue Cross plans. You know, the quality of our Vermont providers is fairly solid, and so we don't see major quality issues. That being said, there's certainly one-offs here and there.

You know, I'm interested to hear

more about what comes out of the Oliver Wyman assessments and eventual recommendations. You know, we have a lot of -- you know, we have hospitals throughout the state and are they each performing the right sorts of services for those community members who are in that area, and are they optimized in the best way that they could be. So I'm looking forward to that. I think that that could really help our spend, it could help our communities, and it may help access, too.

Something I keep coming back to, which really was highlighted by the RAND report, is -- we have this standard, we have Medicare. They look at their -- what they pay people, what they pay providers for each and every code every single year, and they make revisions and they -- they give certain providers more or less, you know, based on what codes they have.

But looking at a percent of Medicare could really make sense, whether it's for community providers, for wellness visits, for things that we want to incentivize that we might pay a higher percent of Medicare for that, for outpatient or professional fees -- for things

that we want to, you know, disincentivize we could pay a lower percent. But when you hear things like, you know, a community provider might get 150 percent of Medicare for a wellness visit, but you know, a hospital might get, you know, 400-plus percent for a professional fee, you know, you can start to think of a way to move reimbursements from one area to another so that we're really supporting community providers, primary care, and wellness.

MS. HOLMES: Reference-based pricing? Okay. I thank you for that.

And I think I will pass it along back to you, Mr. Barber.

MR. BARBER: Okay.

Chair Foster.

CHAIR FOSTER: Good afternoon, Dr. Weigel. Exhibit 1, page 23. There's a chart of the reimbursement changes.

DR. WEIGEL: Yes.

CHAIR FOSTER: And from the chart, it indicates that the non-hospitals, with whom Blue Cross contracts, did slightly better in terms of the reimbursement changes in these -- in this period of time; is that correct?

DR. WEIGEL: That looks correct.

CHAIR FOSTER: And from my understanding, that is different than prior years.

DR. WEIGEL: I believe so. I don't have prior years' data in front of me.

CHAIR FOSTER: I guess my question is why is that. What sort of led to the non-hospitals receiving slightly -- slightly greater reimbursement increases as opposed to the hospital system?

DR. WEIGEL: This would probably be a better question for Martine with that data because I did not prepare this table.

CHAIR FOSTER: Okay. I can ask her. And maybe this one is better for her as well, but I'll ask it. Last year, the Board's Blue Cross order said something to the effect that Blue Cross needed to consider access, quality, and affordability in its rate negotiations. Could you speak to how Blue Cross did that?

DR. WEIGEL: That also might be a better discussion with Martine and Ms. Greene.

CHAIR FOSTER: I'm going to find

one for you.

DR. WEIGEL: Okay.

CHAIR FOSTER: Quality. How does Blue Cross -- what kind of -- what do you look at when you're evaluating quality of providers in Vermont?

DR. WEIGEL: Sure. We have a number of different ways that we do that. We actually have member assessments, you know, of our own providers' quality. We look at quality data around -- I think the examples I had given before were, you know, around control of diabetes or hypertension. So those are quality metrics we have. But a lot of these are things that we do for HIDAs, and so I can certainly send more information about quality, and HIDA measures for that. We also have -- I think I referenced it last year in this hearing, but we have some newer reports from the Blue Cross Association that looks at the quality of our providers versus national providers within -- with other Blue Cross Blue card data and also data from payers like Cigna and United. So we -- we look at quality through that, too.

CHAIR FOSTER: That's one area

where the Board is working on improving our work is on the quality. So anything you guys can share on that, we can talk offline out of this process. That would be helpful. And you said something about the quality in Vermont being, I think you said generally solid. What did you mean by that?

DR. WEIGEL: You know, when we -- when we do things like this ECPC value-based project and when we work really closely with, you know, the four practices that we have in our Vermont Blue integrated care VBP, value-based project, you know, we generally see that the providers are scoring pretty well on the quality metrics, and you know, that we -- we generally don't encounter providers where we have a lot of concern about quality across the Board.

So I think overall, compared to other states, you know, we have a good level of quality of care from our providers. You know, I think I've heard that from many different sources and was also talked about in the legislature that we have a little bit more of an access problem than a quality problem, and we definitely have a cost problem.

CHAIR FOSTER: In your prefiled testimony and in Exhibit 12, there is discussion of some of the high costs of our hospital system here in Vermont. And you know, sort of the sense I'm getting in this hearing is that we -- we should -- the argument is we should approve the rates because you need it for RBC and solvency and the costs are just so extreme, and it seems like the costs are really extreme because they're going up and their utilization is going up.

And my understanding of healthcare reform is it's really designed to one, focus on preventative care, so costs go down; and two, focus on moving care out of expensive places to less expensive places.

And I think with Member Holmes, you discussed the open MRI. And so I was wondering if -- what can be done there on the Blue Cross side. And I know you have Exhibit B, but I was hoping you could speak a little bit more to what an insurer, like yourselves, can do to -- to drive that.

DR. WEIGEL: Yes. I mean, we did -- we made that move with open MRI. You know, imaging is -- is high cost, and there's

very high cost facilities doing imaging and open MRI was lower cost. You know, we -- we are make -- we are -- for laboratory work, there's a similar dynamic. And so you know, some places have very high lab costs, other places fairly low, especially if, let's say, a primary care practice in Plainfield has their own lab that they've, you know, worked really hard to build up.

So you know, we'd like to incentivize using more community labs like that, and so with our ECPC value-based project, we built an incentive in for providers to refer members to lower cost imaging and lower cost laboratory services.

You know, I think the other thing that is -- you know, I will acknowledge -- is that, you know, prior authorizations are going to be removed for primary care providers in 2025. And you know, there's hope that this will reduce provider burden. Some of that expense is built into the rate increase, I think, as you saw, but ideally this will attract more, you know, primary care providers to our state, you know, who want to practice. And if we can shift some of the

reimbursements to those providers, that would help, too.

CHAIR FOSTER: There is a suggestion that affordability is measured by whether or not the rate is enough for solvency without being excessive. And I struggle with that because to me, that sounds like you could make the rate increase 50 percent. And so long as Blue Cross wasn't obtaining additional unnecessary funds from that, that would be affordable -- or one hundred percent or triple. And I don't know that that works. All right?

So I think based on these rate increases, it would be -- I calculated it for a silver plan, I think they're around $33,000 right now without subsidies for a family of four. So 20 percent, you're looking at 600, $700 a month more for a family of four. And BMW 5 Series lease is $695 a month. So it's nearly equivalent to leasing a BMW every single year, and that -- that just can't be affordable. It's just -- I don't know that many people, that many BMWs in their driveway, but it's not.

DR. WEIGEL: Sure. And so you know, I mean, I -- I was a -- before I came to

Blue Cross, I was in the QHP market with a family of four, so that's impactful. And I just got my Town of Fayston property tax bill that I thought I was actually making monthly payments toward to -- to pay it off, but it's still pretty hefty and has gone up quite a bit.

I think affordability is going to be a difficult topic in these meetings if it's not really clearly defined. And -- and maybe affordability is the, the percent of Vermonters uninsured because they choose not to buy it. Maybe it's the percent of Vermonters who rate themselves as underinsured or medically, financially stressed or in debt because of medical debt. You know, those are all numbers that are out there, but that's not really how it's defined, but that -- you know, those are ways to think about affordability in my mind.

CHAIR FOSTER: Yeah. They're -- they're indicators that something's going -- right. Are you -- are you seeing any of that? Are you seeing people buying down to lower levels of insured -- insurance products with Blue Cross?

DR. WEIGEL: I don't have that data in front of me.

CHAIR FOSTER: Okay.

DR. WEIGEL: But we do have that data.

CHAIR FOSTER: I don't have any other questions. Yeah. I got about fifteen percent of the right questions for you. All right. Thank you.

MR. BARBER: Mr. Donofrio, any redirect?

MR. DONOFRIO: No. Thank you.

MR. BARBER: Okay. I did -- I did hear a question for Ruth Greene from Dr. Murman, and I don't think we'll be coming back to her after the executive session, and it didn't sound like confidential material. So I'm wondering if she could be available to just get that squared away real quick?

MS. ASAY: Hi. This is Bridget Asay. Yes. Ms. Greene is on the line so she can address that question.

MR. BARBER: Ms. Greene, did you hear Dr. Murman's question about Exhibit 26 and the equity gains and losses on the VBA business?

MS. GREENE: Yes, I did.

MR. BARBER: And could you try to

answer that as best you can?

MS. GREENE: Sure. That line noted equity gains and losses in parentheses. VBA, that is the 49 percent share of the joint venture that we have to enter the Medicare Advantage market. And the first year we started selling Medicare Advantage plans was 2021. The cost in 2020 were the implementation costs to get set up for open enrollment and do the bid and all of that for that book of business. And the numbers shown in '21, '22, and '23 is the Blue Cross Vermont share of the losses in that line of business.

The losses grew in 2022 and '23, both due to membership growth at a loss, and also because of the unplanned-for higher medical cost escalation that we've been talking about on the commercial business. I hope that gets at the question. If not, happy to elaborate further.

MR. BARBER: Dr. Murman, do you need any elaboration?

DR. MURMAN: So -- so I just want to clarify. So the cumulative loss of the Medicare Advantage program so far is about just over $43 million?

MS. GREENE: Yes, over four years.

DR. MURMAN: And that money has effectively come out of member reserves to fund that; is that accurate?

MS. GREENE: Yes, whenever we enter a new market and grow business, it would -- it would put a drain on reserves.

DR. MURMAN: Okay. And just to clarify, and I -- you said it's a joint venture. Who's the joint venture with?

MS. GREENE: It's with our new affiliation partner, Blue Cross Blue Shield of Michigan. Prior to the affiliation, we were partnering with them to enter the Medicare Advantage market.

DR. MURMAN: Okay. And is the -- what is the current plan for this? Is it to continue -- continue this product line?

MS. GREENE: That is something that we are prepared to talk about in executive session. We have some plans in this line of business, but it's a highly competitive market, and moving into 2025 would be sensitive information.

DR. MURMAN: Okay. Thank you.

MR. BARBER: Yeah. Thank you for taking that out of turn. So --

CHAIR FOSTER: I have a follow up on that.

MR. BARBER: Oh. Okay.

CHAIR FOSTER: So how much RBC is $43.4 million?

MS. GREENE: I can do the math for you.

CHAIR FOSTER: I think you said 10 million is 33 RBC points?

MS. GREENE: So 100 and -- sorry -- 140 points. When we entered that market, we planned on investing about 100 percentage points of RBC. We knew that it was going to cost something, so it cost us more as a business, but you know, we do -- we've been very pleased with the acceptance of that market. We've got 15,000 members and about 7,000 of those are group members, including Vermont teacher retirees, as well as 8,000 individuals that we're serving in that market.

CHAIR FOSTER: So one of the messages throughout this hearing has been that, you know, it's -- I didn't take it like a

offensively in any way whatsoever. It's a -- it's a fair discussion and it's an important discussion, but sort of some of the language around underfunding. But it seems like there's pretty big losses from the Medicare Advantage program.

And I can't say, you know, it's underfunding and then see, like, huge losses in another line of business. Is it the underfunding or is it the loss in the other lines of businesses? And there's many factors, right? Like there's overages, which are also costing a lot of money, but I think it's -- I think it's more nuanced than simply underfunding.

MS. GREENE: Yeah. I think if I come back to the general point about the -- the first order of business is to have premiums that are going to cover the cost of the healthcare for those members and the expenses, and that we need funded premiums. It's -- it's the same for Medicare Advantage. We do have to turn that around --

CHAIR FOSTER: Sure.

MS. GREENE: -- but the main focus here is the QHP market.

CHAIR FOSTER: Thanks.

MR. BARBER: Ms. Asay, do you have anything you want to follow up with around this? I know we took -- took a detour here, but.

MS. ASAY: No, I think we're good.

MR. BARBER: Okay. Then I think -- I don't think we were on the record when we had this conversation, so I'll just -- I'll say it on the record. Blue Cross had suggested that we swear in Ms. Brisson-Lemieux in the event that when we get into executive session, that there are questions that would be best suited for her to answer. So I'll do that now, and then we'll kind of go through the mechanics of going into an executive session. So Ms. Lemieux, are you -- are you with us?

MS. BRISSON-LEMIEUX: I am.

MR. BARBER: Okay.

Whereupon,

MARTINE BRISSON-LEMIEUX,

a witness called for examination by counsel for the Board, was duly sworn, and was examined and testified as follows:

MR. BARBER: Thank you. So just to remind everybody the -- the open meeting law

has an exemption or a couple actually exemptions that could apply to the topics that I think are intending to be covered here, but there's also our rate review statute, which is pretty -- pretty broad.

So it says, "Notwithstanding the open meeting law, the Board may examine and discuss confidential information outside a public hearing or meeting". So that would -- that would be really any of the blue highlighted information in the binder and the confidential topics to which they relate.

So that would be -- you know, I think we've identified a prospective solvency assessments, some detailed provider contracting information, and I think some of the -- DFR has its own unique confidentiality provisions around some of their assessments.

So that would be what I would expect to be covered in an executive session here. And so would anybody like to make a motion to go into executive session to consider confidential information under our review statute?

MS. LUNGE: I move we go into

executive session to consider confidential information under the rate review statute.

MR. BARBER: Is there a second? All those in favor, please signify by saying aye.

IN UNISON: Aye.

MR. BARBER: Okay. So just to remind you that if you have any questions about -- so really this is -- needs to be limited to information that is confidential. If there's any questions about what is confidential that arise, we can talk through that and kind of move to the public session, anything that needs to be done there.

In terms of who should go over to the executive session, I think pretty much anyone that got the invite, so the parties and their representatives, the Board members, Board staff, Department of Financial Regulation folks, court reporter, Blue Cross and its representatives and I think I got everybody, but does everyone -- is everyone clear on who should be moving over? Okay. I don't hear any questions. So then why don't we leave this. Call into the executive.

(Recess at 2:01 p.m. until 3:43 p.m.)

THE COURT REPORTER: We are now

going back on the record. The time is 3:43 p.m.

MR. BARBER: And we just finished an executive session and now turn it to Blue Cross to call their next witness.

MR. DONOFRIO: Thank you, Mr. Barber. I apologize, we just need a minute. Martine Brisson-Lemieux is just moving from one office and basically she's switching seats with Dr. Weigel. So she's just on her way. That's how we have to configure due to the Teams setup, so we just need a moment.

MR. BARBER: Okay. Yeah, just let me know.

MR. DONOFRIO: Yeah. Thank you.

(Pause)

MR. DONOFRIO: Thank you. We're ready. May I proceed?

MR. BARBER: Yes.

MR. DONOFRIO: Okay. Thank you.

Ms. Lemieux, will you please state your name and your current position for the record?

MS. BRISSON-LEMIEUX: My name is Martine Brisson-Lemieux, and I'm the chief actuary at Blue Cross Blue Shield of Vermont.

MR. DONOFRIO: And how long have you been at Blue Cross?

MS. BRISSON-LEMIEUX: I joined the Blue Cross actuarial team in 2009.

MR. DONOFRIO: Did you prepare and submit pre-filed testimony for this proceeding?

MS. BRISSON-LEMIEUX: I did.

MR. DONOFRIO: Would you identify your pre-filed testimony by exhibit number?

MS. BRISSON-LEMIEUX: Yes, my July 12th prefiled testimony is Exhibit 18, and my July 16 supplemental prefiled testimony is Exhibit 21.

MR. DONOFRIO: Was all of the testimony contained in Exhibit 18 and Exhibit 21 true and correct to the best of your knowledge at the time you submitted it?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: And is that still true today?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: Thank you. Were you responsible for preparing the Blue Cross 2025 individual and small group rate filings that are the subject of this proceeding?

MS. BRISSON-LEMIEUX: Yes.

UNIDENTIFIED SPEAKER: (Indiscernible).

MR. DONOFRIO: What was that? Okay. You can proceed.

MS. BRISSON-LEMIEUX: Yes. I was actively involved in the preparation of the filings, and I am fully familiar with all aspects of the filings and the underlying rate developments.

MR. DONOFRIO: And did you certify the filing?

MS. BRISSON-LEMIEUX: I did. And at the time of filing, I certified that they meet all relevant actuarial standards of practice, that they comply with applicable state and federal law and regulations, and with the revision included in my supplemental prefiled testimonies, that certification holds true today.

MR. DONOFRIO: And were you responsible for preparing the information and responses that Blue Cross had submitted to the questions Blue Cross has received from the Board, from Lewis & Ellis, and from the Health Care Advocate?

MS. BRISSON-LEMIEUX: Yes. All the information was either prepared under my supervision or by other Blue Cross departments. I am fully aware -- I am familiar with all the aspects and the material and can answer questions related to the methodologies and the functions in the filings.

MR. DONOFRIO: Thank you. Please turn to Exhibit 12, which is the July 12th responses to questions from the Board, from Lewis & Ellis, and the HCA, and turn to page 11. Tell me when you're there.

MS. BRISSON-LEMIEUX: I am there.

MR. DONOFRIO: Do you see the heading, "Response to May 28 L & E question and June 20 HCA question"?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: Would you please summarize what's being asked in the --

MS. BRISSON-LEMIEUX: The questions were asking about our projected RBC for 2024 and 2025.

MR. DONOFRIO: And are you familiar with the response that follows?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: And are you aware that certain information in that response has been deemed confidential by the Board?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: Without disclosing any confidential information, would you please describe the modeling process in general terms that led to the RBC projections?

MS. BRISSON-LEMIEUX: So we have two ways that we can project future financial results. First, we can do it deterministically or stochastically. In a deterministic model, we determine specific values for the assumptions, like membership, medical trust, investment return, and then we put all of those pieces together and we calculate, say, risk-based capital at a certain date.

In a stochastic modeling, we still define the most likely result for each assumption, but then we put a range of possible outcomes for the distribution around the material assumptions. And then we run the model 10,000 times, which is an enormous amount of time, so that the model can randomly select for each assumption within the range following the

distribution, the different assumption, and that way we have an output that is a range of results and a probability distribution within that range.

MR. DONOFRIO: And which type of modeling did you use in generating the RBC projections that you've provided during this year's rate review process?

MS. BRISSON-LEMIEUX: So we did both. So we started with a deterministic model to set our best estimate, and then we moved on and created the stochastic modeling, that created the ranges around each of the material assumptions. And we believe that looking at the stochastic results is a more useful information in this proceeding.

MR. DONOFRIO: Why do you think that? Why do you think stochastic is more useful?

MS. BRISSON-LEMIEUX: The stochastic model, first it gives us a range of outcome. We know that there's a lot that goes into RBC and all the different components can vary. It also gives us probabilities of being above or below a certain range or a certain threshold. And also, it takes into account all

the variables.

MR. DONOFRIO: Is this the first time you've used stochastic modeling for this purpose?

MS. BRISSON-LEMIEUX: No. This is the third year we've created this kind of model for rate review.

MR. DONOFRIO: Okay. Changing gears a bit, have you had a chance to review Lewis & Ellis' analysis of the filings which are Exhibits 14 and 15 in the binder?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: Would you please turn to page 23 of Exhibit 14 and tell me when you're there.

MS. BRISSON-LEMIEUX: I'm there.

MR. DONOFRIO: Is it correct that Lewis & Ellis recommended six changes to the proposed individual rates?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: And if you would flip to page 22 of Exhibit 15.

MS. BRISSON-LEMIEUX: I am there.

MR. DONOFRIO: L & E recommended five changes to the proposed small group rates,

right?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: And those five are also made in Exhibit 14 with respect to the individual rates, right?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: What is the sixth recommendation that's specific to the individual rates?

MS. BRISSON-LEMIEUX: To modify our application of the silver load methodology, and silver loading only exists in the individual market.

MR. DONOFRIO: And does Blue Cross agree that L & E's recommendations should be adopted in both markets?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: If you could turn to Exhibit 21, your supplemental prefiled testimony.

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: At pages 1 and 2, does your supplemental pre-filed testimony still accurately reflect Blue Cross' position with respect to L & E's recommendations in both

filings?

MS. BRISSON-LEMIEUX: Yes, it does.

MR. DONOFRIO: Beyond Lewis & Ellis' recommendations, is Blue Cross proposing any other changes to the originally filed rates?

MS. BRISSON-LEMIEUX: Yes. We are proposing two changes. First, some of our -- so New Hampshire Hospital, with whom we contract directly, have July 1st renewal dates. So we now have actual negotiated rates for July 1st, 2024. So incorporating those final contract terms and assuming that the next renewal will look like the 2024 renewal, that decreases the proposed rates by 0.2 percent. The second one is that we are now requesting a seven percent contribution to reserve, which is an increase of four percent from the original filing.

MR. DONOFRIO: If you would turn now to page 5 of Exhibit 21, your supplemental prefile.

MS. BRISSON-LEMIEUX: Yeah.

MR. DONOFRIO: Please explain what that table shows.

MS. BRISSON-LEMIEUX: So the table

shows the incremental impact of L & E's recommendation, except for the update in benefits and the change in silver load methodology because those don't have an impact on the average rate. It also shows the two changes I just talked about.

MR. DONOFRIO: If you would focus for a moment on the fifth row of the table that shows the impact of updating medical costs trends for Vermont hospitals, that was one of L & E's recommendations, right?

MS. BRISSON-LEMIEUX: Right. And --

MR. DONOFRIO: Oh, go ahead.

MS. BRISSON-LEMIEUX: Yeah. So this reflects the hospital budget submitted as known on July 16th.

MR. DONOFRIO: So if the -- so just looking at the numbers on the table, if the unit cost trend were set to the hospital submissions, rates would increase by about one percent in the individual market and about 0.9 percent in small group?

MS. BRISSON-LEMIEUX: That's correct. That's the value of the change between

what we assumed in the original filings for cost funds for FY25 and what is in the submitted hospital budgets.

MR. DONOFRIO: And is it Blue Cross' position that those numbers should be used for the final approved rates?

MS. BRISSON-LEMIEUX: No. Our position is that we will apply whatever percentage reduction that the Green Mountain Care Board directs us to use for the hospital budgets for FY2025. Just as a reference point, a ten percent -- ten percent reduction in the commercial rates increase, so a ten percent becomes a nine percent, would reduce our rates by about 0.2 percent.

MR. DONOFRIO: And why didn't you make a specific assumption about the Green Mountain Care Board's percentage reduction of the current hospital budget?

MS. BRISSON-LEMIEUX: Because over the past two years, the Board has reduced hospital budgets by seventeen percent two years ago and fifty percent last year. And given the variance in those results, we decided not to select and assume reduction for this table.

MR. DONOFRIO: So do the final proposed rate increases shown at the bottom of the table on page 5 of Exhibit 21 represent Blue Cross' final proposed rate changes?

MS. BRISSON-LEMIEUX: Almost, but not quite. Again, the final rates should include whatever the Board tells us to reduce the hospital budget by.

MR. DONOFRIO: And have you acquired any information since submitting your prefile -- your supplemental prefile testimony that bears on this topic?

MS. BRISSON-LEMIEUX: Yes. I now know that there has been amended hospital budget requests.

MR. DONOFRIO: And when did you find that out?

MS. BRISSON-LEMIEUX: Earlier today.

MR. DONOFRIO: During this hearing?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: Have you had a chance to process that information and assess its impact on the proposed rate?

MS. BRISSON-LEMIEUX: No.

MR. DONOFRIO: And will you do that?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: Okay. If you would turn to page 3 of Exhibit 1, the actuarial memorandum.

MS. BRISSON-LEMIEUX: I am there.

MR. DONOFRIO: Section 1.3 on page 3 lays out the laws, rules, regulations, and other legal authorities that the filings must comply with, right?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: And in your professional opinion, do the filings comply with those requirements?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: And if you would flip to page 8 of Exhibit 1. Section 1.8 that begins on page 8 addresses the Vermont statutory criteria that guides the Board's review, right?

MS. BRISSON-LEMIEUX: Yes.

MR. DONOFRIO: In your professional opinion, do the fillings comply with those criteria?

MS. BRISSON-LEMIEUX: Yes, they do.

MR. DONOFRIO: Thank you. I have no further questions.

MR. BARBER: Eric? You ready?

MR. SCHULTHEIS: Yeah, thank you, Mr. Barber.

Hi Ms. Lemieux, how are you?

MS. BRISSON-LEMIEUX: I'm well. How are you?

MR. SCHULTHEIS: Hanging in there. So would you turn to Exhibit 12, page 14. I just have a few questions. And I promise I will avoid the confidential part. Just because I can't resist asking fellow numbers -- people numbers questions. I was going to say nerds, but I changed that, Ms. Lemieux. So you list the things that are stochastically modeled, the various lines of business in that claims portion, so the top portion, correct?

MS. BRISSON-LEMIEUX: Yes.

MR. SCHULTHEIS: And then you kind of list out what the assumptions are for '24 and '25, right?

MS. BRISSON-LEMIEUX: Yes.

MR. SCHULTHEIS: And I'm just guessing, and I don't think this gets -- this really doesn't, but like, some weight, some assumptions that get you in the -- that feed into the stochastic model differ and some are the same, yeah?

MS. BRISSON-LEMIEUX: Yes.

MR. SCHULTHEIS: Okay. That's all my questions. Thank you.

MR. BARBER: Ms. Beliveau, any questions for Ms. Lemieux?

MS. BELIVEAU: No questions. Thank you.

MR. BARBER: Board Member Walsh?

MR. WALSH: Thank you.

And good afternoon, Ms. Lemieux. My question is in regards to the table in Exhibit 1 on page 23 of the filing.

MS. BRISSON-LEMIEUX: Yes.

MR. WALSH: I asked it earlier this morning and your name came up as someone who might be able to answer. I'm trying to understand the ramifications of this table or the implications where fifty-four percent of claims in '23 were made by GMCB regulated entities,

forty-six percent, not. And the forty-six percent seem to be growing faster. Those -- and is that due only to cost, meaning price, from those entities? Or does that also include utilization and diagnostic intensity?

MS. BRISSON-LEMIEUX: So this particular table is cost trend only.

MR. WALSH: Okay.

MS. BRISSON-LEMIEUX: And I want to point out, because I've been thinking about it today, that the cost trends for Green Mountain Care Board regulated hospital from '24 to '25, that it says 3.5 percent, right, that is what we included in filing, which for the Vermont Hospital we had assumed that they would follow the Green Mountain Care Board guidance. And just as a point for you, when that number with the updated hospital budgets that I knew on July 16th, that number becomes 5.7. So just a data point.

MR. WALSH: Yeah.

MS. BRISSON-LEMIEUX: For your questions around utilization and intensity, right, we do that separately in the filing. I don't have -- we don't split out in our

projection of trend if it's a Vermont Hospital or a non-Vermont hospital. We do it in total. What we have seen, sort of, come out of 2024, right, is that we are seeing both increases in utilization and increases in intensity or -- which intensity is also known as, like, the mix of services, right, within a broad category.

MR. WALSH: Uh-huh. Yes. And I think there's been some lack of clarity. Member Murman and I have been asking questions about diagnostic intensity with Medicare CMI, the case mix index and if in last year's hospital budget hearings we were presented with information that some hospitals would be trying to increase their case mix index to and in their opinion, more accurately reflect the illness severity of their population.

And so I'm trying to better understand what's driving the April and May surge and what's driving the increase in claims overall. And my understanding is that would be a mix of the utilization of services, the price of each service, and the diagnostic intensity associated with each service. Am I thinking about that correctly?

MS. BRISSON-LEMIEUX: Yes. And I would add to that, and I'm now understanding when you mean the diagnostic intensity, it's -- I'm -- it -- you are referring to how it is coded, right --

MR. WALSH: Um-hum.

MS. BRISSON-LEMIEUX: -- versus what we see also as intensity is different services. And I'm not a clinical person but you know, increases and more intensive office visits for example, right? So that's intensity as well.

MR. WALSH: Um-hum.

MS. BRISSON-LEMIEUX: What's difficult with what's going on in March and April, and May, is that with claims run out, right? So in -- here we sit in July, right? Claims that are paid through July. But really they are for services that are a few months old at this point. And it's difficult to go into that level of detail with no run out because facility claims, for example, take at least two months to be like, ninety percent there.

MR. WALSH: Uh-hum.

MS. BRISSON-LEMIEUX: So I don't have good answers for you yet, but it is

something we are focused on. We have like working groups that are trying to figure it out. I do have a couple data points to share that I think might answer part of your question. On the inpatient side, what I'm seeing is that, and admissions are up two percent. So year ended April 24th to year ended April 23rd. Admissions are up two percent, but our average length of stay is up seventeen percent. Now, I don't know why, but that is a driver, right? The more days you are in, that will be a driver of increased cost.

MR. WALSH: Um-hum.

MS. BRISSON-LEMIEUX: I can also see that on the outpatient side, right, we talked about how outpatient seems very expensive compared to other things. We have a number of visits, which is up four and a half percent, but the number of services and you can have more than one service per visit.

MR. WALSH: Yes.

MS. BRISSON-LEMIEUX: That is up eight percent. So what we're seeing is that in a visit, there appears to be more services done, right. And so that comes through sort of in the

intensity. I don't have the why, but I have the sort of data points with -- and with that we can sort of send our teams to dig into finding out the why, but it takes some time.

MR. WALSH: Yeah. The -- it does. I understand, and I appreciate that. As I'm sure you are aware, there have been concerns about increasing diagnostic intensity without corresponding increases in actual morbidity. And so trying to tease that out would be helpful because I'm concerned.

I do not want to try to cap or limit necessary utilization or disincentivize appropriate coding for more severe illness. But I'm receiving messages of -- of more severity and a need for more services at the same time after four years hearing how healthy Vermonters are. And yes, we've come through a pandemic and there's some -- I think it's important to just build systems that will allow us to explore these issues so that --

MS. BRISSON-LEMIEUX: Yes.

MR. WALSH: -- we address -- we address the right drivers.

MS. BRISSON-LEMIEUX: Yeah.

MR. WALSH: And so --

MS. BRISSON-LEMIEUX: And I share your concern. The one thing I will say is that splitting, right, coding efficiencies from actual morbidity changes is very complicated. And so to the extent we can find things we will share with the Board, but there may not be sufficient evidence for us to say absolute one way or the other.

MR. WALSH: Yeah. I'll keep thinking about that. I think because of the -- a fair proportion of Vermonters with Blue Cross coverage receive care outside of Vermont, the borders may provide an instrument to help examine that issue.

MS. BRISSON-LEMIEUX: I'm going to make a note. That's a really good point.

MR. WALSH: And that similarly the -- the fifty-four percent versus forty-six percent from that table, trying to understand if there are similar drivers across the state for regulated entities and nonregulated. If Vermonters are getting sick, the numbers should -- sicker, the numbers should be going up regardless of whether somebody is regulated or

not.

If something else is driving the changes -- that something else could be something about trying to adjust to being regulated. Then we would see differences in the regulated entities versus the non-regulated entities. That would be independent of health status. So we could -- so those are the things I'm trying to think through. And I hope that that makes sense. And thank you for listening to the questions.

MS. BRISSON-LEMIEUX: It made a lot of sense. It gave me a lot of ideas.

MR. BARBER: Board Member Murman, do you have questions?

MR. MURMAN: Yeah. Let's see here. At the rate, page. I'm sorry. Let me just -- I think I wrote down the wrong exhibit. Let me just see if I can grab it. I apologize. I can't get the -- for some reason I wrote down the wrong one here.

But let me ask you the question in general. What I'm trying to understand is in the medical loss ratio on the medical side of the calculation, and I can find this here. What -- what are --what components are on the medical

side of the MLS (phonetic) ratio that are not direct claims payments?

MS. BRISSON-LEMIEUX: Okay. See I believe you're asking about our Exhibit 8, which is not binder Exhibit 8, but in the exhibit. And so in the MLR calculation, right, claims include the planned payment for fee for service, right, capitation. It includes other provider payments that we make, Blueprint, for example. And I'm going to get them mixed up. But one of the two healthcare tax goes into claims. I cannot remember which of the two.

MR. MURMAN: Here we go. Exhibit 2, page 61, I think may be a helpful guide for this.

MS. BRISSON-LEMIEUX: Right. So in the -- the direct claims. That's right. So the plan payment a fee for service capitation. We have some of our program payments go into claims things that we call non-system claims on exhibit -- in the rate development go into here. So that's all the claims that go into that category.

MR. MURMAN: Okay. So if we just talk through this table here, which is Exhibit 2,

page 61. First line is expected direct claims PMPM, that's what you're expecting to pay out to healthcare providers?

MS. BRISSON-LEMIEUX: Yes.

MR. MURMAN: Is there anything else other than paying for providers or pharmaceuticals that falls under direct claims payments?

MS. BRISSON-LEMIEUX: I believe that this is also net of rebates that we receive from -- from -- from our PBM. But no, that would be it with one of the healthcare claims tax that I -- it's either the vital portion or the healthcare claims tax portion. I cannot remember which --

MR. MURMAN: Yeah. I think that's in column -- the fifth or sixth column, taxes, fees, PMPM.

MS. BRISSON-LEMIEUX: One of them fall -- one of them gets bucketed as a claim in so the healthcare claims tax, the 0.8 percent gets actually bucketed as a claim in the MLR calculation, while the other portion, the vital portion, and I just got confirmation is in that taxes and fee column. It's --

MR. MURMAN: Okay. Okay. So the --

MS. BRISSON-LEMIEUX: -- MLR rules, right, are a little different from kind of our rating process for what the claim, what's the tax, what's a fee.

MR. MURMAN: Okay. So to go through this table, we have direct claims, which is all claims minus P -- minus rebates from pharmaceuticals and a 0.8 percent tax. Then risk adjustment transfers is money that you get from MVP because you have higher risk patients than MVP --

MS. BRISSON-LEMIEUX: Yeah.

MR. MURMAN: I believe, right? Then you pay two dollars per member, per month for quality activities, which I assume this is various quality activities, plus the prior authorization stuff would fall under that amount.

MS. BRISSON-LEMIEUX: I'm not sure exactly what falls under that, but yes. So under the MLR rules, we are allowed to count a portion that in other filing exhibits would go into the administrative costs. You're allowed under the MLR rules to move them to a claims expense.

MR. MURMAN: Okay.

MS. BRISSON-LEMIEUX: -- so they don't hurt you meeting --

MR. MURMAN: Okay.

MS. BRISSON-LEMIEUX: -- the MLR threshold because you're spending it on quality.

MR. MURMAN: So -- so what's the difference? Then MLR claims is the claims paid out, essentially?

MS. BRISSON-LEMIEUX: It's the sum of the three columns before. So it's under the --

MR. MURMAN: Got it.

MS. BRISSON-LEMIEUX: -- MLR definition. Things that count as a claim.

MR. MURMAN: Okay. So when you do the MLR ratio it's MLR claims divided by premium PMPM? Well, I guess you have to check.

MS. BRISSON-LEMIEUX: By the MLR premium. Yes.

MR. MURMAN: By the MLR premium?

MS. BRISSON-LEMIEUX: Yes.

MR. MURMAN: Because the taxes are taken out of that. And that's where he gets to ninety percent. Okay. I was just trying to

figure out, you know, -- let' discuss of your low administrative costs. And if there's anything baked into the medical side, that sort of was something that I felt like I should need to understand, but really, the -- it's basically $2.08, PMPM. Oh, there's one that's $2.09, two of them. That is the quality stuff that Blue Cross does that you're allowed to put in the medical side of MLR. And the rest of it is either taxes or claims.

MS. BRISSON-LEMIEUX: Yes.

MR. MURMAN: Okay. Thank you. Addressed a bunch of these. Can I just ask one question on the length of stay? You just mentioned something that sort of just sparked a little interest of mine. But you say that when a hospital -- when a patient stays in the hospital for a longer period of time with an increased length of stay, that generates a larger claim; is that correct?

MS. BRISSON-LEMIEUX: It can. Yes.

MR. MURMAN: Okay. Because often we hear about length of -- long length of stays leading to reduced revenue -- leading to cost

without additional revenue.

MS. BRISSON-LEMIEUX: That's possible. It will depend on what the hospital sort of reimbursement or payment right, is. If it's under the DRG and the additional day does not change the DRG, right, I can see that not increasing the revenue. If it creates an outlier because they are longer and there's more cost, so it could increase costs.

It was just an interesting data point that we have members who are --appear to spend more time in patient without sort of the -- that's what I can see so far. So again, this is like what we can see so far is happening, you know, through April. And then we will kind of -- I will -- I've shared this information with our clinical teams, and they will go and sort of understand the details.

MR. MURMAN: Okay. There's only one other thing I think you mentioned in your testimony that the Board reduced hospital budgets by seventeen7 percent one year and fifty percent one year. I just want to clarify that that's -- the Board reduced the requested increases to the commercial rate of the hospital budgets by

seventeen percent and fifteen percent, fifty percent, but not they didn't reduce the hospital budgets by those amounts. I just want to make sure that that didn't get misquoted somewhere in the world. But does that seem accurate to you?

MS. BRISSON-LEMIEUX: I appreciate that. Yes.

MR. MURMAN: Okay.

MS. BRISSON-LEMIEUX: It is the increases that were reduced.

MR. MURMAN: Okay. Thanks. That's all I have right now.

MR. WALSH: That was my poorly-phrased question. So thank you for clarifying.

MR. BARBER: Board member Lunge, any questions?

MS. LUNGE: Just a couple. Could you speak to how you -- how you came up with the impact of Civica Rx?

MS. BRISSON-LEMIEUX: Yes. So let me find the page to make sure I can say everything I want to say.

MS. LUNGE: It's mentioned in Exhibit 18 in your prefiled testimony in page 6, if that's the page you're looking for.

COURT REPORTER: Real quick. Can you spell Civica, please?

MS. BRISSON-LEMIEUX: I can go ahead and do that. C-I-V-I-C-A, capital R-X, all one word.

MS. LUNGE: Thank you.

MS. BRISSON-LEMIEUX: Right. And the page I was looking for. Just so you know, where I'm at is Exhibit 1, page 17.

MS. LUNGE: Oh, great. Thank you.

MS. BRISSON-LEMIEUX: So -- yeah. So Civica RX has -- they released a generic version of abiraterone, which is a specialty drug, and that came into the market to our members at least in September of 2023. And we saw a shift from the brand version to the Civica version, like 100 percent. Now, there's not a lot of members on that particular drug, but it was very expensive.

And so what we did, because we saw the 100 percent shift to the generic version in the rating development we have -- so September through December was at the lower cost drug. And what we did is that we took the 1st January through August, it was at the higher cost, and we

said, okay, let's reprice that to the lower cost because everybody switched. And that's how we calculated the impact of that one drug.

MS. LUNGE: Great. Thank you. My other question was, could you also just speak a little bit about your estimations of the H766 impact from removal of prior auth?

MS. BRISSON-LEMIEUX: Yes. So for that, we -- there's a few components and I know we talked a little bit about it. So again, I will just turn to the same page to make sure I tell you things that I'm allowed to say in open forum. I believe we answered it in our response to the healthcare advocate question. So Exhibit 13, page 2. So for prior auth, right, we have -- we did the two sort of main the two places where we have prior authorizations.

We have internal programs, and then we have a vendor that helps us with the radiology prior authorization. And we use the similar methodology, different numbers. I won't quote the numbers, but they are on pages two and three, but redacted.

We use the same methodology for both, where looking at our historical data for

2023, we have information around the savings associated with prior authorization, right. And from there, we looked at the percentage that were for services requested by primary care providers, right. And we assume that those sort of would go away, right, because prior primary care providers were under H766, won't need to submit prior authorizations.

MS. LUNGE: Okay. And did you look at in that estimation, the percentage of prior auth denials versus how many were approved right away?

MS. BRISSON-LEMIEUX: So my understanding of the data I received, right, so my team did not produce the data --

MS. LUNGE: Yeah.

MS. BRISSON-LEMIEUX: -- is that the savings that was provided to me was sort of the end result. So I'm assuming that it was for the prior ops that were denied because if it was denial, then appealed, then it would then show up as approved.

MS. LUNGE: Okay. All right. Thank you. Let me just check a couple more places, but I think my other questions might have

already been asked. That one was. That one was. Okay. I'm good. Thank you.

MR. BARBER: Board Member Holmes?

MS. HOLMES: Thank you. I just have a couple quick questions, probably. One is a follow up to Dr. Murman's question about the inpatient length of stay increases that you're observing. And I know you mentioned that you're going to kick some of this back to your clinical team to review.

And one of the things I think that would be interesting for us to understand, if it's possible, is what proportion of this is driven by increased, you know, acuity of our patients or our, you know, Vermonters or no place to discharge patients because we're hearing a lot from hospitals about having no place to discharge patients to either skilled nursing facilities or mental health beds, or other types of, you know, care. So if that's possible to figure out, that might be helpful as we're trying to think about transformation and some of that work.

My second question is just in terms of Exhibit 5. This was the list of some of the programs that Blue Cross Blue Shield has

incorporated to increase access, quality, and affordability. And I'm wondering if there -- there's a -- there's many programs here. Many of them seem, you know, potentially really helpful in this regard. And I'm wondering if you've done you know, if -- if you have an estimate of the expected net savings to -- to your members associated with each of the programs.

So some of them are value-based payment programs, some of them are payment integrity, some of them are utilization management. What I'm really trying to understand is the -- the benefit in terms of cost savings worth the cost of the programs. And how have you factored in the net savings into the premium rates this year?

MS. BRISSON-LEMIEUX: So for the programs that have been in place for many years, right, the savings or the results of those programs is embedded in our experience period, right. And so we -- in our trend development, we try to normalize for that because we've seen a growth of that program of those programs. So that is really embedded in the experience.

And you know, one of I think a

good example here is when we originally -- and like the original H766 had limitation on some payment integrity programs. And we could say, here are the historical savings from that. And that eventually would go away with this, right? So that's how we can measure that.

For the value-based payment programs they're still very new. And we work with our independent primary care practices with those. And some of the early results are really good. But we're talking about small populations, right. So then applying it to a whole book of business for a relatively new program there's kind of nothing to put in there, but it's still an investment that we want to make in our independent primary care practices.

MS. HOLMES: So does Blue Cross Blue Shield do an analysis over some period of time and decide that they're going to sunset some programs and introduce new ones based on their impact on costs?

MS. BRISSON-LEMIEUX: Yeah. We -- we do look at the programs and whether it's the sort of the big programs you -- you see on the page, you're even sort of the components of each

program. So in our internal utilization management programs, for example, Tom's team reviews the data often, looks at the -- the medical policies and the prior authorizations around, you know, different areas and you know, will remove some of the prior authorizations on areas let's say that, you know, have a really high rate of approval, and we're not seeing the value of this administrative work, let's put it somewhere else. So there is ongoing monitoring of our programs.

MS. HOLMES: One thing I'll just say for future reference, and this is, I guess, to the whole Blue Cross Blue Shield team, but it'd be really helpful for us to understand the impact of some of these programs as you're doing the analysis, we're always, you know, we ask hospitals all the time about their cost containment programs and their impact. Similarly here, this is a helpful set of program information, but it doesn't come with the, you know, relevant impact. So that would be helpful in the future to understand. But thank you very much.

MS. BRISSON-LEMIEUX: You're

welcome.

MR. BARBER: Were you done, Jess?

MS. HOLMES: Yes, thanks.

MR. BARBER: Chair Foster?

MR. FOSTER: The average length of stay increased. Is that something to formally across different hospitals or more isolated?

MS. BRISSON-LEMIEUX: The data I have in front of me is across the whole insured book. But we can dig into sort of where it's coming from. But I don't have that right here.

MR. FOSTER: Okay. That would be great if you could do that. There's, you know, any sort of granularity of where these abnormalities happen. My only other -- (indiscernible).

MR. BARBER: Owen, we're having trouble hearing you.

MR. FOSTER: No trouble here.

MR. BARBER: That's better.

MR. FOSTER: Probably this. My computer kicked me off.

just said, any granularity you have on that that you're able to share would be helpful. My only other question was the Board

order from last year around in connection with your negotiations, taking into account affordability, access, and quality of the providers and negotiating the rates. Can you explain what Blue Cross did in connection with that and how it complied?

MS. BRISSON-LEMIEUX: Yeah. So as I think it was mentioned earlier today. With the hospital, it is very difficult to get any sort of movement on the rate order that they receive from the Green Mountain Care Board. And so as we look at quality, right, and how do we reward providers for providing better quality, it is very difficult through the commercial rates that, you know, the fee for service rate.

And it was one of the things we really considered when we put together our enhanced primary care program, the ECPC program, right, where every metric in that program, it's, you know, there's quality specific, like quality measures, there's a wellness visit threshold and things like that. And so for these practices that are meeting these quality thresholds, we are paying them an incentive. So that is how we can impact the independent practices that have better

quality is by giving, you know, when we set up the ECPC program, but it has been very difficult to do something similar on the hospital side.

MR. FOSTER: Is there any consideration of access, quality, or affordability in connection with the hospital negotiations with Blue Cross?

MS. BRISSON-LEMIEUX: I believe so. I am not the one who negotiates with the hospital. But yes, it is very important to us as an organization. We know it's important to our members, and it's a difficult balance with, you know, making sure that we also provide an adequate network.

MR. FOSTER: What quality is considered in connection with negotiating with hospitals?

MS. BRISSON-LEMIEUX: I don't know the answer to that question, so we can follow up on that.

MR. FOSTER: Okay. And then I don't have the page in front of me, but there is a chart that showed the -- this is probably not the exact phrase you used, but the community providers received larger rate increases than the

GMCB regulated entities. Can you speak to that at all?

MS. BRISSON-LEMIEUX: Well, again, so I believe that's the cost trend table in the memo. Right, and so that was at the time of filing where we assumed that hospital, Vermont Hospital, would follow the Green Mountain Care Board guidance, right. We did -- we -- every year we look very closely at our community fee schedule, right. And I believe last year we made -- we made improvements to the rates, although I do not know specifically if it was across the Board for all rates or you know, sort of targeted to rates that really needed it.

MR. FOSTER: Okay. And nothing else. Thank you. Nice to see you.

MS. BRISSON-LEMIEUX: Great to see you.

MR. BARBER: Mr. Donofrio, any redirect?

MR. DONOFRIO: No, thank you.

MR. BARBER: Okay. Thank you, Ms. Lemieux.

And I think we're doing okay on time. So turn to Kevin Ruggeberg from Lewis &

Ellis next. Then we need to hear from Mr. Fisher and take public comment. So we might, I'm guessing we're not going to get through that in half an hour, so probably will need to go past 5 a little bit.

Does anyone have any conflicts, any problems with -- with that?

CHAIR FOSTER: I can't go much past 5 because the Copley Community Meeting this evening.

MR. BARBER: Would you be able to read the transcript --

CHAIR FOSTER: I can call in.

MR. BARBER: -- and watch the video?

CHAIR FOSTER: Absolutely. Absolutely.

MR. DONOFRIO: Mike, it would be -- on my end it would be good if we push for 5:15 or so just a little bit over 5 if possible.

MR. BARBER: We'll shoot for that. Kevin, are you with us?

MR. RUGGEBERG: I am.

MR. BARBER: Laura, are you prepared?

MS. BELIVEAU: Yes, although we're much later in the day than we're used to. So I might get a little cranky.

MR. BARBER: Let me just swear him in real quick.

MS. BELIVEAU: Yes, thank you.

MR. BARBER: Sorry, I'm getting a little echo. Laura, could you mute yourself?

Whereupon,

KEVIN RUGGEBERG,

a witness called for examination by counsel for the Petitioner, was duly sworn, and was examined and testified as follows:

MR. BARBER: Okay. Go ahead, Laura.

MS. BELIVEAU: Okay. Is this is this echoing for people? That's all right? Great. Good afternoon, Kevin, could you state your name for the record?

MR. RUGGEBERG: Kevin Ruggeberg.

MS. BELIVEAU: And where do you work?

MR. RUGGEBERG: Lewis & Ellis.

MS. BELIVEAU: Okay.

(Indiscernible).

MR. RUGGEBERG: I'm sorry I didn't catch that question.

MS. LUNGE: Ma'am, your audio is going out pretty badly. You're breaking up.

MS. BELIVEAU: Okay. I -- I will switch devices. I'm sorry.

MS. LUNGE: We can hear you magically all good now.

MS. BELIVEAU: Yeah, yeah. I'll still switch devices. It'll be better for everyone. Let's see. I'll be back in one second.

MR. RUGGEBERG: I think the question might have been how long have I been with Lewis & Ellis. I'll answer that while she's changing devices. I believe I'm about to have my eleventh anniversary with Lewis & Ellis.

MS. BELIVEAU: Okay. Is this better?

MS. LUNGE: Much. Thank you.

MS. BELIVEAU: Excellent. So actually was asking what your position at Lewis & Ellis is.

MR. RUGGEBERG: I'm a senior consulting actuary.

MS. BELIVEAU: And can you please turn to Exhibit 22 of the binder?

MR. RUGGEBERG: I'm there.

MS. BELIVEAU: Great. And can you -- do you recognize it, and can you briefly describe the information contained in it?

MR. RUGGEBERG: Yes. This is my prefiled testimony. It contains information about my educational and work background, information on how we review filings for the Board, and a summary of our recommendations regarding these filings.

MS. BELIVEAU: Is the information in this document accurate and correct to the best of your knowledge?

MR. RUGGEBERG: With one exception. As Blue Cross has noted, there was a calculation error in our report. We had said that if our recommendations were followed, that the increase would be 14.5 percent in the individual market and 17.4 percent in the small group market. However, there was a mistake in the calculations there. And the correct values are actually 15.2 and 18.0 as -- as noted in Ms. Lemieux's pre-filed testimony.

MS. BELIVEAU: Great. And with that being noted do you wish to adopt this pre-filed testimony as part of your testimony today?

MR. RUGGEBERG: Yes, I do.

MS. BELIVEAU: Okay. Can you briefly describe your role in L & E's review of Blue Cross and Blue Shield of Vermont's individual and small group filings?

MR. RUGGEBERG: Yes. I am part of a team of several people at Lewis & Ellis who review these filings. I am personally, and you know, responsible particularly for the Blue Cross filings, whereas my colleague Jacqueline Lee is responsible for the MVP. But we communicate constantly throughout that review process. And we also have several other people on our team who assist in our review of these filings.

So upon receiving the filings, I review all of the materials therein, as well as a couple other members of our team. We produce questions to, you know, provide additional information that we need to reach a determination. We discuss internally to make sure that our review of both carriers is consistent. And then we issue a report

summarizing our findings and recommendations for the Board.

MS. BELIVEAU: And can you describe how you submit those recommendations?

MR. RUGGEBERG: Yes. We submit those recommendations in the form of a report that's due 60 days after the filing is submitted. I forget the exact date that that was submitted. Early -- early this month, I believe.

MS. BELIVEAU: And there are two reports; is that right?

MR. RUGGEBERG: Correct. One for the individual market and one for the small group market.

MS. BELIVEAU: Great. And the report for the 2025 individual market is Exhibit 14. And the report for the small group market is Exhibit 15. Could you please turn to those?

MR. RUGGEBERG: Yes.

MS. BELIVEAU: And did you -- I know we discussed in your prefile testimony the changes you wanted to make are those -- those incorporate also into your -- your report. Is that right?

MR. RUGGEBERG: Yep.

MS. BELIVEAU: So using the corrected figures the recommended increase is now 15.2 percent for the individual market and 18 percent for small group; is that right?

MR. RUGGEBERG: Correct. I'll add the caveat that we also recommended the Board consider update -- updated hospital budget information that wasn't available, but yes.

MS. BELIVEAU: Great. Can you explain your standard of review in both filings?

MR. RUGGEBERG: Yes. We review these filings to ensure that the proposed rates are actuarially sound, they are adequate, and that they are not unfairly discriminatory. And also that they're not excessive I think is part of that list.

MS. BELIVEAU: Yeah. And do you review for affordability?

MR. RUGGEBERG: No.

MS. BELIVEAU: Using your methodology and standard of review, did you make any recommendations to modify this proposed filing?

MR. RUGGEBERG: Yes. We made -- I believe it's six recommendations regarding the

individual filing and five regarding the small group. Yeah. Go ahead.

MS. BELIVEAU: All right. If all of your recommendations were to be implemented, can you explain what the ultimate projected rate increase would be?

MR. RUGGEBERG: A few of our recommendations were not quantified. But if I leave off the discussion of CSR, I believe the answer to that question is 16.0 percent for the individual market and 18.8 percent for the -- the small group market. I'm trying to quickly do that mental math and make sure that's accurate. But I believe that's correct.

And then, I believe in the body of our report, we said the Board should consider the input of GFR on the CTR assumption. So I don't want to imply that that's inconsistent with the 21.0 and the 24.0. It's been discussed previously today.

MS. BELIVEAU: Of course. And have you reviewed the other pre-filed testimony in this proceeding? And have you listened to the testimony today so far? Great. I'm sensitive to the time, and I could go through asking about

each of your recommendations, but I -- they are in your -- they are in report and prefile testimonies. So if -- if the Board, if it pleases the Board, we could not go through those item by item. I'm -- if that's acceptable? Great.

So if your recommendations as of today are accept -- implemented, do you believe that rates would be excessive?

MR. RUGGEBERG: Well, I can't --

MS. BELIVEAU: Your audio broke up for me. Could you say that again?

MR. RUGGEBERG: No.

MS. BELIVEAU: Thanks.

MR. RUGGEBERG: Sorry, I can say that again. I said, no. Yeah.

MS. BELIVEAU: Do you believe the rates would be inadequate?

MR. RUGGEBERG: No.

MS. BELIVEAU: Thank you, sir. I don't know if it's me or your audio. And do you believe they would be unfairly discriminatory?

MR. RUGGEBERG: No, I do not.

MS. BELIVEAU: All right. I have no further questions at this time.

MR. BARBER: Any questions from Blue Cross for Kevin?

MR. DONOFRIO: No, thank you.

MR. BARBER: Eric, any questions from the HCA?

MR. SCHULTHEIS: We just have a few quick questions.

So hi, Mr. Ruggeberg. I'm going to ask you just a few questions about Lewis & Ellis's actuarial recommendations that you filed in these cases. Could you turn to Exhibit 14, page 22? That's Lewis and Ellis' actuarial recommendations for the individual filing. Let me know when you're there. Are you there? Okay. So take a look at the histogram up near kind of the top of the page about the histogram showing the distribution of CTR.

So the originally filed contribution to reserves, the three percent places Blue Cross roughly or essentially in the middle of that hump, correct?

MR. RUGGEBERG: Correct.

MR. SCHULTHEIS: And that's the bin that's highlighted, right, the three percent. Now, I'm having trouble hearing you, too.

MR. RUGGEBERG: I'm sorry, yes. The bin that is a different color is reflective of the initially filed three percent. Yes.

MR. SCHULTHEIS: And so as you mentioned in the report, in the memorandum, Blue Cross has changed that CTR request to seven percent; is that correct?

MR. RUGGEBERG: That is correct.

MR. SCHULTHEIS: And then you say in a few in the first, second, third, I guess the third paragraph that that seven is abnormally high. So looking at that histogram above, that would put it in the second to highest bin on the right, right?

MR. RUGGEBERG: I think it would probably technically be the highest bin just because, at least in the individual market, there's also a slight amount for bad debt. So I think it's technically about 7.1. So I think it's actually the highest bin.

MR. SCHULTHEIS: Okay. And so I'm just trying to understand how to read this histogram, and I want to make sure I have it right. So let's just assume we know it's actually higher. But let's say it was in the

second to highest bin when it says 6.5 percent, that means 6.5 percent of the carriers that you looked at filed CTR, that's in that bin, that amount?

MR. RUGGEBERG: Those -- so those ranges are -- so all of the text that you're seeing there is describing the upper and lower bounds of that bin.

MR. SCHULTHEIS: Of the bin?

MR. RUGGEBERG: So --

MR. SCHULTHEIS: Okay.

MR. RUGGEBERG: -- what it's saying is that that bin, which I imagine is one carrier, is everyone from 6.5, I take it 6.500001 up to 7.0. There's one carrier falling in that range.

MR. SCHULTHEIS: Okay.

MR. RUGGEBERG: So a number of carriers is being communicated by the -- the vertical axis. So for example, the bin in which Blue Cross Vermont falls is fifty or fifty-one, or fifty-two -- something in that space -- that many carriers have a CTR in that range.

MR. SCHULTHEIS: And so maybe you can't do this math with the information you have.

But so you had mentioned the three percent places Blue Cross in the what, the fifty-ninth percentile for QHP carriers, for CTR. What percentile would it be in with the seven percent CTR request?

MR. RUGGEBERG: Could I get back to you with a precise number. I can confidently say it looks like 3 or 4 carriers were that high in 2023 out of approximately 300. So that would be about the -- the ninety-ninth percentile.

MR. SCHULTHEIS: Ninety-ninth percentile.

MR. RUGGEBERG: Approximately. So somewhere between 90, ninety-nine and a half, something like that.

MR. SCHULTHEIS: So just to be clear for everyone who's listening, what that means -- that means -- let's say it's -- we'll put it at the ninety-eighth percentile just to be safe. That means it's higher than ninety percent of the carriers that you looked at in terms of CTR requests.

MR. RUGGEBERG: Correct. Granting the ninety-eight percent, as you said, higher than ninety-eight percent rather than ninety, but

yes.

MR. SCHULTHEIS: Okay. Thank you so much, Mr. Ruggeberg. That's all my questions.

MR. BARBER: Do any Board members have questions for Kevin?

MR. WALSH: I do.

MR. BARBER: Why don't you go ahead, Thom?

MR. WALSH: Thank you. Could we turn to Exhibit 14, page 3, the table at the bottom of that page. Would you please describe what constitutes the difference between the gross and net changes in premium as outlined in the table?

MR. RUGGEBERG: Absolutely. Gross premium is a reference to premium pre-subsidy. So that's the premium that is technically being considered by the Board in this hearing. That is the amount that Blue Cross will receive per member per month when members enroll in that coverage. When we say net premium, we're referring to the premium that will be paid by the member, the -- either a small group employer, an individual, or family, et cetera.

There is a -- in the individual

market significant gap between those two numbers because a substantial portion of the premium, especially for lower income households, is paid for by federal subsidies. So when we say, for example, the -- the gross premium is think -- let's see. It's been a second since I read this chart. I want to make sure I'm interpreting it correctly because I see it says -- oh, yes.

So the -- the net premium for many members is actually zero to buy Bronze or catastrophic coverage. That's because the subsidies provided by the Federal Government exceed the gross premium for those plans.

MR. WALSH: Yeah. Thank you. And the sentence right above the table, you use the phrase "a large majority". Can you help me get a better quantitative assessment of what that is?

MR. RUGGEBERG: Yeah. So a very relevant number I would point you to is in the paragraph prior. According to the most recent data we had at the time, eighty-eight percent of households in Vermont's individual market receive advanced premium tax credits. So for those members, the subsidies are increasing very quickly. And so for all of those eighty-eight

percent of members I -- I should be careful. I believe it is the case that all of them will be able to purchase gold in 2025 for less than they could in 2024, at least from Blue Cross.

I'm not able to quantify -- I'm not even sure I can at all, frankly, even with more time. What percent like the distribution of APTC members by metal tier. So to the extent that they choose Bronze plans, for example, their net premiums won't actually decrease because they're already zero. And some of those people receive APTC and purchase silver. Most of the Blue Cross Silver rates, even on a net basis, will increase. But I think it's accurate to say anyone who receives APTC and purchases a Gold or Platinum will see their premium go down. And I think some people who receive APTC, who are currently purchasing Silver, will be able to switch to Gold and get a richer plan for less money.

And so because there's an expectation of people changing plans, it's very difficult for me to talk about very precise numbers here.

MR. WALSH: So that -- and the

thing that I'm trying to keep clear in my mind, we've been talking about extraordinary increases in gross rates. The net rate changes for individuals receiving subsidies would be much less?

MR. RUGGEBERG: Correct. So the small group, none of this applies. But within individual -- within individual, the kind of top line rate increase number that is now being discussed is being 21.0 is not directly relevant to very many members, particularly this year given the change to CSR loads. So the -- the dramatic increases to subsidies mean that individual households will not, in most cases, see a twenty-one percent rate increase if they keep similar coverage.

MR. WALSH: And will the -- what I'll refer to, for lack of a better term right now, the -- the increase as a result of the Department of Financial Regulations' review of going from a three percent contribution to reserve to seven, would that materially change this table?

MR. RUGGEBERG: It -- it would. The subsidies, at least right now, are projected

to be based on premiums for MVP plans. So the subsidies based on the second lowest cost, Silver. As a consequence, changes to Blue Cross rates relative to the initial filing don't change the subsidies. So every dollar of gross premium change flows directly to gross -- or sorry, to net premium as well. Yeah.

MR. WALSH: Would it be possible please, to have a similar table resubmitted but reflecting that change from three to seven percent?

MR. RUGGEBERG: Absolutely. Just for clarity's sake, only the three to seven or also the other changes subsequent to our report?

MR. WALSH: Other changes, inclusive. And then this the increased Silver loading that has taken place this year appears to be pretty beneficial as far as affordability. Are there long-term implications from having such a high Silver load?

MR. RUGGEBERG: The main implication is that it does slightly increase the risk to carriers in this market, in that the -- the profitability of members between metal tiers is made less equitable, you could say. So if a

carrier were to lose all of their Silver members the rate, you know, the rates are calculated under the assumption that they will continue to have those Silver members. So the -- the contribution to reserve would -- would -- would drop to the extent that they lose Silver members. And that -- go ahead.

MR. WALSH: The -- if I'm understanding you correctly, the long term implication is if there's flight out of the Silver plan and everybody goes to Gold or Bronze, there may not be enough dollars coming into the plan?

MR. RUGGEBERG: So that in theory is a concern. That one is less, frankly, a concern than what I intended to say. So --

MR. WALSH: But --

MR. RUGGEBERG: -- any members who are eligible for CSR would generally, especially if it's greater than the 73 percent CSR. If they're eligible to basically have a Platinum plan by purchasing a Silver, there's really no incentive for them to flee Silver because their -- their premium will be based on the subsidies anyway. They don't tend to pay a ton

of premium and wouldn't benefit from switching. So the carriers have already kind of assumed that the small amount of people who would maybe have a reason to make that flight already will with -- with these CSR changes.

MR. WALSH: I see.

MR. RUGGEBERG: So -- so that's not going to be a significant risk in this market to my understanding. What I intend is that those Silver members, who both carriers want, may shift between carriers. And they are attractive to both carriers. So to the extent that they shift, that would benefit one carrier over the other. And that's a problem that exists regardless of our CSR guidance, of course. But it is a risk in the system that is exacerbated --exacerbated by the CSR guidance.

MR. WALSH: I understand. Thank you. Those are all my questions.

MR. BARBER: Board member Murman?

MR. MURMAN: I think Thom and Kevin discussed my area of interest, so I don't have any questions now.

MS. LUNGE: You're muted. But I don't have any questions.

MR. BARBER: Sorry about that. I saw Jess shaking her head. Do you have any questions, Jess?

MS. HOLMES: No. I'm good, thank you.

MR. BARBER: Chair Foster? Okay. So it sounds like Kevin, you'll be submitting an updated table reflecting the net and gross premiums for a hypothetical family of four with an income of $60,000?

MR. RUGGEBERG: Yes, I will do that.

MR. BARBER: Thank you. Mr. Fisher, are you with us?

MR. FISHER: I am.

MR. BARBER: Okay. Are you ready to take the oath?

MR. FISHER: I am ready.

MR. BARBER: Okay.

Whereupon,

MICHAEL FISHER,

a witness called for examination by counsel for the Petitioner, was duly sworn, and was examined and testified as follows:

MR. BARBER: Okay. Please go

ahead.

MR. FISHER: Good afternoon, Board members. It's been quite a long day. And I'll attempt to be brief, but I do have a few things I wanted to say. This is indeed an extraordinary year. I can't remember a year, and ever, you know, a time where the demands of both the affordability side and the solvency side of the equation have been more pressing. I don't envy you in this position. You have precious few options in front of you.

The solvency concerns of Blue Cross does not change consumer affordability. Yet admittedly, the task of finding a balance between these two competing needs is -- is different this year. The HCA and Blue Cross do not have, don't -- don't appear to have -- actually, let me say it differently.

The HCA and Blue Cross do not have an agreement about the appropriate range of RBC. We have -- the HCA has and will continue to push back when Blue Cross, DFR or L & E or others talk about RBC goals of 590 or 740. But you hear something different this year, given the numbers that have been discussed.

You don't hear the HCA pushing back on the solvency concerns. Indeed, this is a strange year. Today I've heard Blue Cross and the HCA and many Board questions in seeming agreement about the hospital prices and the need to focus on hospital budget process as a key component of reducing the spectacular insurance rate increases.

We're not on the same page, though, about the definition of affordability. Quite simply, from our perspective, consumer affordability has to mean can people afford to buy it? We've been having this conversation every year for I don't know how many years about just what affordability means. I look forward to the completion of the affordability guidance, so we don't have to have this conversation again next year.

On a different topic, the HCA has expressed concerns about the theoretical risk of adverse selection between the small group and the self-funded markets for a number of years. Due to the Blue Cross Blue Shield answers to HCA questions this year, this concern is much less theoretical.

In Exhibit 13 on page 8 for 2023, we see the per member per month claims of small groups that left the fully regulated Blue Cross small group going to self-funded at $522 per member per month. And the per member per month of the small groups that went in the other direction, leaving the self-funded market and going to the small group at $883.

The numbers of groups are small. In this answer, we only see the small groups that are moving from Blue Cross small group to Blue Cross self-funded, but this is concerning. We are afraid that we are seeing exactly the adverse selection that we feared, and we understand that even a small number of well-sorted small groups moving has the potential to explode the rates of the small group in the future.

This is concerning enough that I think it warrants more analysis. I think it should be -- I think it is DFR's job to evaluate what is going on, not just in relation to Blue Cross, but across the whole market, and contemplate actions to reduce this dynamic where healthy, low-cost small groups can go save money in the self-funded market with the self-funded

approach, but come back to spread their costs when they become sicker and more expensive.

As was just covered a little bit in the last questioning, there is a bright spot this year. The combination of enhanced premium tax credits for 2025, coupled with Silver loading or CSR guidance as is being referred to here, results in significantly improved subsidies in the individual market. Looking at the proposed rates, this is really good for most of the people in the individual market.

Of course, we don't know what will happen after the current law expires for the enhanced tax credits for '25. But for next year, we will have better income-based subsidies in the individual market than we have ever seen before. As Eric Schultheis said earlier this morning, the small groups, on the other hand, carry the full weight of the proposed increases.

So again, this is an extraordinary year. I'll say it again. I'll say it again. This is an extraordinary year. The HCA will take a few hours. Think about what transpired today, and make our recommendations about our perspective on the balancing act between consumer

affordability and insurance solvency in our post-hearing memo.

You have precious few levers in front of you. As you did last year, we think it's appropriate for you to look at how much of the proposed increases in hospital commercial rates are warranted in a way where it can be afforded. In a way, rate review is where you get to set the budget. This is how much we have to spend.

And in hospital budgets, in a few weeks, you get to decide where you're spending that money. You may decide one hospital has particular needs and really deserves or needs a 5 percent increase, and another hospital really should only get a two percent increase. But in aggregate, you get to decide that in this proceeding. And we think you should take advantage of that power in these proceedings.

And here's the controversial part. This is extraordinary enough that I think the pressures are such that you should even entertain going below the hospital budget guidance in that consideration. I think I'll stop myself there. I'll get to speak to you again tomorrow, in two

days. Thank you for the opportunity to speak. And good luck in your deliberations.

MR. BARBER: Michael or Bridget, Do you have any questions for Mr. Fisher?

UNIDENTIFIED SPEAKER: I don't. Thank you.

MR. BARBER: Okay. And does any Board member wish to ask any questions of Mr. Fisher? Okay. Then I think we're ready to move on to closing statements. Does either party need a few minutes, or should we just move straight there?

UNIDENTIFIED SPEAKER: I'm fine to go ahead.

MS. ASAY: Blue Cross is ready to go.

MR. BARBER: Okay. Then why don't -- why doesn't Blue Cross go ahead with the closing statement?

MS. ASAY: Thank you. Good afternoon. Good afternoon, Hearing Officer Barber, Board members, the healthcare advocate, counsel for the healthcare advocate. I want to thank everyone for the time that we've taken today to consider what is, as everyone has said,

a very difficult and unusual set of circumstances facing Blue Cross and the Vermont healthcare market this year.

Blue Cross's message today is simple. We need the Board to approve fully-funded rates, including a seven percent CTR. As Ruth Greene testified earlier this morning, we do not make this request lightly. We are aware, and painfully so, that this rate increase is not easy for Vermonters to absorb.

We are making this request because this is what we need to, as DFR explains, increase and stabilize our reserves. As always, and as is so important in these hearings, the testimony and the questions have ranged across many of the challenges in Vermont's healthcare system. Those challenges are real. They are impacting Vermonters, and these ongoing conversations are critical.

All the stakeholders in this system have to continue their collaborative efforts to control the growth of healthcare costs. Just as another example of the headwinds that all of us are facing, it's my understanding that during the hearing today, UVMMC filed to

increase its commercial rate increase over its original filing.

Blue Cross, for its part, remains a willing participant in these efforts to control healthcare costs and increase access, and we remain fully committed to that work. But in this proceeding this year, Blue Cross's solvency has to be front and center. Our reserves and RBC are precarious, as you've heard from multiple witnesses today. To put it bluntly, we are closer to insolvency than we are to the bottom of our required RBC range.

As Commissioner Gaffney explained, the starting point for access is having payers in the marketplace. Payers can only be in the marketplace if they are charging fully funded premiums that cover the cost of claims, the expense of providing insurance, and a minimum contribution to reserves. Protecting Blue Cross's solvency protects access.

And charging adequate rates -- allowing Blue Cross to charge adequate rates is the primary factor that Blue Cross needs to maintain its solvency. There's been discussion today about other impacts on RBC, and some

suggestions that our CTR request here is somehow intended to make up for losses in other markets. That's not right. And I just want to make three things clear as we close today.

First, Blue Cross is working across all lines of business to improve its margin. We are requesting 7 percent CTR in large group AHP and medsup. And although Medicare Advantage works differently and it isn't part of the Board's review process, we are working hard to adjust that program and move it to profitability as soon as possible.

We're happy to provide more information about that. The rising claims costs that are impacting other lines of business have impacted the rollout of the Medicare Advantage program, but we are not sitting on our heels at that market. The levers are different, and the process is different, but we are working hard to turn that line of business around as well.

Second, our CTR request in this market is justified and needed to make these markets sustainable. Taking a look at the historical experience here, the difference between Blue Cross' filed CTR and the approved

CTR in these markets over ten years is 47.7 million.

The chart on page 6 of Exhibit 1 shows that we have not gotten in our approved rates, even a minimal CTR, over the past ten years. If we had collected the CTR that we filed for, we would not be asking for 7 percent this year in these markets. Any suggestion that 7 percent CTR is abnormally high has to be weighed against both that historical experience and the unusual and very serious solvency concerns that Blue Cross is facing.

We also urge the Board not to reduce our proposed rates on the theory that membership loss will reduce RBC demands. Membership loss does nothing to increase and sustain reserves. It is not a long-term solution. And even a tremendous membership loss along the lines of 25,000 people would be 100 RBC points that would still not put Blue Cross into its RBC range.

The third point I just want to touch on before finishing, is that the QHP markets are not and have not been subsidizing any other lines of business. So instead, as the

historical experience shows, they have been losing money over time. I want to end where Mr. Donofrio started this morning to acknowledge again that this is a very difficult year.

Claims costs alone are driving a large rate increase, and we have no choice but to request a 7 percent CTR to address Blue Cross's pressing solvency concerns. You've heard from our witnesses and from Commissioner Gaffney and the Department of Financial Regulation on this point. There's no cushion left here.

We are nowhere near our required RBC range, and instead, the current position has triggered a statutory company action level event that requires corrective action, and the corrective action is we need fully funded rates in these markets with a 7 percent CTR. We ask the Board to approve that request. Thank you.

MR. BARBER: Thank you Ms. Asay.

Mr. Schultheis?

MR. SCHULTHEIS: Sure. So you've heard a lot of evidence today about why the massive premium increases for individuals and small businesses are needed. You've also heard, both in this hearing and in public comments, that

Vermonters are suffering. Too many of your neighbors can't afford premium rates now, let alone the proposed increases.

I said at the start of the hearing, your choice isn't about whether Vermonters will suffer, but when. After listening to this hearing, I want to rephrase a bit. Your decision is about how much suffering happens now. The evidence you've heard makes clear that there will be suffering now, however, Vermonters can only bear so much, and Blue Cross' proposed seven percent CTR is too much.

Is Blue Cross' current proposal extreme? Yes. Is Blue Cross proposing to have the full weight of things fall on Vermonters now? Yes. Is Blue Cross' current request a middle ground? No. You don't need to believe me to find out if what I'm saying is true. Consider the current rate proposal against the comments of Vermonters. You will see that there is no doubt that the current rates are too much, that they are too extreme.

I mentioned in my opening three things that might move this broken system in the right direction. I want to briefly reiterate

them now. First, Blue Cross needs to look inwards. The only people who get hurt by the constant finger pointing to assign blame are Vermonters.

Second, define affordability, such that it captures the dual burden of premiums and deductibles on Vermonters. Look, efforts to pull on the levers Dr. Weigel talked about are laudable. They do not mean, however, that a rate is affordable. Reject Blue Cross's claim that affordability doesn't mean the ability to pay for something.

Third, regulate the entire cost equation. I want to admit that I fell into the trap of thinking optimizing the regulation of rate review and hospital budgets meant finding a timing solution. Regulating the entire cost equation is not just about timing, though. It is about having two regulatory processes, both of which have consequences. It is unreasonable to expect things to change for the better when only one regulatory process, the regulation of health insurance rates, has teeth. Thank you.

MR. BARBER: Okay. Thank you all for a long and good hearing today. I think I'm

ready to turn it over to the Chair to take public comment if there is any. But before I do that, I want to check with the parties to make sure there's nothing else we need to discuss.

MR. FISHER: Nothing from the HCA.

MR. BARBER: I do have a rough list of questions going. I mean, well, as in prior years, we'll send out some follow-up questions from the hearing, but please don't wait on me for that. I think you all probably have some notes and -- yeah. So that'll be coming later this week.

And I'll turn it back to you, Chair Foster.

CHAIR FOSTER: Thanks. We'll try and keep the public comment moving pretty quickly since we're over considerably, and some folks need to leave.

Ms. Gutwin, it looks like your hand is up, so if you have any comment, please go ahead.

MS. GUTWIN: Yeah, I'll be brief. I think Blue Cross Blue Shield of Vermont can address lowering costs by encouraging more utilization of the most affordable providers,

which are the nonregulated providers. Right now, it's not -- payments aren't based on quality, access or affordability, but on a class, regulated versus nonregulated.

And the difference is substantial. So are the savings substantial in potential. But most consumers are unaware of the disparity resulting in substantially higher bills that could be avoided if they were made aware and given choice. And UVM does not, right now, make their patients aware that they can have a lower bill if they go to open MRI, for instance.

The substantial added expense of regulated entities hits Vermonters' pockets and all who pay taxes that go into subsidized healthcare. This said, along with the present unsustainable and increasing unaffordable State of healthcare, why is there no discussion about moving towards site-neutral payments with outpatient care based on, like, geographical area?

Until we have payments truly based on quality, access, affordability, Blue Cross and Blue Shield could help reduce the impact of these costs by educating and guiding members to more

affordable care options if the hospital doesn't. Thank you.

CHAIR FOSTER: Thank you, Ms. Gutwin. Any the other public comment at this time? And I'll remind people, we have a panel later this week for discussion of these similar topics. Any other comments? All right. Well, thank you everyone for a very interesting and productive hearing.

These are remarkably, extraordinarily difficult times in our healthcare system, and we're benefited by the able counsel and witness presentations today. So thank you to the HCA and counsel for Blue Cross Blue Shield and all the witnesses. We have follow up. We'll get it out to you, and we'll speak again soon. And with that, I'll turn, and I'll move that we adjourn for the day.

MS. HOLMES: Second.

CHAIR FOSTER: All in favor say, aye.

IN UNISON: Aye.

CHAIR FOSTER: Thank you.

(Whereupon, the proceedings were adjourned at 5:22 p.m.)

C E R T I F I C A T E

I, Tessa Janes, certify that the foregoing transcript is a true and accurate record of the proceedings.

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