BOARD OF ARBITRATION

THE BROTHERHOOD OF MAINTENANCE WAY EMPLOYEES DIVISION/IBT AND INTERNATIONAL ASSOCIATION OF SHEET METAL; AIR, RAIL AND TRANSPORTATION WORKERS,

Unions,

v.

NATIONAL CARRIERS' CONFERENCE COMMITTEE,

Carrier.

HEARING

DATE: Tuesday, May 8, 2018
TIME: 8:58 a.m.
BEFORE: Gill Vernon, Chair; Thomas R. Roth; Kenneth Gradia
LOCATION: DoubleTree by Hilton Crystal City
300 Army Navy Drive
Arlington, VA 22202
REPORTED BY: Samuel Honig, Notary Public

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C O N T E N T S

C O N T E N T S (Cont'd)

E X H I B I T S

EXHIBIT	DESCRIPTION	MARKED	ADMITTED
Exhibit 49	Roth Written Statement	56	72
Exhibit 50	9/16/11 UTU agreement and 4/25/12 BMWED agreement	72	72

P R O C E E D I N G S

MR. EDELMAN: So we are going to have several rebuttal witnesses. Our first witness is Molly Loftus.

THE REPORTER: The mike.

MR. EDELMAN: Is it not on?

THE REPORTER: Just turn it up a little.

MR. EDELMAN: Okay.

MR. VERNON: She is going to need that anyway.

MR. EDELMAN: That is what happens when you work outside of the scope, right?

MR. VERNON: She is going to need that mike anyway.

MR. EDELMAN: Okay. That would have made things simpler.

WHEREUPON,

MOLLY LOFTUS

called as a rebuttal witness, was examined and testified as follows:

MR. VERNON: Molly, just for the record, would you state your name?

THE WITNESS: Yes. Good morning, everyone. My name is Molly Loftus, and I am a senior vice president -- is it on?

THE REPORTER: Just pull it closer.

THE WITNESS: Is that better? No.

MR. EDELMAN: A little closer.

THE WITNESS: Okay. Is that okay? Yes. Good morning, everyone. My name is Molly Loftus, and I am a senior vice president in charge of actuarial and analytics at Consortium Health Plans. I am also a fellow of the Society of Actuaries, with 30 years healthcare experience.

DIRECT EXAMINATION

BY MR. EDELMAN:

Q Ms. Loftus, did you provide a statement in this proceeding; that is, exhibit 42 for the unions? It is a statement signed by you and Lindsey Martin.

A Yes, I have provided such a statement.

Q Okay. And could you briefly summarize what your statement says?

A Sure. I was asked to provide an opinion on the subject of discount convergence. So statements

have been made that across the industry, we have seen the discount gap between the best in market and the worst in market continuously close. And, in fact, that has been a function of a lot of provider consolidation activates, so mergers and acquisitions giving providers more power within the marketplace.

We received data from Willis Towers Watson along with other consulting firms every six months. And that benchmarking data gives us insights into at a market level how our cost position compares to each of the other health plans within that market.

We went back, and we looked at that discount data going all the way back to midyear of 2013 through midyear of 2016. So that was six separate benchmarking reports. And what we saw in reviewing those benchmarking reports was that the discount advantage enjoyed by Blue Cross/Blue Shield has actually grown over this three-year period, instead of compressing and converging.

What we found was that nationally in 2013, on average, Blue Cross/Blue Shield had a held 8.6 percent advantage in over 50 percent of the markets. And by

midyear 2016, that advantage had grown to 3 percent. So we went from .6 percent to a 3 percent discount advantage, and we were now ranked number 1 in nearly 80 percent of the markets. We, similarly, looked at the markets that had the highest concentration of railroad employees, and the findings were very similar. Within those markets, we increased for an average advantage of .8 percent in 2013 to an advantage of 3.2 percent in 2016. And a number of markets where we were ranked number 1 on discounts increased from 46 percent of the markets to nearly 76 percent of the markets.

So, again, significant merger and acquisition activity taking place during that time period. And, yet, discount advantage increased, instead of shrank.

MR. EDELMAN: Okay. That is it for us. Thank you very much.

MR. VERNON: Thank you very much. We have read your report. Thank you very much.

(Witness excused.)

MR. EDELMAN: Next we would like to call Tricia Grey.

WHEREUPON,

TRICIA GREY

called as a rebuttal witness, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. EDELMAN:

Q Ms. Grey, would you please identify yourself?

A Sure. Good morning. I am Tricia Grey, vice president of sales operations at Highmark Blue Cross/Blue Shield.

Q And you prepared a statement that was submitted in this proceeding that was viewed as exhibit 43 under the heading “Highmark”?

A Yes, that is correct.

Q All right. And we have had some testimony here about the time it would take to implement a change in health insurance benefits. So question, if Highmark received a brand new client with 26,000 lives, how long do you believe it would take to implement a plan like that?

A We could typically do it within a period of 30 to 45 days.

Q Now, if you were working for a general plan administrator for an existing plan that had administered the plan for many years and you were provided a crosswalk for changes in vendor to which a participant would be assigned, that showed by ZIP Code to which vendor participants are currently assigned and to which vendor they would be reassigned, how long would it take to implement that in your understanding?

A With the crosswalk and the existing file in place, we could do that with inside of 30 days.

MR. EDELMAN: That is the extent of our questions, Ms. Grey.

MR. VERNON: Any questions?

MALE SPEAKER: None from me.

MR. VERNON: Thank you very much.

MR. EDELMAN: Thank you.

(Witness excused.)

MR. EDELMAN: Our next presenters will be Ms. Mallett and Ms. Gravot.

WHEREUPON,

KAREN MALLETT and GAELLE GRAVOT

called as rebuttal witnesses, were jointly examined

and testified as follows:

WITNESS MALLETT: Just trying to put the PowerPoint up. Give me one sec. Let me get started here.

MR. VERNON: Would you prefer the table or the podium?

WITNESS MALLETT: I am going to go through the table.

MR. VERNON: All right.

WITNESS MALLETT: To begin with, I have to reread this statement. So, Gaelle, can you just quickly go to to that statement so I can read it while you finish being set up? Sorry.

"The PowerPoint presentation was prepared solely for the purpose of arbitration among certain carriers represented by the National Carriers' Conference Committee, the NCCC, and their employees represented by The Brotherhood of Maintenance of Way Employees Division and The National Brotherhood of Teamsters and the International Association of Sheet Metal, Air, Rail and Transportation Workers Mechanical Division, collectively the parties.

"Under the supervision of the Board of Arbitration, the Board, appointed pursuant to the arbitration agreement, information is highly confidential, proprietary, and subject to the various nondisclosure agreements. Therefore, the information is intended for the use of the parties and the board solely for the purpose of the arbitration. No portion of this report may be disclosed or disseminated publicly.

"The report may not be replicated, in whole or in part, unless specifically accepted by Cheiron. All copies of this PowerPoint must be returned to Cheiron or destroyed upon conclusion of the arbitration." Thank you for listening.

So today -- why isn't that turning? Can you just go sit over there? Today we have -- okay. Sorry.

So a lot of information was provided yesterday by the NCCC and their expert witnesses. Today we have to talk to you about -- first of all, we want to begin with the reconciliation of Willis Towers Watson and Cheiron's numbers, and then we want to talk

about three key topics: first, the implementation, and that was a key issue; secondly, the financial impact, the differences between Cheiron and Willis Towers Watson. And, third, there were a lot of extraneous issues that they talked about, and we are going to give you our perspective on the items that were discussed, beginning with the implementation, the reconciliation.

The next page. Looking at the NCCC savings, Cheiron and Willis Towers Watson estimates varied on the measure of the NCCC's plan savings. So if you look at the numbers, you can see Willis Towers Watson had $73.24, $87.03. And the aggregate numbers were $13 million, $27 million, for a total of $40 million.

Our estimates were slightly less. They were both supposedly based on the spreadsheet that UnitedHealthcare did. We believe the only difference is a trend assumption, but we do not know that because Willis Towers Watson didn't tell us how they projected forward the savings between 2017, 2018, and 2019. UnitedHealthcare provided the saving calculations for 2017.

Assuming that they used higher trends -- and we show you what trends we believe they used, but we don't know -- we can match their numbers. And we are fine with matching their numbers. We are fine with saying it is a $40 million savings. We don't have an issue there. We don't want to argue about those points.

Now, going forward to the reconciliation of the 357 Plan phase, using higher trend rates, our savings were going to go up from the 98.88 to 102.32 and from the 102.14 to the 112.42 or the savings would be a total of $51 million.

Now, using their numbers that they had for 2019 and trending them back with the assumptions that we are backing into, we are assuming $8 million for 2018. Now, if you look back at the report, they show $9 million for 2019 for half a year. If we doubled that, we get $18 million. So we are saying that assuming there is no implementation timing difference -- and we are going to talk in great detail about that -- but assuming there is no implementation timing difference, the difference in our savings numbers

would be the $26 million versus the $51 million or $25 million difference.

On the next page, we sum up the 2 comparisons, the NCCC proposal $40 million on both of them. And then we show the 357 proposal, $26 million savings, $51 million. Willis Towers Watson is saying there is a $14 million difference in fact that the 357 Plan is $14 million short. Cheiron is saying that the 357 Plan saves 11 million more dollars. So it is about $2 and a half million more a month is what our savings is coming up with.

The total difference is $25 million. Now, we are going to spend a lot of time explaining why we believe strongly that our projections are accurate, but before we can even begin with that, the next key component is the implementation. And there are two key points that they hit. One is the timing of the 357 Plan versus the NCCC's proposal, and the other one is the design of the 357 Plan.

WITNESS GRAVOT: So when we get to the implementation, if we are looking at the vendors that we have today for the current plan versus the 357

Plan, there is no change in vendors. You still have the same business partners, the same insurance companies. And today these three companies are exchanging eligibility, getting eligibility updates. Aetna and Highmark, we are doing this on a weekly basis. Both Aetna and Highmark send new cards weekly. Highmark and Aetna also stated that impacted members would receive their new ID cards within one to two weeks after they receive the eligibility file from UHC.

This is kind of business as usual. Remember that you are dealing with the top three insurers in the country. This is their business. That is what they do for a living. When we get to the deductible, the out of pocket, the co-pays, all of these accumulators, the information is currently exchanged between the three partners. Aetna receives accumulators two times a day. Highmark received behavioral health accumulators from UHC daily and some other accumulators on a quarterly basis. All three have handled continuity of care routinely. That is also part of their business.

The only benefit that would need to be coded would be for Aetna, the CHCB plan. And Aetna said they would need up to 60 days if anyone would end up in the CHCB plan. There are less than 600 people that we are looking at that may end up in CHCB. We are not even sure it will be up to 600. Worst-case scenario, if Aetna has to delay the implementation for the CHCB plan, we are looking at a 10-cent per QEPM, so per qualified employee per month, impact on the savings.

Dawn Fairhurst, account director at Aetna, stated or commented on the implementation of taking over a UHC railroad. The Amtrak implementation went very well. And member feedback regarding the transition was very positive. It doesn’t seem like disruption was a big issue there.

So for this plan, these insurers have been transferring files to each other for the last 10 years at least. Having to handle a crosswalk and a new eligibility file should not be that big of an issue.

So Willis Towers Watson estimated that the time it will take to implement the 357 Plan is nonsensical. We have a hard time reconciling how it

would take only 1 day to switch the eligibility to reflect the CBG deal but it would take 9 to 12 months to implement a change in the eligibility file only.

A new plan would take less than two months to be implemented by UHC. Let me take the example of Cheiron. We have our health insurance. Actually, we don't have anything against of the vendors. We don't have anything against UHC. And we moved our insurance to UHC effective 1/1/18. That implementation was done in less than 30 days.

Willis Towers Watson has no signed statement from UHC. It is just hearsay. We have Aetna testimony. We have Highmark testimony. We did not contact UHC because when we contacted UHC in the past, they made it clear back in February, then if we ask them anything and when we asked them about the PMPM information, they will not provide any information without the NRLC's approval. And UHC would be basing their estimate on the NLRC's implementation description, which is not what the BMWED/SMART-Mechanical proposal is about.

Looking historically at implementation of

Highmark back in 2007, July 2007, BMWED agreed to add Highmark as an option. August 2007, Highmark option is actually implemented. And members came, joined the Highmark plan. That didn't take nine months.

So Willis Towers has some consonant concerns about the 357 Plan designs. After two years, the NCCC finally has a suggestion on how to implement the 357 Plan design. First, they want projected versus executive contract. Second, they want the discount differential to be greater than two percent. Third, they want members in one SMA or region to have a choice of network, but all the members that could be living in the network right next door may have to be assigned to one network and not have the option of choosing another one.

The NCCC appears to be fine giving extra money to the three large insurance companies they are using as vendors. They show 16 areas where there have been improvements. They show six markets where they want to encourage competition. We will address these points in the next few slides.

So the first issue, the projected versus

executive contract, back in 2016-17, when we did the RFI round 2, the 2017 RFI, Willis Towers requested executive contract. They wanted executive contract because they wanted to make sure the vendors were not going to play games with projected contracts.

So our estimate using the executive contracts give us a savings of $98.88 for 2018 on the per qualified employee per month. Had we used the projected contracts like Willis Towers wanted us to do today, that estimate would have gone up by 3 percent. Had we used the 2018 guaranteed discounts that were included in the submission from the vendors, that estimate would have gone up by 15 percent. So, actually, $98.88 is a conservative estimate.

We used the discount that produced the lowest savings. As actuarial consultant, we would recommend to use either the executive or the guaranteed contract, not the projected contract. The NCCC wants to use the projected contract for the Association of the -- we can very well provide you with a new crosswalk within a day.

BMWED and the SMART-Mechanical do not favor

any vendors specifically. We all believe they are doing an excellent job.

Second concern from Willis Towers, they want a discount differential to be greater than 2 percent. Does that mean that the NCCC is ready to give up up to 2 percent of their savings, potential savings, to the network providers? Wouldn't this be equivalent to basically increasing the actual value by or letting the actual value be higher by up to 2 percent?

On the right, we show you the differential of the 357 MSAs. The first two columns are by default providers, and he second two columns are by actual enrollment. We see that 31 percent of the enrollees are living in areas where there will be no difference between the current and the new discount MSAs, but you get 11 percent where basically, the bottom of the table, you have 11 percent of that enrollment where there could be like savings in -- where there is discount differential in excess of 10 percent.

Willis Towers Watson has concern, and they want members in some areas to have the choice of network. And they show actually six markets where

they want to encourage competition. It seems that Willis Towers Watson forgets what their expert is saying, Dr. Gaynor. Discounts are based on the network's book of business, not the railroad-specific membership.

As for the sixth market, four have less than 1,000 employees. There is no detail for us to look into these examples and see how realistically they could be impacted in the discounts, in the savings.

We do think that this concept demonstrates that some of the MSA would have a choice. Sorry. We think that using the concept that some MSA would have a choice between vendors and some other MSAs would not would be extremely difficult to understand for the members and also difficult to administer and increase the cost of administration of the plan. Again, we question the NCCC in what they would want and whether or not they would want to capture their savings.

Willis Towers Watson has concern with regard to 16 areas where UHC network remediation have made improvements in the last few years. We agree looking at the data between 2015 and 2018, Highmark versus

UHC, that the average difference in the data that were received actually shrank from Highmark having a better discount of about 7.4 percent on average to 6.9 percent. So does NCCC still want to pay 6.9 percent more than they need to?

WITNESS MALLETT: Our conclusion is that on implementation, a brand new plan can be implemented in less than two months. The savings from the 357 Plan is $2 and a half million a month. So even if we are off by a month or 2 months, that is $5 million, and we have a surplus of $11 million.

Our conclusion on their concerns about the plan design, if they want to use the projected discounts or the guaranteed discounts, we can do it. And we can tell you right now how many MSAs will switch between the vendors because to us, disruption is not about who your ID card is from. Whether it is from UnitedHealthcare or Aetna or Highmark, disruption is about who your doctor is. And we believe based on the analysis that we did for the railroad data, that the disruption will be very little, less than 2 to 4 percent. And the switching will actually improve the

out-of-network to more in-network providers.

So we are actually going to have a positive disruption with this 357 Plan. We believe it will be fairly positively received. And, unfortunately, the other unions have not been able to educate their membership like the BMWED and SMART-Mechanical have been able to about what disruption really means and about how doctors work.

So we believe implementation is doable and can be done expediently. That leaves us with a financial impact. For the financial impact, they questioned four different things: the business partner's fees, the marketplace consolidation and discount convergence, the medical management or what they call as everything else besides the discounts, and specific assumptions and methodology differences.

So, starting with the business partner fees, they claim it is going to cost $3 to $4 million extra a year. 2.4 million is for the general/administrative fee increase. Now, they came up with the 2.4 million assuming the full 100,000 qualified employees or 90,000 qualified employees, but we will show in 2

slides down that it doesn't drop like if you did all -- they want us to use just the BMWED. So they want us to use just 29 percent of the population. If we do that, then the number of covered members goes from 59,000 to 46,000. And so the fees are not going to go up by 2.4 million for the general and administration for the entire population.

Next, they claim $600,000 due to the claims administration and network access fees increase. Aetna and Highmark fees are both lower than UHC. Based on the 2016 RFI responses, Highmark would lower their fees even more. There is not going to be a $600,000 increase in network access fees. We are going to show you in a minute that for the 46,000, United is not going to go up enough to offset the savings from having lower Aetna and Highmark fees.

Five hundred thousand dollars due to the plan being separate from the national plan, there is no separation. They trace -- on our side, I already explained. There is no trust. There is no differential. It is just an assignment. It is just a ZIP Code assignment. Already they are currently

assigned a ZIP Code. Now we are changing the methodology to assign the ZIP Codes. We are not doing anything differently than that.

They also claim a $500,000 one-time implementation fee. I want to sign up for that because it didn't cost us $500,000 in the last night to figure out the difference in which MSAs go from 1 plan to the other or that we use the projected or executed contracts.

This is not a realistic situation. They have already implemented on their website that BMWED and SMART-Mechanical has a different plan. If you go on the website, they have already put it on. They had to do that back in January of this year because they implemented the first group, the CBG group. So they don't really need to do anything much there except for point out that you don't have a selection anymore. If you click on "BMWED-SMART," you can't select what network plan you are. They turn that switch off. That is done.

BMWED and SMART-Mechanical have said they will take care of the member communication. They

don't need to send out any papers. All they need to do is generate an eligibility file they do every week but change the methodology one time based on the ZIP Codes that we have provided.

Now, showing the real numbers on the next page, we look at table 1. And this shows for the entire plan the current amounts. It is based on the fees that we were provided by Dave Marcus back in 2016. Those are the most recent fees we have. We also updated and input some projected fees that Peter Kennedy gave us through 2018. We come up with a total cost of $50.58 per member, per qualified member, per month.

Now, it is important to point out right now that the claims admin fees, they total all up. They are $48 million. When I get to some guarantees that are going to be provided, we are going to need to know that $48 million figure. So the total is $55 million.

Now, under the proposed fee, Aetna has the same membership. Their fee shouldn't be changing. Highmark's membership, it goes down. So their fees go down based on a table that they provided to us and we

provided in our rebuttal material on Friday evening.

The general/administration -- UHC's fees would go up slightly based on what they told us, but we increased it even further just to be conservative to get our $1.29 that was in our number. And then the general and administration because this is the entire plan would go up from the $5.24 to $7. Summing it all up, that is where we get the $1.29 savings.

Now, they want us to use just the $3.56, the BMWED plan. So we did a chart, table 3. And we show Aetna is still the same fee. Highmark remember was $36.23. And now it is $40.51 based on the new schedule.

UHC's fee we kept the same because based on the table they provided. The general and administration fee we also kept the same based on the table that was provided.

All in all, the savings, instead of being $1.29, would be 94 cents, or 35 cents, less. Now, if you cross-multiply this 35 cents, you have to do it for all 90,000 people. You can't just do it for the 20,000 because that is what this fee is based on.

This is the total. We are summing up the total, the amount.

So that is going to give you -- let me calculate it -- $1 million?

WITNESS GRAVOT: No. It is like about --

WITNESS MALLETT: Oh, 600. It is less than $600,000. Yes. It is about $570,000 for the 18 months.

So, again, remember we have that $11 million extra savings, which we are going to proving. And so if you get rid of $600,000 based on what they want of our savings and you get rid of the 2 months delay that could possibly exist, which we don’t -- that would be an outside amount, based on the testimony you heard today, from a typical plan for even new implementation, then you are still at $6 million over the NCCC proposal.

That takes care of the fees. Now for the marketplace consolidation and discount convergence. I want to remind you that Dr. Gaynor never said that medical provider mergers or insurance company mergers would result in insurance companies giving the same

discounts. He never claims in his statement discount convergence. He talks about marketplace consolidation. He talks about mergers, both for insurers and for providers. But he never says that the discounts are going to get closer.

On page 8 of his PowerPoint, he shows that Blue Cross/Blue Shield dominates the marketplace. And he talks about how having a larger market share yields a greater discount. Dawn Fairhurst asked her team, the contracts to providers, what they thought of the statement of discount convergence. And she explains Aetna does not agree with the provider merger or will result in complete convergence of insurer discounts by the end of 2019.

We agree that some convergence will take place over the next five years for broad network products, but complete convergence often means revenue loss to consolidating hospitals as they give more favorable discounts to insurers. And this is unlikely to be an acceptable outcome of a merger.

In addition to this market dynamic, we are seeing partnerships between insurers and providers in

markets to build high-performance networks, ACOs. These partnerships could actually drive divergence as the partnership seeks differentiation in the local market context. So Aetna, the people who actually contract with the providers, they think it could possibly diverge. They see no convergence.

Molly Loftus and Lindsey Martin provided a written statement. Molly testified there is no evidence of this convergence. There is actually evidence of it going the opposite way. So the only one that is saying that there is going to be discount convergence is Willis Towers Watson. And they say it is based on their analysis. They say looking at the data that was provided to both Cheiron and Willis Towers Watson it was 2.2 to 1.6. It went from 2.2 to versus 1.6. And we show you what is a very highly confidential chart of the comparison of discounts between these vendors and the best in class from 2015 to 2018 using the executed contracts. It is important to use executed contracts because those are real. Those represent more real discounts, as opposed to projected.

They talked about how we were misinterpreting UHC's file. And I don't know what file UHC provided to Willis Towers Watson, but last night myself, Gaelle, and a couple of other people from Cheiron looked back and the file that we got from UnitedHealthcare. It was in the exact format that Willis Towers Watson had requested. They asked for executed contracts, projected contracts, and discount guarantees. The column to the far left, or the discount guarantees, was in every single one of the vendors' contracts. We did the comparison of the three different methodologies last night. And we showed, and Gaelle showed, you earlier if we use the other two methodologies, we actually get a larger savings. We are actually getting a better deal for the carriers.

In the graph here, using the executed contracts, we show that the difference between Highmark and UHC over the 4 years is between 3.1 and 3.3. We can't match their numbers. And we also show very importantly that Highmark is very consistent within 1 percent of the best discounts. So the black

line that we are producing right there, that is what the 357 Plan results in. It results in the best in class discounts. And it is important to understand that. So that is the extra savings that would be given to the plan.

I am trying to see if there is anything on this slide that I haven't already said. I guess the one important thing I want to point out is they say provider discount improvements are achievable through plan administration on page 57 of their Power presentation yesterday. There is no reason, no logical reason, why plan administration where a plan can go to a medical provider and say, "Lower national panel, lower discounts," that they would provide it unless the railroad employees national panel was willing to do an exclusive deal with them and shift members directly to them. That was one of the options that we presented yesterday we decided was too difficult to do at this time, but we are not talking about that. So there is no logic that plan administration can approve discounts in this plan. It is illogical.

I think I said the other two bullets -- I don't need to repeat those -- on the prior slide.

Going on, on the Highmark's comments, Molly already said these. So I don't think we really need to repeat these. This is the same, the same basic information that was presented by Molly.

The 357 Plan. So we are showing they submitted between 47 -- I am going to skip this slide for now and go on to medical management analysis.

So what did we decide so far? Just repeating, we have said, "Okay. On the discount, on the fee, business partner fees, we might be off by $600,000." On the convergence, we have no evidence from any source except Willis Towers Watson's interpretation of data, which we believe is incorrect.

So now for the other item that they list, medical management is one component or any other items. This is a very complex topic. And we have created a timeline here to show that we tried to get at this topic.

Back in March of 2016, we recommended that medical management, all of their components of savings

and discounts be incorporated. Willis Towers Watson in September 2016 when they wanted to redo the RFI for the uniform data standards, we asked them to include the medical management parts. They said no. They said it was not valid. In February of 2017, we presented our new information based on the RFI, and we again asked for that information. They said it was not needed. Now, we found it extremely interesting that we have found out in the last two weeks from Aetna that they were given a copy of Willis Towers Watson's railroad medical analysis in February of 2017.

So they gathered the information. They had the information. They just didn't want Cheiron to have it. They just didn't want the union to have it.

Again, in September of 2017, we asked, but Willis Towers Watson declined, saying it is not needed.

In January of 2018 was the first time that we heard from the NCCC, not from Willis Towers Watson, that something other than discounts were going to be considered in reviewing the 357 Plan. That is the top

part of this tidal mine. On the bottom, we show that -- remember we told you all the large consulting firms could get the UDS data on a regular basis? So we tried to get it. We hired someone that was an expert in handling UDS data. They were from Aon. And we thought that that would help us become part of the consulting firms that get it.

We have 60 credentialed actuaries. We are in the top 10 of consulting firms, actuarial consulting firms with credentialed actuaries. So we asked for the data in June of 2017. And what happened was that by October of 2017, Aetna had said that they would give it to us on a project-by-project basis. Also by October, Cigna had said they would give it to us on a project-by-project basis.

From November 2017 to February 2018, we asked UHC. UHC we thought had agreed to provide us the information on a project-by-project basis, but by February 2018, when we had the account executive for the railroad on the call, they very clearly -- and Aetna had already provided the data to us, they very clearly said they would not provide it for our

analysis.

Highmark and Blue Cross/Blue Shield, they began providing us the data. We started working with them in January. They never said that they wouldn't provide us the whole dataset, but when it became clear that none of the other major vendors were going to provide it to us, it made no sense for them to provide it. But they did provide it on a this-project basis.

So we got information, what Willis Towers Watson refers to as PMPM information. We also had plan-specific information. So we did two analyses: one, the PMPM analysis, which Willis Towers Watson did back in February of 2017 and Molly talked about how it is inconsistent with the other three major insurance companies and we did it just using Aetna and Highmark.

Now, I have a lot of detailed charts, way back in here -- and we can go through them if you want -- about our analysis. And these charts we shared with Aetna and Highmark because we are required to for their approval for us to do it. But I am going to go back to this slide that has just the conclusion because we have a very tight timeframe.

For the data that we had, we only had 50 percent of the railroad Metropolitan Standard Areas. It represented 50 percent of the membership. It was actually less than 50 percent of the MSAs. We only had 118 credible MSAs. And we used a credibility of 1,000 lives. And for that, we came in with that Highmark would be less than Aetna by $3.28 per QE per month.

Now, we had some questions that we shared with Aetna and Highmark that made us not think that this was completely valid, but we didn't have time because we were so crunched to do this analysis since we have only known since January that it was even going to be brought up.

But, that being said, it is a million dollars at most, a million dollars at most, between Aetna and Highmark. So now the $11 million extra savings, 5 million at most because of delayed implementation, which we do not believe is going to exist, at most $600,000 for fees and at most a million dollars for Aetna being best in class, at most.

On the plan-specific data, we don't have full

credibility because of the way the red, white, and blue map is designed. Remember, Aetna and Highmark aren't supposed to be in the same area. So there shouldn't be any crossover between the three carriers. So what we did was we looked at Highmark versus Aetna and Highmark versus UHC.

Now, in the Highmark versus Aetna area, we had to go down to only 100 members. And we came up with Highmark being significantly better than Aetna. But in the Highmark versus UHC areas, we could go down to 500 members. And Highmark was twice as good as UHC as they were from Aetna. So based on risk-adjusted industry-standard actuarial analysis, we concluded that Highmark was best in class, but it is not fully credible.

Therefore, we believe that if medical management is actually taken into consideration, our savings are going to increase. For this analysis, we haven't included any savings for medical management, none, zero, because we don't have a full set of data and we had very little time to do the analysis. But we honestly believe based on our detailed actuarial

analysis, which is consistent with what we have heard from Aetna and Highmark, that savings would actually improve, not deprove.

Now, to the point that Mr. Glass and Mr. Scofield made that if you use the 357 Plan, that it is -- all the risk is on the carriers, first of all, if you use the carriers' plan, all the -- for their estimate, for the savings as a benefit, all the risk is on the carriers. There is no guarantees.

But the reality is, is for these network vendors, Aetna, Highmark, and UHC, provided discount guarantees. And they put their fees at risk. They put that $40 million that we talked about at risk. And how much they put at risk, 25 percent for a UHC, 30 percent for Highmark, 30 -- up to 35 percent for Aetna. Highmark's guarantee is actually the best guarantee.

So if you take 25 percent of $40 million, you've got a $10 million guarantee. You've got a $10 million cushion right there that the network vendors are guaranteeing.

The risk of the 357 Plan is not on the

carriers. It's on the vendors, where it should be. It's the network vendors. And, to the best of our knowledge, there has been no guarantee for the benefit savings. No one has said, "We're going to guarantee that $73." And, yet, we have a guarantee for the $98.

Questions on Willis Towers Watson's number. So Arbitrator Roth asked Mr. Scofield to quantify his calculations for the 357 Plan on page 40, the convergence on discounts, the adjustment for cost differences other than discounts and the discount basis reflected. He wanted to know what portion of savings went to each one, which ones were negative and which ones were positive. And Mr. Scofield said it would take him more than a day to do that, and it would require NCCC approval. Nowhere in Willis Towers Watson's report is there a list of data that they relied on, assumptions they made, or the methodology they used. And it would take Mr. Scofield more than a day to figure out how he put together his calculations.

Expert credibility. Evaluating the financial impact above discounts and medical management is best

done by qualified actuaries. Actuarial standards of practice, number 41 -- and Mr. Roth obviously has heard this before in his arbitration -- requires an actuary to list the sources of data, assumptions, methods, and scope of services, not just in a pension report but in all actuarial reports. For ASOC 41, actuarial communications, we list in detail here the wording from it.

But, again, Willis Towers Watson's reports have numerous deficiencies with respect to disclosure for the actual standards of practice. They all fail to disclose and identify their principal. Who was the report done for, the scope of the engagement, the assumptions and methods used? Identify the responsibility -- that responsible actuary, the actuary who is responsible for each assumption, and acknowledgement of qualification, qualification standards. They do not provide a credible actuarial report.

So in deciding between Cheiron versus Willis Towers Watson numbers, you have from Cheiron fully certified actuarial reports signed by three fellows of

the Society of Actuaries. You have BMWED and SMART-Mechanical providing two FSA expert witnesses with signed statements and testifying that they have consistent results with Cheiron's report that Blue Cross/Blue Shield has superior discounts in 75 percent to 80 percent of the railroad marketplaces. You have in testifying that Willis Towers Watson's analysis of the other services are inconsistent by three other actuarial consulting firms and by our own analysis that we showed you done two different ways versus what do you have from Willis Towers Watson?

Now, I want to say that my friend Mr. Scofield, I truly respect him. And I truly believe that had the NCCC allowed Willis Towers Watson and Cheiron in any of the requests that were done multiple times to try to reconcile the numbers, we wouldn't be having a "He said," "She said" conversation right now. We would have an agreement or if we didn't have an agreement, we would have a specific reason why they weren't in agreement. But we don't have that.

What we have from Willis Towers Watson is an unsigned, uncertified report that does not meet

actuarial standards of practice. And we have NCCC providing by one associate of the Society of Actuaries their expert witness. So, for your knowledge, the difference between an FSA and an ASA is an FSA is a fully credentialed -- they have reached the highest level of being an actuary. An associate actuary is about half that level, so just trying to let you know what the initial stamp or -- I'm not saying -- Mr. Scofield is a very smart person. And, again, I honestly believe we could reconcile these numbers.

But, that being said, the preponderance of the weight is in favor of Cheiron's numbers. We've got five fully credentialed, signed actuaries saying our numbers are reasonable.

With that being said, I'm going to hand it over to Gaelle.

WITNESS GRAVOT: In this section, we will touch on the other items that was brought up by Willis Towers Watson: consumerism, actual value, antitrust, member and provider disruption, and additional significant concerns.

The Rand health insurance experiment, that

study is over three decades old. Back in 2006, they actually did a follow-up study, and Rand reminded us of 2 important takeaways. First, cost sharing reduced the use of both highly effective and less effective services in roughly equal proportion. So that low-value services that was brought up by the NCCC's witnesses yesterday, you are also like actually having an effect on the highly effective, so the high-value services when increasing your deductible and co-insurance. Subsequent Rand work on appropriateness of care found that economic incentives by themselves do not improve appropriateness of care or lead to clinical sensible reduction in service use. In addition, cost sharing may not address the principal cause of cost growth.

So some basic concept about consumerism. Value-based contracting drives utilization down, not increasing your deductible or your co-insurance. Medicare was able to reduce utilization. And they did this through value-based contracting. If you look back at historical Medicare deductible, they have not increased that substantially.

Medical necessity, criteria for determining medical necessity also have an impact on consumerism.

In the last round of bargaining, we agreed on the scope reduction, the generic co-pay was actually back in -- what year was it, 2005, the $10 going down to $5?

WITNESS MALLETT: That happened in the last round.

WITNESS GRAVOT: The last round.

WITNESS MALLETT: Two thousand twelve.

WITNESS GRAVOT: So for 2010, the deductible --

WITNESS MALLETT: '12.

WITNESS GRAVOT: '12. Sorry. The deductible went -- on generic went from $10 down to $5. That actually increased your generic utilization by 5 percentage points. As a result of that increase in utilization, because more cost-effective drugs were used, the plan saved money.

The NCCC proposal for the Rx benefit, this round of bargaining is actually reversing their position from last time and increasing that generic

co-pay back to $10.

We show you three links to articles on this slide that actually shows you -- show you that when you increase people's deductible, co-insurance, or co-pay, they don't necessarily know where to go to find the right care. So increasing their cost did not actually let the people know where to go and how to shop. They are missing that part of the education.

The BMWED/SMART-Mechanical proposal was including also vital smart shoppers. That program was incentivizing members to actually shop around for identifying more cost-effective and maybe higher quality providers. The NCCC rejected the vital smart shoppers program.

WITNESS MALLETT: Going back to consumerism, our point is that we are trying to make here -- and this is a really important point -- is they are trying to get the members to be smarter consumers. And in their proposal of their $73, they say $9 of it is driven by consumerism. I want to take a second here to think about it. We used the wrong extended numbers for having better consumers with a plan for using

network providers, so the plan being a better consumer and assigning people correctly to the networks. They give $56, $56. That's six times more consumerism.

I also want to point out that every single business partner, Aetna, UnitedHealthcare, and Highmark, agreed. The CHCB plan, which does not promote consumerism, does not promote in-network use of providers, could almost be completely eliminated. But, yet, they want to continue to stick with that mapping that was done 27 years ago. The plan had an opportunity here to show and be a good consumer, but they chose not to do that. And they are still choosing to fight against consumerism for the plan.

WITNESS GRAVOT: Actuarial value of benefit. So we never really like defined what actuarial value of benefit means. There are actually so many different definitions. Do you include in-network benefit only? Do you include out-of-network and in-network? Is it on medical benefit only? Is it on medical and Rx? Are rebates included? Does that mean -- is it -- is the calculation of the actuarial value adjusted for administration fees or part of the

administration fees? Are HRA or ASA included in the definition of the actuarial value or in the calculation of the actuarial value?

The actuarial value at the individual level varies. If you think about somebody who is healthy, they have no claim at all. In that case, the actuarial value is close to zero or about zero while unhealthy people would hit their out-of-pocket maximum. And, as a result, their actuarial value would actually converge towards 100 percent.

The graph on the top of this slide show you -- shows you the comparison of what we call the benefit ratio. So it’s based on the definition, a consistent definition, of actual value that we used. The comparison of the BMWED, it is smart current benefit versus the NCCC 2018 proposed benefit, the NCCC 2019 proposed benefit, and 10 other railroad system.

We find that the average of all the other transit union benefit ratio is about 91.4 percent compared to the 92 percent benefit ratio for the current and MCP brand for the BMWED/SMART-Mechanical.

That benefit ratio of 92 percent is not an outlier for that industry.

The NCCC witnesses brought up issues with the Blue Cross/Blue Shield Association antitrust lawsuit. We have some statements from Darren Gold from Highmark, “On April 16, 2018, the defendant filed a request that the court grant an interlocutory appeal of its per se ruling to the 11th” -- sorry -- “Circuit Courts of Appeals. If the request is not granted, the parties will proceed to the class certification of the case which the defendant, Blue Cross/Blue Shield Association, will vigorously defend. If the court grants class certification, it is likely that the initial bellwether trial against the Alabama Blue Plan will begin in 2019.”

We have additional statement from Lori Schoonmaker, also at Highmark, “The April” -- and I will let you just that --

WITNESS MALLETT: You can read this if you want. The important part is this is not a 357 Plan issue. It is an issue for the current plan, the UnitedHealthcare, everyone issue, but it is not unique

to the 357. It would impact the NCCC proposal as well.

Let's go on to the next thing. I just want to give a -- the member and time -- the member and provider disruption, we already told you the percentages in the differentials. And we have also told you that the members have been educated, provider disruption, the professional people.

Going on to the next slide, conclusion. Rich, what is our time check? Do we have time to conclude or not?

MR. EDELMAN: I don't --

WITNESS MALLETT: No. Okay. So, with that, we will -- we made all of our key points. Thank you for your time. Any questions?

(No response.)

(Witnesses excused.)

(Pause.)

MR. EDELMAN: This is the written statement that Mr. Roth is going to summarize, not going to read the whole thing. We do have an extra copy.

MR. VERNON: Of this?

MR. EDELMAN: Yes.

MR. VERNON: I just have one.

MR. EDELMAN: I know. So you are going to sit down, put Fred.

MR. VERNON: Okay. Got it. I think this is on, Freddie.

WHEREUPON,

FREDDIE N. SIMPSON

called as a rebuttal witness, was examined and testified as follows:

THE WITNESS: Good morning. I am Freddie Simpson. I will identify myself again, president of BMWED.

Just one --

MR. EDELMAN: Pull that mike closer to you, please.

THE WITNESS: Can you hear me now? Hello? All right. Okay.

Just one point of rebuttal. As I said as I closed yesterday, I felt the BMWED and SMART had done all they could do to try to get to a deal with the National Carriers' Conferences. But in Mr. Glass'

testimony, he said the solution was to race in the door and get the first deal and get out and you could get yourself a contract.

Well, just for the record, BMW/SMART tried that. We started early, well before, years before we could serve notice developing a healthcare committee to try to get to the bargaining table. We assumed or thought healthcare would be very important in this round of arguing. So we tried to get ahead of the game.

In 2015-2016, we first presented the 357 Plan to the National Carriers' Conference. The National Carriers' Conference didn't respond until September of 2016.

In 2017, February, we coordinated with the Transportation -- or TCU Coalition Group, which -- with regard to our notices. And in February, BMW/SMART and TCU pushed an identical proposal across the table on wages and healthcare to the National Carriers' Conference. We also retained -- we also made some modest changes to the benefits. And we also retained the 357 Plan.

At the end of February, the National Carriers' Conference came back to the table with a worse proposal than they had previously given us. They said no retro and no change on plan design, worst of all options previously discussed. They came back, in other words -- and I hate to say it, but they pissed backwards again.

And we have done all we can do in this round of bargaining to try to bargain fairly. And we have tried to be the first in the door to get a deal, a fair and reasonable deal. And that's the only point I want to make today.

(Witness excused.)

MR. EDELMAN: We need a minute. I'm sorry.

(Pause.)

MR. EDELMAN: One of our other witnesses just arrived, Ms. Lindsey Martin, who has coauthored the paper with Ms. Loftus. So we just have two questions to ask her.

WHEREUPON,

LINDSEY MARTIN

called as a rebuttal witness, was examined and

testified as follows:

DIRECT EXAMINATION

BY MR. EDELMAN:

Q Will you identify yourself, please, Ms. Martin?

A Yeah. My name is Lindsey Martin. I am an actuary with Consortium Health Plans.

Q And did you coauthor that paper with Molly Loftus that is in exhibit 42?

A I did.

Q Now, Willis Towers Watson has made a claim that UnitedHealthcare has a cost advantage of 3 percent excluding provider discounts. And this is at Scofield exhibit 25, page 21. What is your view of this claim by Willis Towers Watson?

A My view of that is we have seen results of these similar models from other firms. And while many of them are consistent, Towers is an outlier. We did not see the same result from other firms.

MR. EDELMAN: Thank you. That is it, questions.

MR. ROTH: Could you just describe for the

Board exactly what the consortium is and what you do?

THE WITNESS: Yes. Apologies.

MR. ROTH: Yes.

THE WITNESS: The consortium is an entity that does behalf -- does work on behalf of a number of Blues plans. As you know, some of the Blues have rules with each other, competing rules, that they can't see each other's data. We do a lot of data work on behalf of virtually all of the Blues plans.

MR. ROTH: I see. Okay. Thank you.

THE WITNESS: Yes.

MR. EDELMAN: Okay. Thank you.

THE WITNESS: Thank you.

(Witness excused.)

WHEREUPON,

THOMAS R. ROTH

called as a rebuttal witness, was examined and testified as follows:

MR. EDELMAN: Mr. Roth has a written statement that we have marked as unions exhibit 49.

(Unions Exhibit No. 49 was marked for identification.)

DIRECT EXAMINATION

BY MR. EDELMAN:

Q Mr. Roth, can you briefly summarize what --

A Right. Well, I know how anxious the chairman was to have some more information on pattern bargaining. So I prepared this last night. But, actually, I wanted to round out the record with respect to those cases that are among the national rounds of bargaining that occurred since 1955, when the health and welfare plan was created.

As you recall from my earlier statement, I mentioned that there were some 19 non-op rounds of bargaining over that period of time. And I had accounted for about 9 or 10 of those in my earlier statement regarding the application of the pattern principle. And so I wanted to add to that in order to round out the record a couple of more of those wage and rules movements and what occurred during them with respect to the pattern application.

They were -- a couple of them were mentioned by counsel in their -- counsel for the NCCC in his opening argument, PEB-229, for example, and I think

211. And I was curious as to why, but I thought you should have some analysis of exactly what happened during those rounds.

So, without reading this at you, I am just going to identify for you the 1970 round, which involved the PEB-178. That was one where -- the chairman there was Lou Gill -- they rejected the application of the existence of a kind of controlling or a motivating pattern totally. As you can see, it was made clear in their analysis. There were four organizations that had settled prior to the PEB-178, which involved the BMWED and the UTU, the hotel restaurant employees, and the clerks, BRAC union at the time.

The pattern alleged by the NCCC at the time was a shop craft deal that called for approximately 13.8 percent over a 3-year period. The ultimate recommendations to the BMWED and the other organizations was for 37.3 percent over 3 years. That is the consequence of kind o rejecting outright the application of the pattern and during that round.

The 1984 round is also instructive. This is

PEB-211. And, again, the short story here is this is rather complicated, but the short story is that during this round, the carriers had settled with the operating crafts. And that was followed by a BRAC deal that translated some of the concessions that the operating crafts made into concessions of their own with respect to wage restructuring of certain lower-level classifications.

The question then was, what do we do in 211 with the subsequent unions that came? And they involved some shop crafts plus the BRS, the BMWED, and -- let me see -- I think one of the outlying shop craft unions as well.

In any case, I represented the BRS and the BMWED and a few others in that round of bargaining. And essentially, I record for you on page 5 the consequences of the recommendations, that on the surface, you would think if you read the report was for following the BRAC pattern, but, in fact, the results, the recommendations, the specific recommendations, for the BRS, the shop crafts, and the BMWED were wholly different in the wage change and the

restructuring that was proposed.

The point is that this is an illustration of where while the Board wrote language with respect to the existence and the importance of the pattern, it made recommendations which were wholly different and unequal, if you will, for the participating organizations.

So this is a case where it is not only different but unequal. My earlier statement was kind of recording for you those rounds of bargaining where we had explicit different terms where the boards and the parties subsequently had attempted to with some precision provide equal arrangements among the organizations.

The next one here in this list is the 219. That is not a pattern case per se, but there was the oft-quoted phrase that the Board had in its report that I quote on the top of page 6 of my summary here that says, “The Board had concluded that wage proposals of all organizations, both those representing the operating crafts and those representing the non-operating crafts, should be

treated uniformly." So, having said that, they went on to make recommendations on wages which were wholly different among the organizations. And I analyze that for you in the bullet points that follow on page 6.

The 1995 round resulted in the establishment of 3 PEBs. Two twenty-eight was with the clerks. And Rolf Valtin was the chair of that. And I think you served on that panel as well, Mr. Vernon.

MR. VERNON: Along with Jake Seinberg?

THE WITNESS: Yes, right. In 229, that was with the BMWED. And the chairman of that, as I recall, was Dave Twomey.

And 230 was a shop craft group. And was Dick Mittenthal's group.

The boards were all appointed within the same month. They issued reports that were dated, they are all dated, the same day. And while there were -- you know, of course, the NCCC took the position that -- and I am quoting here from the carrier exhibit number 4, which outlined their position -- that there was a pattern in effect that should guide these 3 panels in making their recommendations. And then I go on to

analyze for you exactly what happened. And you may or may not recall, but it was pattern plus. So this was a round of bargaining where while there were patterns established and while these boards recognized that there was a pattern, they, nevertheless, made recommendations which gave extra wage increases to the organizations before it. And that was true with 228, 229, and 230.

The form of those extra wage increases varied. In your case, as you remember, you eliminated the 11 percent wage cut that would otherwise be applicable to the TCU clerks under their national salary plan that was incorporated as part of PEB-219 recommendations.

And then let me see. Okay. In any case, I just wanted to add that, add the necessary information on those rounds of bargaining. I want to say, though, in -- to point out my conclusions here, on page 13, because I listened to the carrier in this case.

And I have a quote here from the carriers' position, which I found in their opening submission to you. And it raises two points with respect to the

application of the pattern principle. They say that the terms must be -- if you are going to apply the pattern principle, the terms, the exact terms, of the pattern must be applied. That is their position in this case. They say there are two exceptions, however: unusual -- and I am quoting -- unusual cases where work rules or compensation elements are craft-specific or, and/or, the second exception is where the parties agree otherwise.

This gets us to the testimony of Mr. Glass, who said, yes, the -- you know, what is wrong with the unions' presentation and the unions' view of the pattern application in this case is that they focus exclusively on situations where the parties had agreed to either monetize certain elements of compensation across the crafts or to, you know, convert these terms into value equivalent to what the pattern maker had received. And so somehow, they should be discounted by you.

Well, I say a couple of things here in closing. With respect to the first exception, you know, the NCCC is ignoring the history. If you think

that the concept of different but equal has applied exclusively or regularly to elements of compensation that are craft-specific, you are just wrong. You are just not understanding what happened. It is not enough to read the PEB recommendations themselves, read the report. That is not enough. Analyze what happened. Analyze what actually happened to those elements of compensation. So they are completely wrong and have a very shallow reading of the bargaining history if you think that the doctrine of different but equal applies only to craft-specific-type rules; for example, like cert pay. That is not the case.

Secondly -- and this is really an objection that I think several of the carriers' witnesses made to my presentation, in particular, is that my examples focused on those situations that involved agreements between the parties, as opposed to agreements which were imposed by an arbitrator.

The notion that the Board should discount a voluntary agreement as to the proper application of a recognized pattern is just patently ridiculous. The

proper function of an interest arbitration board is to ascertain to the best of its ability those terms that would best replicate what the parties themselves would have agreed to had the negotiations been successful. Now, how better to do that but to analyze what the parties have voluntarily agreed to in the past? So the precedential value of prior PEBs and prior agreements seems to me to be higher among those agreements and those contracts that have been voluntarily reached, as opposed to those imposed by an arbitrator.

Moreover, if you look at all of the wage and rules movements between 1955 and today on the freight side, you won't find any interest arbitrations that involved the BMWED. So where would you go if you are going to discount the voluntary agreements in trying to determine what is acceptable to the parties and how they view the proper application of a pattern? Then you will have no precedence, which seems to be very silly.

So my suggestion is that in trying to figure out how best to apply a pattern where there is some

mutual recognition where the pattern exists, you had best look to what the parties have done in their voluntary decisions over the past several decades.

And, finally, just to close, I want to comment about one other topic here. We have a wide-ranging set of opinions from Member Gradia and Mr. Scofield and others regarding the effect on employee morale or kind of labor relations generally under circumstances where you have two separate plan designs.

I think, you know, the examples that Mr. Scofield was giving involved two employees working side by side, one having a big deductible and one having a lower deductible and somehow that the one with the higher deductible is upset and morale is -- labor relations has just stabilized. Okay? Let me say a couple of things about that.

We have had generations, we have had decades in this industry where the contribution rates toward health and welfare had varied among the organizations. This is particularly true with the BMWED.

Now, different contributions among the

employees is something that is highly visible. In other words, you can look at -- you can compare paychecks and figure out exactly who has the better deal or the lower contribution. It is easier to figure out than who has the bigger deductible because you are not comparing your insurance bills. So if that is not destabilizing and has not been and nobody is alleging that it was, then why would a different plan design be?

Secondly, we have, even within the BMWED and the SMART-Mechanical coalition, a substantial difference in their health and welfare coverage. The eligibility requirements for the sheet metal workers involves having performed one compensable day in a month. In other words, if you have one compensable day in a month, you are covered by the plan. The BMWED's rule is seven days.

Now, what is more fundamental to coverage, to health and welfare design than determination of eligibility? That varies, and that is not causing any problems that we know of. So why would a different design change?

And one other comment on -- again, you have wide-ranging opinions on this matter. I just want to offer my own two cents. And this is really in response to Mr. Glass' testimony where he invokes, you know, the airline industry, where he had spent a lot of time.

While he was spending a lot of time on USAirways, by the way, I was engaged in restructuring on TWA, United Air Lines, Alaska Airlines, American Airlines, Hawaiian Airlines, and Northwest Airlines. And I have done more of those cases than -- probably 10 times as many restructuring cases as Mr. Glass has. I have got a little bit of experience there as well.

There is no model in the airline industry with respect to design common and uniform design changes across the crafts. If you go to United Air Lines, for example, there are almost 50 plans across the country, different plans with different contribution rates. It is not causing a problem there. Nobody proposes to eliminate it.

The same is true in Alaska Airlines, where the health insurance plans vary between the pilots and

the flight attendants and the g round service employees. So there is no labor relations model when it comes outside the railroad industry that makes it a religion that we have uniform benefits across the board. And there are a whole lot of other examples that I know you are even aware of but I would like to mention.

Take the building trades, for example. Stick your head out the window here, and go to one of these construction sites. And you will see that working side by side, you have electricians and plumbers and carpenters, each of them participating in different Taft-Hartley-defined -- I'm sorry -- health and welfare programs, each of them with different plan designs. That doesn't cause them to riot over their circumstances and cause destabilization in the building trades.

So, too, of the Metro workers here in town. I have been managing their collective bargaining activities for over 45 years. There are five collective bargaining units. Each of them have their own plan. Each of them have their own plan design.

In fact, the bus operators, most of them represented by the Amalgamated Transit Union but some of them at one garage represented by the teamsters, they have totally different plans, completely different health and welfare plans with totally different health and welfare designs. That has not caused any destabilization.

And it is interesting to note that this has always been the case here at WMATA, the Washington Metropolitan Area Transit Authority. And, yet, no one has ever proposed to change that.

So this whole notion about “Oh, we can’t. We have got to have uniform benefits because it is going to be destabilizing” is a fantasy that those in the cocoon over at the NCCC’s offices imagine, but if they got out in the field, they should listen to President Simpson.

And what really hurts morale is when you have somebody else’s deal shoved down your throat. That is the problem. It is not the problem that the benefits are different.

And that is all I have to say about that.

BY MR. EDELMAN:

Q I have one question. Mr. Roth, you were involved in the round bargaining that ended up with the UTU agreement in 2011 as a BMWED agreement about the PEB in 2012?

A I was.

Q Yes. And there were health and welfare changes in both of those agreements, right?

A There were.

Q And did those health and welfare changes happen at the same time?

A No, they didn't.

Q And was there a true-up, any kind of form of adjustment for timing of implementation between the UTU agreement?

A There -- not to my recollection, there was not, no.

MR. EDELMAN: I am going to just provide to substantiate the different dates of implementation, meaning exhibit 50, which is the agreement of the UTU, entered 16th day of September 2011; the BMWED agreement, April 25th, 2012, showing the different

implementation.

(Unions Exhibit No. 50 was marked for identification.)

MR. EDELMAN: There has been testimony there was no true-up.

MR. MUNRO: Mr. Chairman, for the record, the NCCC objects to the entry of these exhibits. Under paragraph 12, the arbitration agreement clearly states the Board shall only consider evidence made known to the opposing party prior to the hearing before the Board.

MR. VERNON: We will note that object for the record, take it into consideration. We will receive the exhibits.

(Unions Exhibits Number 59 and 50 were admitted into evidence.)

MR. VERNON: The Board will decide in its deliberations as to what is properly colored within the lines and what isn’t.

MR. EDELMAN: Thank you.

THE WITNESS: Anything else for me, Rich?

MR. EDELMAN: No, Tom. Thank you.

(Witness excused.)

MR. VERNON: The two exhibits and one number, do you want to mark 50A and 51 or 50A and 50B?

MALE SPEAKER: These are marked.

MR. VERNON: Oh, they are already marked. Sorry. I was looking at the top. Sorry.

MR. EDELMAN: Just a moment, please.

(Pause.)

MR. EDELMAN: Okay. We don't intend to call anybody else. I will note that Marc Rifkind, who gave a statement saying that there is no need for a new trust or anything of that nature, is in the room if the Board has any questions for Mr. Rifkind.

MR. VERNON: No, I don't have any. Ken?

MR. GRADIA: Do not.

MR. VERNON: Nor does Mr. Roth. For those of you who are not familiar with it, it was a fairly straightforward statement with respect to the requirement as to whether or the question as to whether it requires a separate trust. It, like I said, is straightforward. And we understand what he said.

MR. EDELMAN: I haven't seen him in like 25 years.

(Laughter.)

MR. EDELMAN: That is the close of our --

MR. VERNON: All right. Let's take 15 minutes. We will be back at 5 to 11:00.

(Off the record.)

(On the record.)

MR. VERNON: We are back on the record. Will the carrier begin its rebuttal case, please?

MR. MUNRO: Thank you, Mr. Chairman. For our first rebuttal witness, I would like to call Dr. Gaynor back to the witness table.

WHEREUPON,

MARTIN GAYNOR

called as a rebuttal witness, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. MUNRO:

Q Dr. Gaynor, if you could just reintroduce yourself to the Panel?

A Board members and Chair, I am Martin Gaynor.

MR. VERNON: There is a switch at the top.

THE WITNESS: Got it. All right. Let me try again.

Board members, Mr. Chairman, my name is Martin Gaynor.

BY MR. MUNRO:

Q Dr. Gaynor, you heard the testimony from the unions' witnesses this morning regarding discounts, a discount divergence or convergence. Is that right?

A Yes, I did.

Q And do you recall that the testimony was that from 2013 through 2016, there is evidence that discounts have diverged? Do you recall that?

A Yes.

Q And they further stated that during the same period, there was market consolidation. Do you recall that?

A Yes.

Q What is your reaction to that testimony?

A Well, though -- I don't have any knowledge of the study. So I can't comment on the results of divergence.

But looking at what happens nationally to discounts or prices and consolidation isn't meaningful because markets for hospital, doctor, all kinds of healthcare services are local, not national. So there are really no meaningful association between consolidation at the national level and price and their discounts.

Q And is there a distinction between prices and discounts in this context?

A Oh, absolutely. Prices are what matter. Prices are actually what providers get paid, and that is what things cost. Discounts are discounts off charges or perhaps off something else. And you could have a large discount but not necessarily a low price. For example, compare a situation where there was a list price of $1,000 with a 20 percent discount. So the transaction price is $800 and a list price of $500 with smaller discount, say 10 percent. So the transaction price is $550. I think we would all prefer to pay $550, rather than $800, even though the discount is smaller.

Q One last question, Dr. Gaynor. Is it your

testimony that discounts are converging and will converge completely by 2019 or just that there is substantial uncertainty over the direction of discount trends?

A I did not say anything about convergence or divergence. I did say there's a lot of disruption in the market that creates a lot of uncertainty in general.

MR. MUNRO: Thank you.

THE WITNESS: Thank you.

MR. VERNON: Thank you very much.

THE WITNESS: Thank you.

(Witness excused.)

MR. MUNRO: Mr. Chairman, for our next witness, I would like to recall Dr. Goldman.

WHEREUPON,

DANA GOLDMAN

called as a rebuttal witness, was examined and testified as follows:

THE WITNESS: Hi. Dana Goldman from the University of Southern California.

DIRECT EXAMINATION

BY MR. MUNRO:

Q Dr. Goldman, you heard the testimony this morning regarding Cheiron's views on behavioral change?

A Yes, I did.

Q And could you offer your thoughts in response?

A Yes. I feel Cheiron's analysis really fails to appreciate that we can control health spending in two ways. We can reduce price or we can reduce quantity. Their analysis focuses on discounts. And, as Dr. Gaynor just pointed out, that is not the right way to even think about reducing prices. And it is subject to market forces that are well beyond the control of the parties here.

On the other hand, controlling quantity; that is, utilization, is actually much better understood. Yes, the Rand study is three decades old, but, really, that is a study about basic human behavior. And in that sense, what I mean by that is it says when healthcare goes on sale, like any other good, people use more of it. And so the converse of that is that

modest increases in cost sharing can actually control use.

And it is precisely because this study was so old that I undertook the analysis of the PEB 243 cost sharing on the railroad population specifically. And the results of that analysis were very clear. Cost sharing reduces utilization, and it does so without any measurable effects on health. And this makes the proposed changes a reasonable strategy for controlling spending.

MR. MUNRO: Thank you.

MR. VERNON: Any questions?

MR. ROTH: Excuse me. Just one. In your study of the last round of bargaining here between the parties and the effect that the design changes had, did your analysis distinguish between and among the various changes that were made; for example, ER co-pays versus, let’s say, adding a deductible?

THE WITNESS: We focused on the changes in cost sharing measured by the coinsurance rate and the deductible because research has shown that the immediacy of those are really the ones that have

affected people's behavior.

MR. ROTH: Okay. Thank you. That is all I have.

MR. VERNON: Thank you.

(Witness excused.)

MR. MUNRO: And, finally, Mr. Chairman, I would like to recall David Scofield.

WHEREUPON,

DAVID SCOFIELD

called as a rebuttal witness, was examined and testified as follows:

THE WITNESS: Chairman, Board members, I am Dave Scofield from Willis Towers Watson, still glad to be here.

(Laughter.)

THE WITNESS: So, just to open, I just want to say that the document that I submitted on behalf of the carriers and the analysis that was done there was done in a manner that was fully compliant with actuarial standards. The work was done with competence. It was fully reviewed, involved the senior actuaries of my company. So I think anyone in

the audience or here who knows me would expect nothing less than that.

My table of contents here looks I think a lot like Cheiron's. We're going to address the reconciliation of the savings and in my view discuss the lack of equivalence between the 357 Plan and the pattern, go over some key assumptions that drive those differences, and then get to some other remarks that have been made recently or in the recent past. And then beyond this, there will be some other comments that I will make after this prepared stuff.

So when I said yesterday that it would take more than a day to come up with this reconciliation, I underestimated myself. We worked on this. Me and our group worked on this last night and put this together. Obviously, we had all of the analysis together wanting to get approval from the NCCC to be able to discuss it in this way.

But what this page shows is, first, I am showing the numbers at the top that come from the Cheiron report. And I will talk about those in a minute. At the bottom, I show the Willis Towers

Watson valuation of the pattern plan design and then in between show various aspects of the Willis Towers Watson valuation of the 357 Plan.

So what we wanted to do was try to make an effort to reconcile with the numbers that we are coming up with, which I think if you look on this chart, you will see there is a row that says, “Willis Towers Watson Valuation of the 357 Plan.” And the first number to the right of that is you see $54.78. That’s what I have per employee per month in 2019. And that reflects selecting the best lowest -- highest discount vendor by market and doing that in all the markets across the country. That compares with the Cheiron number of $102.14. Cheiron did adjust that number that they described to increase the savings within, you know the past few days. And I’ll come back to that in a few minutes because I am reconciling to this $102 number for 2019.

So I thought that I made the rationale for my assumptions pretty clear yesterday, but I will go back over those again here and throughout the presentation. So, first, on the convergence, you know, what this is

shorthand for is convergence of network discounts. My rationale for coming up with that assumption is looking at the discount data that was supplied to us by Blue Cross and UnitedHealthcare and focusing primarily on Blue Cross and UnitedHealthcare since that was the shift, the primary shift, in the enrollment. We looked at the 2015 discounts for both Aetna -- excuse me -- 2015 discounts for both UnitedHealthcare and Highmark and also looked at the 2018 discounts.

We, very importantly, feel like we reflected the UnitedHealthcare network remediation data in order to come up with this analysis in the assumption here. So we do believe that the network discounts are converging between 2015 and 2018. So that is one source of difference, just the convergence of discounts in general, as well as reflecting the 2018 remediation data that UnitedHealthcare supplied to us. So that is the second row.

The third row, 1 percent cost difference other than discounts, that relied on the per-member per-month cost data that I referred to yesterday where

we found that there was a 3 percent difference in the per-member per-month cost associated with Blue Cross/Blue Shield versus UnitedHealthcare, 3 percent closer than the discounts alone would imply. We understand that care management is being carved out and being awarded to UnitedHealthcare across the board. So care management, which is maybe a significant piece of that cost difference, is not a difference that is on the table for this analysis, for this plan.

So what we chose to do was to say -- we could either have said, does the full 3 percent go away because of that consolidation of care management or do we still have something else that drives cost difference? What we chose to do was to say we still have something else that drives some cost difference and we left with a 1 percent assumption.

And then administrative fees, we have discussed that. I spoke about it yesterday quite a bit. Cheiron spoke about it today quite a bit. I've got another page in here that we'll elaborate on why we get the figure that we get.

And then, beyond that, we have now, as we have had from the very first time we looked at it, some unknown amount of difference. And I think that Cheiron would acknowledge, although I don't know, way back at the start of this project, we did discuss this. We, at least for some time, made some effort to try to identify what the differences were. We were not able to do that and subsequently did not have conversations on that. So it remains a question to me and I think to them as well. But that adds up to the total difference on this page. So from our calculations, the valuation of the per-employee per-month figures are pretty roughly half.

Now, what we did there going to the right is to convert first that these per-member per-month costs into a 2019 full-year number, so what this would look like on a 12-month basis. And a number that I -- you know, maybe people will remember, one of the numbers in the Cheiron deck just before was $32 million of savings in 2019 for the full year. And you can see that at the top of the page, 32, 31.9 million.

So we, of course, as we have said and as

Cheiron objected to, you know, we don't think that the January 1st, 2019 date is feasible. We have said that April 1st is more likely. So what we have done in the column to the right is to reflect that April 1st implementation date. So, rather than getting 12 months of savings in that 2019 year, you get 9 months. So the 32 million would go down to 24 million. I am not saying that is what Cheiron says. I am saying that is what I say if we apply the April 1st implementation to their numbers, but then, really importantly, what you get, what I get for my numbers if you look down at the Willis Towers Watson valuation of the 357 Plan, 17 million if it was for the full year, we don't think that is achievable, but for the 9 months that's left, about 13 million.

We also recognize, though, that the parties have agreed to certain programs with ESI that in the information that was part of what was submitted with the exhibits in the carrier submission, we included the savings associated with the ESI programs. So if someone is trying to reconcile to a savings number from that exhibit, the per-employee per-month savings

number that you would find is $61.28. That includes the combination of the impact of the 357 Plan and the ESI programs. So you can see the per-employee per-month and the 12-month and the 9-month figures here.

So, then, lastly, at the bottom, the Willis Towers Watson valuation of the pattern plan design, $87.03 per employee per month and then $27 million for 2019.

And I will say that this is really not just my calculation, Willis Towers Watson's calculation. This was a calculation that was done with the combined effort of UnitedHealthcare, Express Scripts, me from Willis Towers Watson, and the consultant from the CBG all to put together a modeling spreadsheet that would be used by the bargainers to evaluate a variety of different plan design changes. That program was in my opinion quite well-done. And it was used by UnitedHealthcare in their effort to come up with the renewal estimates that the carriers would use for their updated contribution to the plan for 2018.

And I understand from Cheiron's comments that that spreadsheet, the model was supplied to them and

they used that. And they -- if you may recall, they came up with different numbers than what me and UnitedHealthcare and others came up with. And they then, therefore, said that they have to increase the trend in order to match the numbers and then, therefore, had that increased trend to inflate their 357 Plan numbers.

But I was involved in the development of the spreadsheet. I talked extensively with UnitedHealthcare about the application of that spreadsheet to the 2018 cost estimates because my client, the NLRC/NCCC, they really want to know how much they'll save and how much to reflect in the upcoming rate. So I can tell you that that spreadsheet generates the numbers that are consistent with what Willis Towers Watson came up with. There's no need to adjust for trend. There's no need to do anything like that. So the numbers that get produced are find the way they are. Cheiron -- you know, I don't know -- didn't get the same thing, didn't maybe quite understand the spreadsheet and felt like they had to -- in order to get the same number as we got,

had to adjust the trend. I can't really say what that was, but in my opinion, this spreadsheet was fine the way it was. It reflected the trends that UnitedHealthcare was already using. So there's no need to change the trend.

So we don't accept the Cheiron suggestion that the 357 Plan should save even more because of that higher-than-usual trend.

We can come back to this, but if anyone has any questions on this, I went through a lot. There's a lot of numbers here. This may be an important point for clarifying what is going on. If there is any assumption that I have described in adequately, I do have some slides that address some of the assumptions further, but I can spend more time on this if anyone wants.

Okay. Implementation timing. This is very significant assumption that needs to be identified. Since we are looking at carrier savings over the last one-plus partial year of this bargain round, it really makes a big difference whether something goes in June 1st; July 1st, 2019; or April 1st, 2019.

Most of the words here have already been said, but I will reiterate UnitedHealthcare is a central administrator and has been for 60 years. It is my view that Cheiron acknowledged that they discussed the implementation timing with Highmark and Aetna but not UHC. And I understand that Highmark and Aetna think it would take -- what I can decipher is that they would say that it takes 30 to 60 days for them to implement this plan once they have the eligibility file transferred to them.

So my timeline doesn't take into account anything about additional time that Highmark or Aetna would need. I assumed that that would just get absorbed and that they can accomplish that between now and whenever UnitedHealthcare has been able to effectively put the systems together that are necessary to administer this plan. So I will make a few more points and get into some details.

I had several conversations with UnitedHealthcare, Tom Butera, Dave Trombley, Frances Hart, Ken Krampitz. You know, anyone who knows them, you know that they take every one of these questions

seriously. They don't go out on a limb with anything. They take their time. They're very thoughtful. You know, they said a 30- to 60-day implementation is absolutely impossible. They said that unless they had a full ZIP Code assignment of the new vendors by April 1st, they couldn't guarantee that they would be able to hit a 1/1/19 implementation date.

Now, UnitedHealthcare has been doing this for 60 years. The central admin role, I've described some of the things that they would have to do. But, again, just to reiterate, just in general -- this has to do with whether it's BMWED, UTU, any of the other crafts -- they take work history data that's supplied to them by the railroads, and they convert that to a work history, which then feeds their eligibility systems. So UnitedHealthcare is figuring out who is eligible for this plan based on data that the carriers sent to them.

And then, in addition to that, UnitedHealthcare has to maintain a ZIP Code database that will identify which vendors and which plan options are available across the country. That system

is built for the current red, white, and blue map. That system is not built for the BMWED plan.

UnitedHealthcare provides this service to the plan, and they have done it very well. And they have got a dedicated staff from 60 to 65, but this is not part of the thing that they do in the normal course of business. And what they have to do is duplicate that system in order to be able to tell. And they have to do this, you know, not just once, but they have to be able to every month send a file. Maybe it is more than once a month but at least monthly send a file to each of the vendors under the plan, saying who is eligible for what. And they have to know which vendor each employee is eligible for. And, you know, maybe the high-level description of that sounds easier than it is, but there are things like members who go from one craft to another, members who move throughout the course of the year, people who are offered COBRA, all of these things that sound like they don't amount to much, but it makes these people at UnitedHealthcare stay up at night. Every time you bring up anything, they get frantic about "What are we going to do about

this? What are we going to do about that?" because they have to program their system to do it properly for a plan in total that covers 400,000 people across almost every ZIP Code in the country.

So our assumption here, you know, our assumptions that we laid out, assuming that we have to redo the vendor discount analysis -- and I'll talk more about -- or say again why I think that is crucial. It would have us -- you know, if we said 12 months from about now, that would say that June 1st, 2019 would be the earliest you could possibly implement. What we reflected in our material yesterday was, you know, implementation dates that straddle that. April 1st we used and July 1st.

One anecdotal note. But anyone who has been working here may remember way back around 2000 or a little bit before, the UTU plan, which prior to that didn't really exist. The UTU plan was created. And Blue Cross/Blue Shield came on the scene. Before that, it was just Aetna and United. It was a very big deal in negotiations.

The unions brought in Blue Cross/Blue Shield

of Michigan, the big, big bad Blues of Michigan. They came in, and they said, “We’re going to -- you know, we’re going to be -- offer them to the UTU plan. And we’ll be the central administrator for the UTU plan.”

And, you know, the carriers and, you know, their attorneys and consultant, me, you know, we conferred with, you know, us, UnitedHealthcare, and, you know, understand the capabilities that an organization like Blues of Michigan have, which is extensive, but we concluded that, you know, the Blues’ discounts were great, but we said, “Guys, you can’t do this. We just know you can’t do it.”

And Blues of Michigan said, “Oh, yes, we can. We can.” And so we said about -- I don’t know how many months it was, 3 or 4 months, where we went to the Blues of Michigan, 30 of us, you know, me, people from the NLRC, their attorneys, groups of people at UnitedHealthcare, to try to explain to the Blues of Michigan what was involved. And so we had three or four meetings over two or three months, four months.

And recognize the Blues stood to gain a lot, millions of dollars in administrative fees for

breaking into the railroads. They so desperately wanted to get into the railroads. So when the head of operations at the Blues of Michigan had to come into this room of 30 people and tell us, “You were right. We can’t do this,” it really was a shock.

And the Blues of Michigan wound up never being offered under the plan. The plan had to move to a different Blues plan. It was Regents Blue Cross/Blue Shield that later gave way to Highmark. I just make that comment to -- even though it is, of course, not the exact situation, it was a -- just another situation where the central administrator role was completely underestimated and the time that things are involved and how difficult it is.

So the last point here, the comparison to the Amtrak implementation is in my view totally misplaced because it doesn’t really align very well. There is no 357 Plan structure. This is a -- in the entire population of a single organization with one medical vendor, it just doesn’t matter that Aetna was able to implement that cleanly and effectively in a short amount of time. That has no bearing whatsoever on the

ability to implement the 357 Plan.

Administrative fees in any normal setting should be a relatively straightforward calculation. At least compared to the provider discount analysis, it should be. I think both of us, Cheiron and me, would say it is simply a matter of multiplying the per-employee per-month rate times the headcount and adding it up, you know, the headcount being determined based on, you know, the assumption of which employees would go to which vendors in the national plan.

So Cheiron described their calculation of fees based on the full implementation of the entire national plan and what that results in. And, you know, the numbers I don't remember exactly, but it was something like 70,000 employees went to Highmark Blue Cross/Blue Shield, which is -- you know, that's the result that they got for the plan-wide. What that does is that it drives the fee that you find on the Highmark schedule really low when what is happening -- you know, rather than the 70 percent of the full national plan, what is going to happen in reality is that Highmark is going to get an additional maybe 70

percent of the BMWED population. So the Highmark fee will not go down nearly as much as that, not anywhere close. And so that's kind of the one point.

So there's a significant savings on the -- just the regular claim administration fee that gets built in as the result of Cheiron's approach. The other side is the central admin fee. Cheiron put up on the board that my calculation of a $2.4 million increase associated with central admin was based on an assumption of the full national plan being included in the 357 Plan, and that's just not correct. My 2.4 million was based on the membership lost at the UnitedHealthcare -- that UnitedHealthcare would have for the proportion of the BMWED population that they would lose.

This is another case where it is not always clear what the vendors mean when they submit spreadsheets to you and you have got to look at stuff and try to figure it out. And the increase in admin fees for central administration that Cheiron presented, which, you know, goes from a current fee of something like $5 per employee per month up to a fee

of $7 per employee per month, that is what the UnitedHealthcare admin fee increase would be. And it would apply to the entire national plan, even though it's only the BMWED members that UnitedHealthcare would be losing.

So the $3 to $4 million fee increase that I come up with is a combination of Highmark getting a modest increase in enrollment, UnitedHealthcare losing a modest portion of their enrollment and applying the fee schedule, as was submitted by the vendors and as was clarified through conversations with UnitedHealthcare.

Discount data and discount convergence. I don't, still don't, know for certain, but I do believe that Cheiron is not using the same provider discount data for the UnitedHealthcare for its plan savings calculation as I am using. I've got a couple of things to say here, but, first, in late 2016, we went about working with Cheiron.

So Peter Kennedy, Dave Marcus, me, and Cheiron, put together a request to send to the vendors to say we wanted discount data in a certain format,

and we wanted everyone to give us the same format. And it was to give us provider discounts with a pretty significant degree of detail for each MSA.

And we wanted them to do that on a couple of different bases. One was to do it based on executed contracts. One was projected contracts. And the reason that in this case, it is very important to consider projected, rather than executed, it's that at the time, which was back in 2016, we knew that nothing was going to be implemented, if it ever would, until 2018-2019.

So from my clients' point of view, when you are looking at -- you know, you are sitting around in 2016 and they ask me, "What kind of discounts can -- you know, what kind of discounts can we get?" it just doesn't help you to restrict yourself to deals that are currently in place. There could be things that are going on that you will want to reflect because, you know, as the group has noted here many times, this is the first time in 27 years that we are making this change. You sure don't want to make it and then have, you know, many, many more years go by and you've made

a mistake because you didn't have the most updated projected data. So the reason we are going through this effort was to get the projected data in the first place.

UnitedHealthcare submission was not clear. They had some discounts put out that they put out for 2018. And they had a guaranteed discount for 2018 that simply when you look at the two of them together, they did not make sense. And, you know, try as I could, in conversation after conversation, I finally convinced UnitedHealthcare that the numbers in one column on the spreadsheet didn't make sense with the discount guarantee. And what turned out was that they realized that they did not include the impact of the network -- the provider discount remediation in the discounts that they had submitted. It was only in the guaranteed discount column.

I know that's a lot of technical blabbering, but what it needed to have happen in order to reflect Blue Cross -- in order to reflect the United properly was to get additional information from United where they actually had to give in a way that you could see

what the difference is the impact of their remediation efforts.

And, you know, we know that they are going through efforts because UnitedHealthcare as a business has lost business to Blue Cross/Blue Shield because their discounts are inferior. That's been going on for years. UnitedHealthcare recognizes it. They know they're at risk in a number of railroad markets. And they've been working at this very hard. They're trying to capitalize on other deals they have in the marketplace for other very large clients, and they are doing this in many locations.

And so to not make use of the discounts that you get from this, whether it's on purpose or by mistake, just undermines the analysis. And I think if there was no conversation with UnitedHealthcare on this, there's no way that Cheiron would have been able to figure out what this remediation effort was because I certainly couldn't. It took me like five conversations.

So with respect to discount convergence, I know that, you know, there's a -- we'll have a couple

of comments later on about Aetna and Highmark making some reference to “Well, there’s no discount convergence,” but my finding of discount convergence is based on the data that the Blue Cross and United submitted to us with 2015 discounts and 2018 discounts.

If you look at the 2018 discounts, including the remediation effort by UnitedHealthcare, there is a convergence. There's no doubt that, on average, across the board, Blue Cross/Blue Shield is superior. Just on this -- and I’ll get -- I’ll say this again later, but no one on our side, me or anyone else, said that there would be complete convergence of discounts by 2019. I think the word we used was “gradual” or something like that. So over time, discounts would converge.

Okay. The impact of medical management -- and, again, I’ll talk more about this in a later slide, but I thought in the submission and in my comments that, you know, it was clear in our view that medical management and the differences in cost due to medical management were off the table to the extent

that the parties had agreed to carve out care management and give it to UnitedHealthcare, whether the member's in United, Highmark, or Aetna. So that effectively takes away the care management difference between the plans.

What -- the point that I tried to make and that was missed somehow is that, even though care management is an important piece of the difference that drives the cost, cost differentials other than discounts, it is not the only thing.

You heard Dr. Gaynor just not give a very simplistic but instructive example where one organization has a very high discount matched with a very high submitted charge. And you compare that to an organization that has a lower discount percentage but a lower submitted charge that that discount is applied to. And, lo and behold, the one with the lower discount has a lower cost also. So you'd make the wrong choice if you picked the organization with the higher discount in that case.

So not trying to make more of a big deal of this than it is, but simply what I did was just assume

that Highmark Blue Cross/Blue Shield has a 1 percent higher cost for things other than discounts. It is not a phenomenally important assumption. It's supported by the data that my firm gets signed off on by the Blues consortium and Highmark. So I'm pretty comfortable using that data.

And, just in the rebuttal, pages and pages of the Cheiron rebuttal go to this issue. And I just think it inflates the importance, completely over-blows the importance of this.

And, just the last note, Cheiron's position on the impact of medical management has evolved over time. And I'll describe what I mean there in a few minutes or now, actually.

So now I am moving into some comments at various points in time that Cheiron made. And, you know, I don't mean to be unfair because they have every reason to have had the view that they had at the time, but still this is the way I see it. The March 29th, 2016 meeting where Cheiron presented their initial results for the potential for the 357 Plan, they gave a tremendous amount of detail in a lot of

different combinations. They did full replacement. They did, you know, full replacement with the Blues, full replacement with United, picking the best vendor by MSA. They did a whole bunch of different combinations. It was a huge document.

They presented that to the NCCC. And yesterday they made reference to they claimed that there was a $100 million that the plan could save. Then they further went on to say, “Okay. So that’s $100 million without recognizing the impact of care management.” When they recognized the impact of care management, their assumption in that meeting that they presented to us was that UnitedHealthcare would have superior care management that would shrink that $100 million savings by $55 million. So, you know, this is a couple of years ago, but that is a big number, $55 million. We never disputed that, never agreed with it, but, you know, of course, we noted it.

Then about a year later -- and this was, I think, in a mediated session, maybe not. Maybe it was -- I can’t remember if it was mediated or not, but Cheiron presented their analysis of the updated

discounts because we -- between 2016 and 2017 updated the discounts as I described a couple of moments ago and Cheiron presented their new results. And they still were coming up with something along the lines of $100 million savings on discounts with, you know, the 357 Plan or with the Blues, but they now no longer were convinced that UnitedHealthcare's medical management is superior. So they took out all reference to the medical management and just simply went with the impact of the discount so as to say that medical management has no bearing.

And then now in their most recent material -- and I don't think this was even in the submission. It wasn't until the rebuttal material. Their view seems to have changed. Well, it has changed again. And I know it's based on this detailed analysis that they've gone through. But now they think that there's -- you know, I think that they might have used the word "significant" but the significant medical management savings possibility for the 357 Plan. And I don't know what that's in reference to because, like I said, care management is being carved out of each of the

vendors and is being consolidated with UnitedHealthcare. So, you know, it would only happen if, you know, the vendors maintained their respective separate care management approaches, which isn't going to happen. But, anyway, you know, this runs down their evolving view on care management and its impact on the numbers.

Cheiron's changing numbers with respect to the pattern. It wasn't very long ago, back in December 2017, in a presentation they made to the NCCC and to the mediators they presented some numbers on what the pattern would save. And they said that this was equivalent to the 357 Plan. So they got numbers like $92 per month in 2018, $114 per month in 2019.

And we -- you know, we took this in our side. And my guys are like looking at me like "How do you come up with $73 in 2018 and $87 in 2019 when Cheiron projects a higher number?"

And I'm like "I don't know. I mean, I get numbers working with the sophisticated spreadsheet that I used with UnitedHealthcare that labor signed off on. I'm comfortable with my numbers. I don't

know where they got their numbers. And they're certainly higher."

Sometime between that point and the submission, it appears that Cheiron got information from UnitedHealthcare, this modeling spreadsheet, and they revised their numbers. And, again, like I said before, I think that if they would have used the spreadsheet right, they would have exactly gotten the numbers that I am using. They got something a little bit different.

So, then, now with their rebuttal, they have revised to match, you know, the numbers that I get, but they say, "Well, that's associated with a -- you've got to assume a higher trend in order to get that," which is not true. Those numbers are based on with UnitedHealthcare's work the trends that they have used.

So, I mean, you can see that, you know, pretty big swings in these numbers over a very short amount of time when -- I mean, the plan design changes are well-known. And it's pretty -- well, I say this, pretty easy to calculate the impact of a deductible

change, pretty easy to calculate the impact of a co-insurance change. That's pretty standard underwriting techniques.

So, you know, if something like this can have such a swing with regard to, you know, the estimate, you know, it really is -- could have huge swings when you're looking at something as complex as the provider discount analysis, which is much more cumbersome. So the variability in that kind of a calculation could be much, much larger.

So the savings associated with the 357 Plan, Cheiron's views on this have changed, not as much as with the pattern benefits, but back in December, Cheiron told us or, I mean, the BMWED told us that there was an estimate of savings of about 47 million. That 47 million continued as their estimate for savings for 2018 and '19, up through their submission.

And then they very recently changed to gain $4 million of savings, you know, almost 10 percent, based on in my view, which is this mistaken need to have a higher-than-market trend be applied to the calculation of the pattern savings. They went ahead

and just applied that to the 357 Plan, which I don't think makes any sense. And it's just -- you know, of course, you can get the numbers by just multiplying them, but I don't think that's the way you're supposed to do it.

So now on factual clarifications -- and, again, these are the facts in my view. Someone else might have a different view, I suppose, but it was said here "January 2018, the NCCC for the first time makes a statement to discount analysis is impacted by medical management." I don't know how anyone could make this claim because, you know, we had so many conversations with Ken Gradia and he reported our view about the discount analysis.

And we would always, always caveat it that, first, what we're trying to do is just put out a number that is first aligned exactly with how the Cheiron analysis went. You know, they didn't -- at some points didn't assume impacts of medical management. Then they did. Then they took it out. But, first of all, you know, we tried to get some common basis before you look at medical management.

We mentioned it every time as a caveat that we think it, you know, has bearing here, very difficult to quantify. So I don't see how anyone could say that we brought it up for the first time. And, in fact, right after January 2018 is when we stopped bringing it up because we knew that the consolidated care management was going into effect. So that really negates the need to even reflect any differences of care management.

The many references to Willis Towers Watson's statement of medical management analysis is not needed, that is true, but it is in the context of this. When we were preparing to request the updated provider discount information, we also were faced with whether we should ask for information with regard to medical management. And I consider the data that you get when you look at this kind of PMPM stuff and the adjustments that you have to make on it much less credible in small quantities than the discounts would be.

So I think that this kind of analysis looks fine if you're looking at a population across the

entire country, but the way Cheiron wanted to do it was to collect data on this by MSA, which in my view would have been just an exercise, of course, in like a spreadsheet mathematic exercise and you would get results and you would have differences in medical management that you would calculate, but there would be completely not reflective of what is going on because the data volume is just too small. So Dave Marcus and I decided that we should just say we don't think we should do this because we don't think it's important. And the thing that wasn't important was not the medical management analysis at all but to do it on a market-by-market basis we thought would just be phenomenally time-consuming with no value added.

There is a comment in the rebuttal material that was supplied to us. It wasn't directly said today, but it said in the written rebuttal that Blue Cross/Blue Shield has not approved Willis Towers Watson's use of this -- of the PMPM data. And that is just not true. It's completely untrue. I have written approval to use it. There's approval from correspondence between Highmark, the consortium. It

goes back to March 2017. The railroads were part of a pilot. It was highly scrutinized by all of the senior actuaries at my company, signed off on by the senior actuaries at Highmark and the consortium. So there's no doubt that I was able to use this.

And I don't understand why someone would suggest that I didn't have approval for this when, first, you don't know it and you're just -- it just speaks to what you think of my use of this kind of data. Why would I use something that I wasn't approved to use?

This is a minor point, but we feel like it's interesting to mention. So the provider disruption, it's described as being manageable. And it's presented as if the 2 to 3 percent of members that are disrupted by, you know, losing their doctor from the network, that it's offset by the 4 to 8 percent of out-of-network doctors that move into the network. So, I mean, of course, 4 to 8 percent numbers-wise does -- you know, they are bigger than 2 to 3 percent. But those 2 to 3 percent of people who lose their doctor aren't going to feel like it's offset by the

other people who gained their doctors in the network. Those 2 to 3 percent still will be disrupted.

I admit 2 to 3 percent is not a big number, but the offset comment is just a slightly misleading approach here.

So further clarifications on other statements that were made and comments that were made in the rebuttal: first, the folks from Highmark. So since 2017, there has not been nor will there be significant convergence in discounts in the marketplace. You know, so since 2017 -- you know, we are in May 2018. What is it that they would have seen in the 4 months since 2017 ended that would give them the ability to say anything about this? What do they know about UnitedHealthcare discounts? What do they know about even their own discounts through the first 4 months of 2018? I don't understand how someone can make such a statement and try to rely on that as justification for that there is no convergence of provider discounts.

The comment was made that in June 2013, Blue Cross showed a discount of .8 percent advantage and by June 2016, that had increased to 2.3. I mean, that's

fine. I don't dispute that. It shows that the discount advantage can change from one time period to another. It says nothing about whether the discounts between June 2016 and 2018, 2019, which is when my client is concerned with what the discounts would be -- it says nothing about that. You could certainly have Blue Cross/Blue Shield's discount advantage expand and then contract. It's not the craziest thing in the world.

And then we believe that there will be a convergence -- let's see. We believe that if there would be a convergence impact, it would have been -- it would have displayed itself by now. Therefore, we do not agree that network discounts between insurers will converge by end of 2019.

So, again, first of all, no one ever said and I don't think that discounts will converge by 2019. It will be a gradual convergence over time. And just because you haven't seen any evidence of it up until now, I mean, things can't change a year, a month, two years from now? Of course, they can. So just because you haven't seen any evidence up until now tells you

really nothing about the future. So relying on these statements, you know, I just don't see how much weight you can give them.

So the statement by the attorney, you know, the carriers contend that adopting the 357 Plan would require the establishment of a separate health plan and trust, I know that wasn't necessarily said that way today. That was in the written submission. The carriers' comment was that a trust could be required but not that it would be. So there are circumstances that would still have to be explored.

And this attorney says, "In my opinion, ERISA does not require the establishment of a separate trust to implement this plan." We agree with that, of course, but our view, my view, the carriers' view is that, for administrative reasons, maybe someone among the parties attached to this plan might want the BMWED in a separate plan. Maybe it's the BMWED. Maybe it's the carriers. Maybe it's the other crafts. The other crafts would have the BMWED in their plan, and they would have a higher benefit level, maybe leading to higher costs. You could see CBG and TCU organizations

wanting the BMWED in a separate plan. So it could happen. We're not saying that it has to happen, but it could.

A quote of Dawn Fairhurst, "Aetna does not agree the provider merger will result in a complete convergence of insurer discounts by the end of 2019." Again, we never said this.

Oops. Let me see if I have any other comments to make and, Don, if you have any questions. So just a couple of things on the provider discount analysis.

Willis Towers Watson is part of I guess the four consulting firms that get this information from the insurance companies twice a year. And, you know, we have been doing that for 10 years. And it was presented I felt like this morning that Cheiron somehow blames me or my firm for them not getting it, and we've got nothing to do with that. Whether they get it or not is their relationship with the insurers.

Cheiron asked me to give them the per-member per-month data that I have. You know, they make a big deal about the NDAs that they have, you know,

nondisclosure agreements, so they can't turn over data that they've got just under an NDA. Well, we have the same things. You know, my firm gets this data from Aetna. And I can't give it to a non-client for their use. Just, you know, I don't see how they would expect me to be able to do such a thing. So it's not me, it's not my firm preventing them from getting it.

If we go back to the start of this project, which was -- you know, I think was back in early 2016, Cheiron requested discount data of the vendors. And it was a very detailed request similar to how -- similar but not identical to the data that Willis Towers Watson gets through our twice-a-year data submission.

And, you know, a lot was commented on how we delayed and how we didn't -- you know, didn't engage with them, but what they don't know is that we have that -- you know, similar discount data that was submitted to us under a universal data standard specification. The data that they had from their request was not submitted under the same specification. So the vendors gave data that was a

little bit sloppily put together. And, in particular, you know, it's very important to put the buckets properly. There's inpatient discounts. There's outpatient discounts. And there's professional discounts. And you weight them together for this analysis, and you get an overall composite discount.

Everyone has to put the different service areas together in the same buckets. Otherwise, when you weight them together, you get an apples-to-apples result and one that's just not valid. We knew that looking at the UDS data that we had, that Aetna was doing something different with the data they had submitted to Cheiron. We didn't want to tell them that. We had no reason to tell them that. But that's what led us to want to re-request the data under the universal data standard format that we subsequently did.

So what was portrayed as dragging our feet or not wanting to engage, it was not so much that as it was -- you know, we knew there was something messed up somewhat with the data, like what the impact is, you know, we really didn't know. And it really didn't

matter because we felt strongly that we needed to request new data that was projected to a time that was closer to when this might one day be implemented. And that's what we eventually did.

Just another point on the admin fees. So, you know, Cheiron showed where, you know, I claimed that there's a total $3-$4 million increase associated with their 357 Plan. 2.4 million was due to central administration, which I still stand by. Six hundred thousand is due to just the reshuffling of the headcounts across the claim administration for the three different vendors.

And then I added. And someone might accuse me of arbitrarily adding it, but I added $500,000 for implementation, and I added $500,000 as an estimate for what would be I thought an increase in fees to administer the 357 Plan, which is more -- well, it's more complicated and it's different than the current red, white, and blue map. I admit that maybe it's arbitrary, but when you ask insurance companies, UnitedHealthcare in particular, to do things, they always charge you for it. And, you know, how much it

is I don't know. When I first talked with United about this, which wasn't that long ago, I said, you know, "I need you guys to tell me, you know, an estimate of what it would take for you to administer this."

And they said, "Okay. Well, we can get you that estimate in three months."

And I go "I don't have three months." And so I said, "Would your fees be higher?"

They said, "Yes, they'd be higher."

And then I had to basically suggest to them, you know, "How much higher?" And they wouldn't tell me. So I had to pick a number myself. And I don't -- I just in all of this didn't want it to be lost that these fees will go up because what the -- what they had quoted on was not their 357 Plan. It was just reshuffling of the current red, white, and blue.

The discount guarantees that were mentioned earlier today, you know, they're fine, but those discount guarantees were quoted on a basis of the 357 Plan applying to the full national plan, that the vendors would get less enrollment. If it's only the

BMWED population, that means that those guarantees would just really not apply any longer. Maybe they -- maybe the vendors would uphold those guarantees for the subset, but I doubt it because what -- their guarantees are based on where the individual members live. And since we don't know, no one knows, Cheiron doesn't know, BMW doesn't know, NCCC doesn't know where the BMWED members reside relative to the national plan, I think that those guarantees are just invalidated.

Thank you. That's all I have. I can have questions now if you'd like.

MR. ROTH: Dave, I need some help reconciling the costing differences. If you could go to slide 1 for me? I think it was slide 1. That one there. Thank you.

The $6.50 number on the bottom there, that is the addition of the ESI program.

THE WITNESS: Yes.

MR. ROTH: As I recall in the presentation of Cheiron, that number on the agreed-upon items was much larger. Can you tell me what items you had priced in

that line item, which of the agreed-upon items are included in --

THE WITNESS: Yeah. So I will just -- I can talk about that just briefly. So -- and this applies in both 2018 and 2019. There are a number of agreed-upon items that the parties will do. And the numbers that I have reflected here are the ESI programs. And that's medical channel management; screen Rx; fraud, waste, and abuse. And what those programs will do will affect the claim costs somewhat and will affect the rebates somewhat. And this figure was an estimate that I had from developing the estimate of what the pattern would say. These are identical programs under the pattern. So it is very easy to translate.

I know that Cheiron included some other things in their number that I acknowledge they impact cost, but they're not reflected in my $6,000.50. You know, one of those items is the pharmacy, the bit of the pharmacy management program. And I think that's probably the biggest piece of the difference between what I have here and what Cheiron had.

MR. ROTH: Yes. They had $6.68.

THE WITNESS: Yeah. And so that program by agreement is to be -- you know, the project is going on now to select the -- you know, a new, possible new, plan administrator and achieve better discounts. And that would be implemented January 1st, 2019.

It's notable that Cheiron counts savings for that PBM RFI bid in both 2018 and 2019, even though it wouldn't be effective until 2019. So if you'll see the 2018 number for Cheiron being much larger than the 650, it's I think a misplaced savings associated with that pharmacy rebid, which wouldn't happen until 1/1/2019.

MR. ROTH: Okay. So there may be additional savings associated with some of the agreed-upon items?

THE WITNESS: Definitely, yep.

MR. ROTH: But we should understand your $6.50 as being as matching what you embedded in the 8703 for the pattern design change?

THE WITNESS: Yes.

MR. ROTH: Okay. So --

THE WITNESS: Yes, that is correct. Yeah, that -- exactly.

MR. ROTH: Understand that I'm --
THE WITNESS: Yes.
MR. ROTH: -- looking at the apples and --
THE WITNESS: Yeah. The 8703 would be lower if I wasn't counting the ESI programs. So just -- so --
MR. ROTH: Go ahead.
THE WITNESS: Oh, I'm sorry.
MR. ROTH: No. Go ahead.
THE WITNESS: Yeah. So the 87, it includes the estimated impact of changing the deductible, co-pays, co-insurance. It includes the ESI programs. And it assumes behavior change.
MR. ROTH: Okay.
THE WITNESS: So all of those, those three pieces, comprise the 8703.
MR. ROTH: Okay. Can you elaborate? Maybe I missed some of this, but the biggest single difference on the page is the 2234 for the unknown. How should I understand that? If it is unknown to you, it is unknown to us.
THE WITNESS: Well, it is. So to go back to

2016, Cheiron did the analysis and presented it to the carriers. And they came up with, you know, $100 million savings or something like that. And they, you know, waited some time for us to do our analysis. And we came back. And there were a number of references to 70 percent, 75 percent. The savings that I came up with, which I was trying to be on an apples-to-apples basis. So if you don't count the convergence of discounts, UHC remediation, the 1 percent difference because of things other than discounts, administrative fee impact, if I don't count those assumptions that I've made, I'm about 80 percent of the Cheiron number. So it's not that different from the 70 to 75 percent that we talked about at the very beginning of this process.

We went through not a very lengthy discussion, but there was a time when Don Griffin, Ken Gradia, you know, Karen, Peter, me, Dave Marcus, we sat in a room, and we tried to figure out a couple of things that came to mind. And we looked at, well, you know, is it a mix of provider services? And we couldn't get that. And was it, you know, a couple of

other things, headcount? We couldn't identify what the -- what was driving the differences, although, you know, we acknowledge that it was there. And each side understood that we didn't know why there was a difference. And we never revisited it.

So I don't have an answer other than to describe that as the background.

MR. ROTH: All right. But I should understand that that difference emerged by your kind of independent analysis of the 357 Plan?

THE WITNESS: My independent analysis compared to Cheiron's independent analysis, yes.

MR. ROTH: Okay. Could you go to I think it is slide 7 or page 7 in the presentation? I think it is maybe the next one. Thank you. Right. This is the pattern settlement. I mean, my recollection is -- and may be incorrect, but at some point in bargaining earlier on when the pattern design changes first emerged, that Cheiron was not in a position to price all of them and that some of the pricing came about later in the process. So could part of this explanation on the changing or the evolving costing

from Cheiron be explained by the components that it was being asked to price out? Do you know?

THE WITNESS: Well, by December 2017, the pattern plan design was available for everyone to know. So the actual provisions of the pattern were known.

What Cheiron had in order to come up with their estimates, I don't know. I think I recall that the numbers that are -- that you see there from December 2017 were based on, you know, their estimate using whatever software or techniques that they have back in their office. You know, whether it includes stuff like the ESI programs and -- I don't know, but I do think that subsequent to that December 17th -- the December 2017 meeting, they received, you know, the detailed modeling spreadsheet that we worked on with UnitedHealthcare. And, you know, then they used it to get, you know, much closer to our number, but, you know, again, it's my opinion if they use it exactly the way it was intended, you come up with the numbers that I have because that's exactly how I did it. I took UnitedHealthcare's spreadsheet, took out the

things that, you know, we needed for the purposes of developing overall funding, but the -- you know, weren't relevant for this purpose and you get the numbers that are on the page there.

You know, it sounds to me like, you know, Cheiron did that, got slightly different numbers, and assumed that that difference was somehow attributable to the need to apply a higher trend. And that's just not the case.

I mean, I know that comparing two numbers, you get a percentage difference. And then if you apply that to another number, you know, all the numbers go up, but that's just not the way that it should work.

MR. ROTH: Okay. What was the date where -- the spreadsheet from UHC that we all used at the bargaining table at some point, when was that published or when was that available for the unions to use? Do you recall?

THE WITNESS: Well, yeah. So this spreadsheet was developed in large part by Ken Krampitz. He didn't have all of the access to the

pharmacy data, but -- you know, Ken at UnitedHealthcare. You know, I think he's viewed as a pretty impartial guy. I think he gives answers to labor and management, kind of in equally annoying doses to either side. And, you know -- and he's very smart and competent. So we got him to do most of the heavy lifting on developing this spreadsheet.

I probably worked the closest with him in reviewing it and making sure that it worked the way that I thought it would be done. The consultant for the CBG to a lesser extent was involved, but what happened was over the course of the spring and early summer 2017, this modeling spreadsheet was developed. And for the CBG, we had many meetings where we had a number of different plan designs that we were looking at, some that are -- you know, were wildly different than the plan design that we now wound up with, but we used that spreadsheet to model all of these different plan designs. It wasn't until -- so the spreadsheet was developed in the summer. The actual pattern design itself wasn't nailed down until, you know, sometime before the October 6th date, when the CBG and

the carriers came to agreement. So it was sometime just before that that the pattern design was put into this spreadsheet. So it was -- so it's -- you know, so I would say sometime fall, fall 2017, when this spreadsheet was done.

MR. ROTH: Okay. And that would have been available to the BMWED group as well at that point?

THE WITNESS: I don't know.

MR. ROTH: Okay.

THE WITNESS: I suppose it would have been available if they knew to ask. I don't know that they would have any --

MR. ROTH: Yes.

THE WITNESS: -- knowledge of its existence.

MR. ROTH: Okay. All right. That is all I have for now. Thank you.

MR. VERNON: You are excused. Thanks.

THE WITNESS: Thank you. Don, leave this on or turn it off?

MR. VERNON: Leave it on.

THE WITNESS: Okay.

(Witness excused.)

MR. MUNRO: Mr. Chairman, that concludes the carriers' rebuttal presentation.

MR. VERNON: Off the record.

(Off the record.)

(On the record.)

MR. VERNON: Step up.

MR. EDELMAN: Okay. And I will make sure that -- let's see. Which is on? Okay. Hello? Okay.

First of all, we appreciate the Board members paying attention to this, considering it is a complex issue. All of the complicated information has been put before you. We appreciate your attention to it because it involves matters that are very important to these unions and to their members.

For the last two days, we have shown a number of things. In this case, we do not dispute the primacy of the pattern principle but assert that the unions' proposal produces an agreement consistent with the pattern because the savings in the 357 Plan are equivalent to those of the deal the NCCC negotiated with the CBG unions. For that reason, again, we do not have a burden of making a compelling argument to

deviate from the pattern because we not trying to deviate from the pattern. We have also shown that pattern does not mean the same terms. It means equivalent value.

Now, the NCCC's main response to this is to say the examples we cited are relevant because it is supposedly different when the equivalent deal is arrived at by agreement instead of by award. This makes no sense. If it is routinely accepted in multiple negotiations that an equivalent value deal matches a previously negotiated or arbitrated pattern, then that is demonstration of an industry norm and law of the shop, the pattern has value, not terms. As Tom pointed out, if agreements constitute the highest form of mutual acceptance of an understanding, then a history or recognition in negotiations, the pattern means value is persuasive on that question. And while whether particular combinations of terms are equivalent is going to be a case-by-case question, the concept that pattern is equivalent value, not the same terms, is a matter for general principle and not one for case-by-case determination.

It is also contradictory to argue that agreements reached by some carriers and some unions constitute a pattern but agreements -- so that is a pattern, right? Union/carriers negotiate agreement, and agreement creates pattern. But agreements aren't persuasive as to what pattern means.

And it is commonly said that the goal of an interest arbitration is to arrive at the deal the parties would have reached voluntarily if they could given that there is no basis to say that agreements have no weight with respect to what pattern means, only interest arbitrations do. In any event, I do note that the BLET suit case that was decided by Mr. Eichen and is relied on by the NCCC was an arbitrated award. And it specifically said that pattern is equivalent value. And I quoted this in my opening yesterday and the Metro submission in the case with the signalman, where it said that there were three agreements that had different elements of compensation but lower GWIs but had the same value was consistent with the overall pattern.

Now, the NCCC has argued that pattern has to

be same terms because if it doesn't, then first settlement has no meaning. It won't resolve anything. There will still be efforts for one-upmanship.

Well, we don't get it. If an agreement sets the total value for the pattern, it establishes the parameters for bargaining. The pattern controls the sum total for the other deals. The elements may vary, but there is a known total value. So the assertion that the first settlement has no meaning if pattern doesn't require exact same terms is wrong.

Beyond that, as President Simpson said, BMWED and SMART-Mechanical tried to settle early. They even proposed an additional healthcare benefits concession, but the NCCC wasn't interested.

The NCCC has said that our position is that one side can dictate the equivalence determination; whereas, the carriers say it is open to debate. That is another illogical point. If pattern is value and value is calculated, then it is not subjective or a matter of opinion. If the numbers add up the same, then the value is the same.

Another odd argument from the NCCC is that

they say we seek to pick and choose from the pattern; in particular, that we accepted certain health benefits changes that are in the CBG dale, but we don't want their increases in co-pays and deductibles. So we took those other terms. But the NCCC and BMWED and SMART-Mechanical agreed to those other health benefit terms. They are in appendix B. The NCCC could have taken the position that no healthcare benefit terms are agreed and nothing would be in the agreement without the co-pays and deductibles and the whole thing, all healthcare, has to be arbitrated, but they didn't. They can't say they agreed to include those terms as part of the agreement and to arbitrate only the co-pays and deductibles versus the 357 Plan and then complain that the other health benefit terms being agreed are in the plan, are in the agreement.

Now, we have also demonstrated there is no special requirement for uniformity among agreements with regard to healthcare benefits, as opposed to some other terms of collective bargaining. And the carriers haven't refuted our showing on that point, and the evidence and precedence on that are compelling

or that are contrary to the positions the carriers are taking.

We have also shown that the NCCC's position denies the role of the unions as collective bargaining representatives of their crafts. We represent the members. And the bargain is to reflect their priorities. And, again, I cited the ARASA versus Soo and UTU versus Grand Trunk decisions. Both held carriers and unions have a right under 2/3 to refuse national handling. And those decisions showed the carrier's position -- it has to be the exact same terms -- would negate a statutory right, and they have no viable answer to that.

The NCCC also argues that the union's proposal should be rejected as destabilizing to labor relations. Now, putting aside the many examples of different but equivalent that we have cited, the specific contention of the NCCC is internally inconsistent. The NCCC told this Board that the CBG unions found the 357 Plan absolutely unacceptable. Mr. Gradia put a slide up on the PowerPoint to show the CBG saying just that, but the NCCC is also saying,

"Well, the Board can't adopt the 357 Plan because the other unions will be angry and resentful at such an outcome."

Does the NCCC posit that they will suddenly change their minds on this? It can't simultaneously be that the 357 Plan is unacceptable to the other unions but they will be mad if BMWED and SMART-Mechanical succeed in their arguments for it.

As for the assertions that the differences will be upsetting to other rail workers, well, their unions rejected this proposal. So why would they be upset? And since Mr. Scofield said that the CBG deals were ratified with high percentage votes, even after BMWED publicly expressed its objections to its members and since Mr. Gradia said the CBG unions wrote to their members telling them not to be persuaded by what they heard from their coworkers in the BMWED, we can presume that the members of the CBG unions voted to ratify those agreements with the knowledge that the BMWED and SMART-Mechanical proposal was what it was and they chose the CBG deal. So why would they now be made that maintenance of way employees and sheet metal

workers got the 357 deal?

With regard to Mr. Glass' assertion that difference is only acceptable if there is an explicable reason, well, we don't agree, but, nonetheless, there is one. BMWED and SMART-Mechanical were willing to accept the risk of disruption, and the CBG unions and their members were not. The agreements will be different because BMWED and SMART-Mechanical sought something the other unions rejected. So we submit we have shown that pattern does indeed mean equal value.

Speaking of disruption, Mr. Scofield said there would be massive disruption under the 357 Plan, "Just look how many employees would be moving from UHC to Highmark." But that is not disruption. Disruption is a change in providers. If an employee walks into a doctor's office and there is a placard there on the desk that says they take Blue Cross/Blue Shield and UHC, then there is no disruption if the employee has been moved from UHC to Highmark or the other way around.

Employees don't have loyalty to these

insurance companies. Nobody grows up with insurance company pennants on their walls.

Regarding behavioral change and employee skin in the game, again, we are engaged in a collective bargaining exercise. Again, basically a division of earnings between the carriers and their employees over the term of an agreement while the carriers have an interest in the share of the cost, if the 357 Plan delivers equivalent cost savings, then that is the end of it. Making employees better healthcare consumers is not a cognizable interest here if we deliver the cost savings. The question here is, does the unions' proposal hit the target?

Likewise, the mainstream argument is, similarly, irrelevant. If the 357 Plan provides the same value as the pattern, the comparison to other industries is simply beside the point. And the carriers, again, are in no position to argue for comparison with other industries while they are arguing in courts challenging state laws in various states that laws that apply to employees generally cannot apply to railroad workers because compensation

and benefits are idiosyncratic in the railroad industry.

We have also demonstrated that the 357 Plan does indeed provide value equivalent to the CBG deal. And Cheiron has shown that the 357 Plan is projected to achieve savings similar to what is projected. And I want to say that again because they only have projections, too. And, in actuality, the savings will be greater.

Now, the NCCC says, “Well, and that’s just projections again. It’s just projections based on assumptions and experience.” Well, so is their proposal.

The testimony of Cheiron, Karen and Gaelle and Molly Loftus and Lindsey Martin from the consortium, showed that there is no force to the claim by the NCCC and its experts that the value of any savings while the 357 Plan will be eroded by the alleged network discount convergence. The reality has been that there has been no convergence and, actually, the Highmark difference has increased.

Mr. Scofield said there is no reason to trend

forward with what the consortium representative said. Well, why not? Everybody here is trending forward. That is what you do when you are beginning negotiating an agreement going forward.

And even Dr. Gaynor's statement shows that the Blue Cross/Blue Shield market has steadily -- share of the market has increased over the years. And since the NCCC witnesses recognize that discounts are driven by market share, the increased market share contradicts the assertion of discount convergence.

Now, Mr. Scofield has referred to the mysterious UHC network remediation, that you can't make sense of discounts from the documents provided by UHC. You have to work it out with UHC and go back and forth multiple times and read between the lines. And that is what the NCCC relies on. But this Board can't rely on Willis Towers Watson's forwarding inscrutable information from UnitedHealthcare.

Now, speaking of Dr. Gaynor, I repeat that speculating on the outcome of a lawsuit is just that. It is speculation. And when you are not actually a party, it is a fool's errand. And that is

particularly so here when the only source cited in Dr. Gaynor's paper about the supposed danger to Blue Cross/Blue Shield is in an article, a modern healthcare blog or something, or an article in there and it says -- and you can see this in the footnote. It is at page 11 and 16. That is the source for the danger to Blue Cross/Blue Shield. He didn't even say he read he briefs or the court decisions. His arguments on this litigation should be given no weight.

And, by the way, if what he speculates about does occur, there will be repercussions for the railroad industry plans regardless since Highmark is already a major component of the plan.

These criticisms are also true of the Willis Towers Watson claim of secret data that they have that nobody else has. Well, that is not a basis for a decision by the Board.

Mr. Scofield has said he gets three sets of discounts: executed, guaranteed, and projected. He said executed and guaranteed data he had were correct and the ones that Cheiron used there, but he prefers

projected, which, by the way, has to be manipulated. But executed is the most accurate and most conservative method. It doesn't have to be manipulated.

And we have shown that among the analysts, Willis Towers Watson is an outlier on the issue of discount convergence. He can say all he wants with all the certainty of everybody else in his firm he talks to, but that is just their firm.

I want to address the question of Cheiron's numbers changing over time. Now, the numbers changed as new data became available. Much of it was based on correspondence with UHC, and it needs to be recognized that data was trickled out to them and they got bits and pieces of this and that and had to ask for more over time. And the NCCC and Willis Towers Watson kept constantly saying, "Well, we disagree with you. So, you know, we don't get your explanation. So we had to go revisit that and redo it." It was like a moving target. The NCCC kept asking for recalculation on new data as the years went by. Remember, this went on for, what, two and a half years or so.

On the question of the guarantees and whether that is meaningful, we assert the 357 Plan is guaranteed by vendors by their putting 30 percent of their fees at risk. Now, there is no reason that the plans can't get discount guarantees based on the whole plan. And that won't be affected by whether BMWED and SMART-Mechanical members are being assigned to different insurance providers in different MSAs. The point is that discount guarantees are based on the book of business by MSA and not on the number of participants there.

And, frankly, a lot of this reflects the failure over the years to negotiate with the vendors for guarantees over that period of time. In essence, frankly, the NCCC seems rather -- you know, they would rather not negotiate with the vendors and providers to pay less. And, instead, they want to make the employees pay more.

Back to a comment by Dr. Gaynor for a moment. He and Mr. Scofield assert that the total cost, not discount, matters. This is addressed on page B-1 of Cheiron's presentation from Friday and page 51 of

today's PowerPoint, which show that the Uniform Data Standard Group does not think that is a significant issue.

Now, today Mr. Gaynor said, "Well, we haven't proved greater divergence because he questions the use of national data," but one thing is clear. We don't need to prove that the divergence is getting greater. They have to prove the convergence, which is not happening.

It is also not a problem that the BMWED/SMART-Mechanical groups are a subset of the whole national plan. The same is true for the NCCC proposal. We don't know what cost-saving measures will be the same for the BMWED and SMART-Mechanical as for the CBG unions, but, in any event, that is controlled by our use of the PQEPM measure.

Now, this takes us to the NCCC's assertion of factors supposedly undercutting savings from the 357 Plan based on implementation issues. I repeat that all of those assertions that are set forth in Mr. Scofield's statements, both his written statement, his PowerPoint yesterday, and his PowerPoint today, are

all secondhand from UnitedHealthcare. There is no witness here with firsthand knowledge to back it up. There isn't even a written statement to support it.

Mr. Scofield rattled off a bunch of names of people who he spoke to and says they are really great guys and smart and whatever, blah blah blah. None of them provided a statement under their own name to explain this or justify their self-serving assertions. No one is here today. No one them provided a statement. And Mr. Scofield merely reported what he says he was told by UnitedHealthcare. He didn't even opine that it was reasonable.

In this regard, I want to note the significance of the admission -- and Mr. Scofield's papers were not signed. It didn't have an actuarial certification. Mr. Scofield dismissed this as a concern, saying he is an actuary, so what is the difference. But signing a report like that with the necessary certification has significance. It bolsters credibility. It means it is an actual expert report to be given credence, not a mere witness opinion. And it is not just a matter of sitting there saying, "Oh,

I adopt my statement as an actuary" because for a certification to be meaningful, certain requirements have to be met, like the work shown, the backup provided. The explanation with data is provided in such a way that another actuary can validate the conclusion.

This is not the type of report that has been provided to you. For example, in a true actuary's report, he couldn't just throw in numbers given to him by UHC and rely on them for a conclusion.

In any event, there is no merit to the musings on these points. We have shown by the testimony from Cheiron and Tricia Grey that with an existing plan like this one, all of the known information and implementation can be done in 30 days. It is absurd to assert that it will take nine months to implement the unions' proposal. And there is no one here from UHC to explain why that time is actually required. What would cause it to be so long?

Willis Towers Watson says, "Well, they are built in. Six months of that nine is for a refresh of data." But why? What is the basis for saying that is

necessary?

Cheiron and Ms. Grey have shown that the claim of the implementation time is without basis in fact. And there is nothing you have been given on the other side to support that on which you can rely.

There is no need to set up a separate trust. Mr. Rifkind explained it is not necessary. Now, Mr. Scofield today said, “Well, we didn’t say you have to have one. We said it could be required.”

Well, you know, there is a sizeable law firm over here. If one were required, they could figure it out, not saying, “Well, maybe you might have to do it.”

I said in our opening the other asserted administrative cost claims are arbitrary and unsupported. No substantiation for those numbers has been provided to you. Again, no one from UHC produced to explain it. And Cheiron readily debunked all of those numbers. And today they went through them fully and explained them. And, again, Mr. Scofield said, “Well, those are based on conversations with UHC, which aren’t documented.” And, by the way, if UHC is

unclear on what they are doing and why, you can't rely on Mr. Scofield's conversation translating that to the Board.

And, again, there is no need to take time to sort the vendors into MSAs since Cheiron already did the sorting. And acceptance of our proposal will mean the sorting is done.

The NCCC objects that Cheiron's analysis is based on old data, but it is actually based on the contracts in effect through 2018. This data is more current than what the NCCC relied on for the changes in negotiating the CBG deal, which appears to be 2016 data trended forward.

We have also shown you today that the analysis could be done a different way, using guarantees. And the result is actually more in our favor, but Cheiron used the more conservative approach and more accurate approach.

Regarding the general differences between Cheiron and Willis Towers Watson, Willis Towers Watson, the basis for this is, first, really provided in the recent statements from Mr. Scofield. And he

said, “I really can’t account for this.” And he has got that big unknown number, which is, you know, the largest bulk of it. We have just never been able to sort that out.

Now, at the time we were negotiating the arbitration agreement for this proceeding, Mr. Arbitrator, we, the unions, proposed a meeting between Cheiron and Willis Towers Watson to reconcile their numbers. And the NCCC said, “No, that’s not necessary. Nothing will be gained there.” That is what they said. We made that a specific proposal to be part of that reconciliation, what happened before submissions were put in.

And this is the same answer we were given multiple times when we made -- said, “Let’s get together and reconcile the information.” One can say those are unknown, but there was no effort for them to be known.

And this characterizes all of the dealings on this. Rather than make an effort to engage, to come to a common understanding on the data, the NCCC has resisted, laid in the weeds, popped up, and made vague

challenges to the data, and then dismissed the entire effort.

By the way, with regard to the point of the wanted model, Willis Towers Watson model done with UHC and Mr. Scofield noted it was done with the healthcare consultant for the CBG unions. It should be noted that the consultant for the CBG unions is also from Mr. Scofield's firm, Willis Towers Watson.

We also submit there is no need for a true-up here because the value of the unions' proposal is equivalent to the NCCC proposal. And they have no authority that actually supports their position. And their position is belied by the last round.

PEB-243, where the UTU signed a deal in September of 2011 and the health plan changes were implemented for them on January 1, 2012, but the post-PEB agreements based on the PEB-243's reports, an acceptance of the UTU healthcare terms were implemented on a rolling basis, with the first changes implemented on July 1, 2012, 6 months later than the UTU deal. And it wasn't even fully implemented until sometime later. And there was no true-up provided for

in the PEB report or the agreements.

I also want to point out that the unions made an offer in December of 2017 to take the GWIs and the CBG deal but our 357 Plan. It is the same position we have here now. If that had been accepted by the NCCC then, we could be on our way to implementation. We could have started months ago with the process.

Now the carriers say, “Well, we will lose the gains by the loss of time in implementation based on the UHC timeline,” but the cause is on them. They can’t say they are prejudiced by delay when it is their delay. We could have had this deal in December and be on.

I repeat that there is no basis for a penalty here. The Board simply lacks jurisdiction to do that. The NCCC tried to claim that this is somehow complicit in question number 2 in the agreement. That is plainly a timing true-up question. And a penalty would be so extraordinary it would have to have been stated as an issue if it was part of the agreement as to the scope of the arbitration, not something unstated but inferred. The NCCC has cited nothing, no

prior case, no precedent, nothing to support their claim, just their frustration with the unions doing their job. Again, this is an interest arbitration board, not an adjudicator of bargaining conduct.

I won't repeat the other reasons why the NCCC has no basis for seeking the penalty, but the carriers are wrong in the characterization of BMWED's conduct in recent rounds, and they certainly lack clean hands in seeking a penalty based on their own conduct and the conduct of the corporations involved, I would add.

So, in conclusion, we submit that we have shown that on this small part of the overall agreement, this particular aspect of healthcare benefits, the unions' proposed cost savings for healthcare benefits are similar to those projected for the NCCC proposal. Since the value is similar, the Board should adopt the unions' proposal.

Thank you.

MR. VERNON: Thank you.

MR. MUNRO: Good afternoon, Mr. Chairman, members of the Board. To sum up our case, I am going to come back to the issues that I identified at the

outset of my opening statement. And it is perhaps ironic that this may be the only thing on which Rich and I agree, that the issues that this Board needs to decide or that it should consider are, what does pattern mean, are the proposals equal, and what about this true-up or penalty?

Nothing in the parties' presentations has changed the contours of those core issues, but in the interest of not just repeating my opening statement to you, I am going to vary the order of discussion.

So the first thing I am going to cover is the questions about equal value. I would like to summarize the problems with the 357 Plan and explain again, summarize all of the evidence you have heard as to why we believe it is not equal to the pattern.

Second, I am going to show you that the Board doesn't even need to decide that issue. It can simply conclude that pattern in the context of this case means the same terms.

And, finally, like Rich, I will address the true-up and penalty.

All right. So starting with equal value,

there is no debate that the pattern includes significant savings. What the carriers are proposing includes a large amount of money that is saved. But it is notable that we don't even agree on what exactly that number would be. Willis Towers Watson estimates it at $48 million with an implementation date of February 1st. Cheiron can't even match that number without manipulating the trend, which, as Mr. Scofield explains, is inappropriate and not how he calculated that number. So this points up the complexity and variability in the parties' approaches. We can't even agree on what the pattern is.

The bigger issue, however, is the value of the 357 Plan. And the simple answer here is that there is no way to say with any certainty what, if any, value the 357 Plan will provide. Why? Because at the end of the day, it is founded on assumptions, speculation, and guesswork. Hope, Mr. Chairman, is not a strategy. And that is what they have got because their whole case depends on their hope about what will happen.

As Willis Towers Watson explains, there is a

whole lot of things that have to go right for there to be any savings and that there is a very high likelihood there will be no savings at all. Let me stress this. We don't agree that the 357 Plan necessarily represents any value at all. Think about all of the moving parts that have to fall into place.

First, there actually have to be discounts out there for us to capture. Now, they are using 2015 data. It is three years later. Now, they say that it is the same, but we disagree. We think the markets have moved. And Dr. Gaynor explained this. He said there is massive uncertainty out there about where discounts are going. And it is speculation, pure speculation, to say that the discounts are the same today. That is the point of the Blue Cross/Blue Shield litigation. It is just an example of the kinds of things that are going out there in the marketplace that undermine their assumption.

Even their own witnesses admit this. Dawn Fairhurst's statement is that there will be "some convergence over the next five years." It is at page 20 of the Cheiron rebuttal. Their witnesses testified

discounts are constantly changing. Well, that is true, and that is the problem.

Second, the discount differential has to be meaningful. As Mr. Scofield explained, if the discounts are just within 1 or 2 percent of one another, we are within the margin of error and there is reason to doubt that there is any benefit to doing this at all. That is true for many of the MSAs.

Third, you have this debate about these other costs. I think we agree that there are other cost drivers beyond discounts. I mean, that is obvious. So just because there is a greater discount does not mean that there is a guarantee of savings. That was Dr. Gaynor's point about the difference between price and discount.

All right. Then we come to implementation. And this is a big one. Their argument, as I understand it, is, "It is easy. There is no problem here. We will get it done in 30 days. No worries." Cheiron said, "We are pretty sure they can do it in 30 days."

Well, when has any insurance company ever

done anything in 30 days? My insurer can't even deny my claim in 30 days. And they have gone lots of practice. To expect them to do something on this scale and to actually get it right is foolish.

Moreover, they are ignoring the biggest piece of the puzzle: UHC. Now, to quote Casablanca, we are shocked, shocked, that Highmark says that they can take on lots of new business and make lots of new money within 30 days. But it doesn't matter. That is not the issue.

The issue is, before that happens, we have to extract the information from UHC. And the only evidence before this Board is that that is not going to happen. It is not going to happen on the timeframe that they suggest. They criticize our evidence as hearsay. Well, they have nothing, nothing on the other side.

The bottom line is this. The 357 Plan is this Rube Goldberg device. It has lots of moving parts. It has lots of complicated details. And if any piece of it goes wrong, it doesn't work.

And, just to put a point on this, the unions

couldn’t even describe the 357 Plan accurately the first time around. Their initial statement only had 213 MSAs in it, not 357. And I am not saying this to highlight the fact that they made a mistake but to point up that there are lots of things that can go wrong when you are talking about something of this complexity. There is lots of details. There is a lot we disagree about. But, more importantly, there is a vast amount of uncertainty and speculation behind their proposal.

And what happens if things do go wrong? What happens if the discounts aren’t there or they fade over time or the fee estimates turn out to be wrong? Well, I will tell you what happens. We get screwed, to use the technical legal term. In other words, the carriers bear all of the risk. They want us to pay 94 percent of plan costs and just hope that these vendor discounts actually come through.

Cheiron sure isn’t guaranteeing anything. They don’t have anything on the line here. If they are wrong, so what? Tough luck. They say, “Well, these discounts are guaranteed. No worries. The

vendors have all of the risk." Well, that misses the point because that assumes that the discounts are in place, that the 357 Plan has been implemented. And, as you have heard from Mr. Scofield and our other witnesses, there is a whole lot that has to happen before that occurs.

So how big is the risk? Do you want to take my word for it? Do you want to take Rich's word for it? You know, we disagree. Well, the biggest objective indicator out there of how much risk is associated with this is the fact that no one else is buying this gimmick. Cheiron said yesterday, "We are baffled as to why the carriers won't do this. We are baffled as to why none of the other unions would come along." Is it because we hate saving money? Is it because we hate our employees and just want to make them pay more? No. It is because no one believes it will work.

These are sophisticated parties, Mr. Chairman. The CBG unions, they are not dummies. They don't tend to shy away from saving money for their members when it is available. But this, there are

just not sufficient guarantees it is going to work. No one believes them. The only people who believe in the 357 Plan are sitting on this side of the room in the entire railroad industry.

The other aspect where these proposals are not equal is the impact on utilization. As I said yesterday, it is undisputed that the plan produces change in utilization and the 357 Plan does not.

Now, Mr. Roth asked yesterday -- and I don't know that he ever got a clear answer -- "What is the dollar value of behavioral change?" The Willis Towers Watson expert report addresses that. This is exhibit 25, page 14. Mr. Scofield explains that the dollar value of behavioral change is about 15 percent of the value of cost shifting. He says the standard that they used based on his experience and what they have actually seen is 30 percent, but to be conservative, they are using 15. And that works out to the $9 per employee per month.

Now, they don't debate that. They don't deny it. They don't have contrary data. They don't have their own study. They have no response to Dr.

Goldman. They haven't done their own analysis of what happened after 243. They don't deny that utilization can have a dollar value beyond cost shifting. Their only argument on rebuttal this morning was, "Well, Medicare doesn't do it that way."

And, by the way, people don't know how to get their own care. They can't figure this out.

Well, Mr. Chairman, as you may recall, they made those arguments before PEB-243. They made the pitch that utilization doesn't justify shifting costs. And PEB-243 rejected that argument, thoroughly rejected it. And this Board should as well.

They also say, "Well, we have a philosophical difference about this." Well, even if you feel strongly that you are right, that is not a basis for departing from the pattern. Strong feelings and philosophical differences are not a basis for a decision.

Another point about equal value, they overlook the fact that we already have methods to capture discounts. You heard the testimony from the carriers' witnesses that we already seek discounts.

There is a complex ongoing negotiation. This is not 27 years of doing nothing. So they want to take something that we already have and sell it back to us. I'm sorry, but that is not equal value. And it doesn't matter how you define the concept.

If they want to implement the pattern and then come and have a mutual discussion about how we could work together to improve discounts, we are happy to have that conversation with them. But to say that that should be the sum and substance of healthcare change in this round is simply not going to work.

One minor point on this idea of disruption. My counterpart made the argument that there is no loyalty to insurers. And, actually, I think I agree with that, but I think it is notable, as Mr. Scofield explained, that you have this huge population that can already elect Highmark, but the vast majority of them do not. It is less than 25 percent of our employees voluntarily choose the organization that they want to force everybody to accept. That is odd at least.

Now, finally, I think it is a measure of the lack of force to their case that they resort to an

attack on the credibility of Mr. Scofield. They have made a big deal about the fact that his report is unsigned.

Look, the Board can weigh credibility. That is what boards of arbitration do. But let me just say that, aside from however you may feel about Mr. Scofield and whether he is honest and credible in his statements, I can't make heads or tails of what Cheiron is saying. They have got the fancy statement at the end of their report. Well, where do they get their data? Where are the spreadsheets that they rely on? I can't find them. What is the exact source of the $25 million difference they claim? They needed to look to their own report before they throw rocks at Dave Scofield.

One other thing that Cheiron does is make an unbelievably weak response to the benchmarking case. They actually compared us to transit systems. Now, that is just silly. Transit systems are not railroads. It is not the same industry at all. Those are government or quasi-governmental entities. They are subject to their own statutory bargaining regimes.

And Mr. Roth and I just spent weeks doing this for WMATA. Nobody argued in the Metro case that railroads are the appropriate comparison. In fact, Mr. Roth argued vigorously that transits are their own industry and can't be compared to anybody else.

Now, I don't agree with Mr. Edelman's comments that you can't benchmark to any other industry. I do think that, given the pattern in this case, this is just a sideshow. But, in any event, Cheiron's effort in this regard is unpersuasive, to say the least.

All right. So does the Board actually need to decide all of this? Do you need to weigh all of these factors and decide whether the proposals are equal or not? No. No. You do not. The Board could and should decide that the pattern here is the same plan design because the parties have not agreed on an alternative. In other words, the rule, the rule to be applied, is in the absence of an agreement to vary terms, pattern should be the same terms agreed to by the settling unions, which, by the way, is the same value. By definition, the same terms have the same

value. Why is that the rule? Well, again, it is inherent in the pattern principle itself.

Look, there is endless room to debate moving value around. Unless you have a default, what is going to happen if we can't agree to move the furniture? Then the pattern principle is worthless.

Now, Rich said, "We don't get it. We don't get it. If you don't use the same terms, so what because there is not going to be any impact at all?" But this a recipe for endless disputes, as this proceeding itself shows. Why wouldn't every union hold out for its preferred rearrangement of value?

So to reinforce the pattern, the Board should hold that the pattern plan design should be applied so long as the parties can agree on what equivalent terms are and there is no need to translate value across craft lines.

The unions had two responses to my argument on this point. It is a little unclear whether they are accepting the pattern concept or not. I think I heard Rich say they accept the primacy of pattern, but at the same time, he is citing you these 6th and 8th

Circuit cases for the proposition that pattern undermines their ability to bargain. The 6th and 8th Circuit cases have nothing to do with this. Those cases involve the question of whether an entity can be forced to join a coalition and bargain with others. Can a railroad be forced to join other railroads? Can a union be forced to join other unions? And the court said, “No. That has nothing to do with this case.”

Their other response was Mr. Roth’s supplemental statement in which he says, “Well, you are just discounting voluntary agreements, and that is silly. Why would you possibly do that?” Well, they are setting up a straw man here. We are not arguing that you discount voluntary agreements. He is conflating two entirely different concepts. Voluntary agreements can set a pattern. Of course, they do. They set a pattern in this case. The CBG deal is a voluntary deal. That is not the question. The question is, in the absence of a voluntary agreement with the non-settling unions, what does an interest arbitration panel do? Does it accept one side’s view of equivalence or does it take the pattern terms which

are unequivocally equal and use those?

They don't cite one example, not one, of an interest arbitration panel imposing different but equal in a situation where the parties haven't agreed to it. Now, why is this important? Well, in part, because, as Mr. Glass explained, it is not just the carriers' perspective that matters. It is also the settling employees' perspective, the people who aren't in this room.

I made this same point to PEB-243 about the UTU when these same unions were making a similar argument about how the Board should depart from pattern. I said then, and I will say it again, put yourself in the shoes of a trainman or a conductor who settled back in January. Do you think that individual thinks that the 357 Plan is the pattern?

Mr. Edelman says, "Who cares? They didn't want it." But the track repairman that President Simpson talked about has a deductible now under their approach that is $150 less than the trainman. So, of course, they care.

Moreover, how do you think this will play out

in the next round of bargaining? The 357 Plan is imposed, and their benefits are different. They are paying less for healthcare.

What are the other unions going to say when we come around to the 2020 round? Is it possible that they will say, “We want to go back to the old plan design”? I think it is fairly likely that they will say that.

And I think the unions’ response would be “Well, fine. You can just get more discounts.” Are those discounts going to be available then? This is so speculative and introduces so much uncertainty that unless the parties are agreeable to it, it can’t be adopted.

Now, they have no response to the employee-perspective argument except for this one argument that Mr. Roth where he said, “Not to worry. We have had a history of differing contributions. Happens all of the time. People pay different amounts for healthcare.” Well, not anymore. Not anymore. Those contributions have been equalized through collective bargaining. What does that tell you? It tells you

the parties clearly did view those differences as problematic. And otherwise they wouldn't have changed them.

Well, that brings me to the final question, the true-up and the penalty. Now, you know, at some point here, we are just chasing our tails because of the different definitions of what the pattern is and equivalent value, but if you don't accept the notion that the 357 Plan is equivalent value or you accept the proposition that a pattern means the same terms, then a true-up has to be part of the package because the true-up is the pattern. The implementation date itself is part of the pattern. That is true when you have retro pay, and it is just equally true when you have plan savings.

Would these unions be okay if our position was that retro pay should be delayed pending arbitration? I don't think so. Well, the same is true here.

So we heard, "Well, there is no support for this because you haven't had a true-up every other time that there has been some delay. Look at the 2011

round. Look at what happened about PEB-243."

Well, this just brings me back to one of my basic themes. Of course, the parties can agree to forego a true-up. That happens all of the time. There are tradeoffs in collective bargaining.

Maybe the carriers forewent a true-up after 243 because they had other goals, other things that they wanted. But in the absence of an agreement in the situation that we have here today, where the pattern is imposed, it is certainly appropriate to incorporate the implementation date as part of the answer. And that is certainly true when the unions can evade cost savings by simply dragging this out.

And to this point, I have to contest the characterization that we heard yesterday and this afternoon that the timing of all of this is the carriers' fault. As the Board may recall, we advocated for a much earlier hearing date. We were told no. But, in any event, we are the ones who are losing money every day unless the Board awards a true-up.

As for the penalty, how else do we prevent

this from happening? I am open to suggestions. The IBB, which reached a voluntary agreement, took a true-up back to January 1st. Well, if that is so, why should these unions, which held out, do any better?

Ken suggested that the appropriate penalty is the CBG implementation date. That is an adjustment for delay. That is within the Board's jurisdiction. That is part of question 2. And it is eminently appropriate.

Finally, let me take a step back and just review the issues here from a 30,000-foot level. Ultimately, there is a choice here between two different approaches. One is a plan design approach that we have used in the past and has proven to work. They say, "Well, your plan design element is speculative." No, it is not. It worked after 243, and it is working right now. As we speak, there are savings derived from the current plan design that applies to the CBG and TCU unions.

The other option is the 357 Plan, which is an unproven, risky gambit, which does nothing to improve utilization. So even if there were no pattern at all,

even if there were no other considerations, the carriers' proposal is the common-sense option. Now, common sense is perhaps underrated in this day and age, but I think it is still a good basis for decision.

In conclusion, Mr. Chairman, I would like to thank opposing counsel for his usual professionalism and courtesy. I do enjoy our time together, Rich. I will refrain from telling the story about how Rich, Bill Bonn, and I ended up at a bar called Woody's in Laguna Beach.

(Laughter.)

MR. MUNRO: Maybe in the bar later.

And I would also like to extend my appreciation to Don Griffin on his retirement. He has also been a pleasure to work with.

And, finally but certainly not last, I would like to acknowledge, just as Rich did in his opening remarks, my dear friend and mentor, who is also stepping down at the end of this proceeding, the general counsel of the NRLC, Joanna Moorhead, whom I love dearly. And I wish her well in her retirement.

MR. VERNON: Well, thank you. And may I say a couple of things? Best of luck to everyone who is pulling the pin.

(Laughter.)

MR. VERNON: I wish I had the fortitude to do it, but I am plugging away. And for those of you who don't know me, I came out of this industry. My seniority date as a crew dispatcher or a crew caller was February 13th, 1973. And so I have been in this industry since then.

I am proud to have come from it, and I have had the good fortune to work with you and work with many parties throughout this country. And perhaps it is a matter of family pride being a railroader, but I don't know if you realize how good you are. You are in the middle of a dispute. And marriages, they say, aren't measured by how good you are when you are good. They are measured by how good you are when you are bad. And that is a way of saying I appreciate very much you agreeing to disagree agreeably. Not everybody is fortunate enough to have the professionals from top to bottom, from Ken Gradia to

the track worker, who are professional and part of a family and can duke it out, shake hands, and walk away for the better good. So thank you, everyone.

And that concludes our hearing.

(Whereupon, at 3:00 p.m., the proceeding was concluded.)

CERTIFICATE OF NOTARY PUBLIC

I, SAMUEL HONIG, the officer before whom the foregoing proceeding was taken, do hereby certify that the proceedings were recorded by me and thereafter reduced to typewriting under my direction; that said proceedings are a true and accurate record to the best of my knowledge, skills, and ability; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

SAMUEL HONIG
Notary Public in and for the
Commonwealth of Virginia

CERTIFICATE OF TRANSCRIBER

I, SARAH VEACH, do hereby certify that this transcript was prepared from audio to the best of my ability.

I am neither counsel for, related to, nor employed by any of the parties to this action, nor financially or otherwise interested in the outcome of this action.

May 10, 2018

DATE SARAH VEACH

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